COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON--COMMISSIONER

October 23, 2008

Appearances:

Bernard Coffey, Q.C. . . . . Commission Co-counsel
Sandra Chaytor, Q.C. . . . . Commission Co-counsel

Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL

Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al

Daniel Simmons . . . . . Eastern Regional Integrated
. . . . . Health Authority

Pam Taylor.. . . . . Members of the Breast Cancer
. . . . . Testing Class Action

Mark Pike, Q.C. . . . . NL Medical Association
Jennifer Newbury . . . . . Canadian Cancer Society (NL Division)
Blair Pritchett. . . . . Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

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LIST OF EXHIBITS

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THE COMMISSIONER:
Q. Please be seated. Mr. Coffey?
COFFEY, Q.C.:
Q. Thank you, Commissioner. The two witnesses this morning, Commissioner, are Donald MacDonald and I'll refer to him as Dr. Reza, can't pronounce your last name, Doctor, in any case.
DR. ALAGHEHBANDAN:
A. Sure.
THE COMMISSIONER:
Q. We have a small technical problem which we'll resolve here with the chairs, okay.
MR. DONALD MACDONALD, SWORN
REGISTRAR:
Q. Would you please state and spell your complete name for the Commission?
DR. MACDONALD:
A. Donald Morgan MacDonald, D-O-N-A-L-D M-O-R-G-A-N M-A-C-D-O-N-A-L-D.
REGISTRAR:
Q. Thank you.
DR. REZA ALAGHEHBANDAN, SWORN
REGISTRAR:
Q. Would you please state and spell your name for

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the Commission?
DR. ALAGHEHBANDAN:
A. Sure. Reza Alaghehbandan, R-E-Z-A A-L-A-G-H-E-H-B-A-N-D-A-N.
REGISTRAR:
Q. Thank you.
DR. ALAGHEHBANDAN:
A. You're welcome.
EXAMINATION BY BERNARD COFFEY, Q.C.
COFFEY, Q.C.:
Q. Commissioner, there are some new exhibits, if I could, please?
THE COMMISSIONER:
Q. Yes.
COFFEY, Q.C.:
Q. They are Exhibits P-3472 and then 3485 through, just want to get this right, 3556 inclusive.
THE COMMISSIONER:
Q. Entered.
EXHIBIT ENTERED AND MARKED P-3472
EXHIBITS ENTERED AND MARKED P-3485 THROUGH P-3556
COFFEY, Q.C.:
Q. Then there are 3560, 3561, 3562 and 3563 and 3564

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THE COMMISSIONER:
Q. Entered.
EXHIBITS ENTERED AND MARKED P-3560 THROUGH P-3564
COFFEY, Q.C.:
Q. Thank you, Commissioner. Now I'm going to start with--and as I've indicated, I'm going to call you Dr. Reza. Dr. Reza, I understand that you are a--you're qualified as a medical physician and you are employed where?
DR. ALAGHEHBANDAN:
A. I was employed with Centre for Health Information since 2004.
COFFEY, Q.C.:
Q. And what is your--what are you employed as? What do you do for them?
DR. ALAGHEHBANDAN:
A. My position title is Medical Research Associate and basically I'm responsible for leading and coordinating projects, research projects, and supervising junior staff and knowledge transfer exchange through attending conferences, preparing manuscripts for peer reviewed publications journals and ensuring the quality, the confidentiality, privacy of the data that we maintain at the Centre.

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COFFEY, Q.C.:
Q. And Mr. MacDonald, could you give the Commissioner and overview of your background and your current position?
DR. MACDONALD:
A. I started off back in the early '80s as a policy analyst with the Department of Health and Community Services, moved in 1997 to the Centre for Health Information as an information consultant. In 2000, I became the director, which is my current position, of research and evaluation. From an education perspective, I have a diploma in electrical technology, clinical epidemiology, undergraduate degree in mathematics and statistics, a Masters in science and a PhD in science. My research expertise or area is around the benefits of technology in health care.
COFFEY, Q.C.:
Q. And in relation to the Masters, at that level, the aspect of the benefits of technology in health care was what, what particular aspect?
DR. MACDONALD:
A. Pharmacy.

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COFFEY, Q.C.:
Q. Pharmacy at the time, and your PhD?
DR. MACDONALD:
A. And my PhD was focused in on radiology.
COFFEY, Q.C.:
Q. And in terms of your involvement with academia, I take it that you, in fact, have continued your formal education, at least on a part-time basis, up until this year when you received your PhD?
DR. MACDONALD:
A. Yes, only recently convocated, only a couple of weeks ago.
COFFEY, Q.C.:
Q. Now I take it, Mr. MacDonald, are you Dr. Reza's boss?
DR. MACDONALD:
A. We're colleagues.
COFFEY, Q.C.:
Q. Colleagues, okay.
DR. MACDONALD:
A. But yes, in the hierarchy of the Department, I suppose I would be.
COFFEY, Q.C.:
Q. Could you tell us, please, you're the

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Director?
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. Of the?
DR. MACDONALD:
A. Research and evaluation department.
COFFEY, Q.C.:
Q. And what is it that--and referred to now, I take it, as NLCHI?
DR. MACDONALD:
A. The Centre.
COFFEY, Q.C.:
Q. The Centre, okay. Newfoundland and Labrador Centre for -
DR. MACDONALD:
A. For Health Information.
COFFEY, Q.C.:
Q. And what was its name before that or has it always been called that?
DR. MACDONALD:
A. It's always been the Centre for Health Information, yes.
COFFEY, Q.C.:
Q. And is it part of any government entity? I

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mean, I take it it's a government agency?
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. Is it part of -
DR. MACDONALD:
A. It's an agency of the Crown. We had existed actually since 1997, but we were on the auspices of the former St. John's Health Care Corporation and then after that, Eastern Health, from an administrative purpose. Recently, about a year and a half ago, we have our own legislation. We now are an agency of the Crown with our own Board of Directors. Our Board of Directors are appointed by Cabinet and we're overseen by the Ministry of Health.
COFFEY, Q.C.:
Q. And in relation to that, when was that? That occurred when?
DR. MACDONALD:
A. Our legislation?
COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:

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A. I believe it was April 1997.
COFFEY, Q.C.:
Q. And in terms of the most recent change you referred to? You say at one time you worked with the Health Care Corporation.
DR. MACDONALD:
A. Oh, when we got our own legislation, we formally--like we were not a legal entity, I would suspect.
COFFEY, Q.C.:
Q. I'm sorry, it was -
DR. MACDONALD:
A. April 2007.
COFFEY, Q.C.:
Q. April, that's what I was getting at, okay.
DR. MACDONALD:
A. Okay.
COFFEY, Q.C.:
Q. Because you had said 1997 and -
DR. MACDONALD:
A. Oh, sorry.
COFFEY, Q.C.:
Q. - and you said the original--it was originally set up in '97.
DR. MACDONALD:

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A. We were actually established in 19--became operational in 1997, but got our own legislation in 2007.
COFFEY, Q.C.:
Q. Yes, and as of April 1, 2007, you were legislatively a stand-alone Crown agency?
DR. MACDONALD:
A. Crown agency, yes.
COFFEY, Q.C.:
Q. With the structure you referred to.
DR. MACDONALD:
A. With our own Board of Directors.
COFFEY, Q.C.:
Q. So I just wanted to, in terms of that, so the Commissioner understands, since that date, you are not part of Eastern Health?
DR. MACDONALD:
A. No.
COFFEY, Q.C.:
Q. And you don't report to Eastern Health?
DR. MACDONALD:
A. And that was more from an administrative side. Like, for example, just the logistics of payroll, purchasing. As a new entity, we didn't have those resources, so Eastern Health

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provided them for us. But other than that, we were, you know, in a sense a stand-alone agency still, just without legislation.

COFFEY, Q.C.:

Q. Before the -

DR. MACDONALD:

A. Before April -

COFFEY, Q.C.:

Q. Before April 1st, 2007.

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. But since that time, you've been a stand-alone agency?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Now Mr. MacDonald, could you tell the Commissioner, please, about--I take it that--well, I'll refer to you as NLCHI because I appreciate you might call yourself the Centre, but in this context, you've been pretty well uniformly referred to as NLCHI.

DR. MACDONALD:

A. Yes, understand.

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COFFEY, Q.C.:

Q. Can you tell the Commissioner, please, about, from your perspective, how NLCHI got involved in this?

DR. MACDONALD:

A. That would have occurred back in June 2007 and what actually happened, I was forwarded an e-mail from my CEO, from Robert Thompson, requesting help from the Centre to answer some questions around the creation of a database that could support the Commission of Inquiry and also the Task Force in their work with respect to patients that had been tested for ER/PR. Subsequent to that, we put together a small team and started to speak to some people at Eastern Health as to what the actual issue was, because to be quite honest, I never knew what an ER/PR was until some of these initial meetings, and we formulated what we figured would be a good approach to answering some of these initial questions from Robert Thompson.

COFFEY, Q.C.:

Q. And do you recall, in a general way, what your initial impression was, in terms of what the questions were and how involved it might be initially?

DR. MACDONALD:

A. Well, initially, as I said, we were very naive actually to what the issue was. Until we actually--it was months later when we actually started to get a handle on things, so no, it was a very complex undertaking. It took us a number of months even to understand what was required and what we would have to do. So I think in our initial stages, we were somewhat overzealous, I would say, in reporting to Government how long it might take to answer some of their questions.

COFFEY, Q.C.:

Q. As it turns out, the estimates of the time frame that it might take to answer the questions posed, you were overly optimistic?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Based upon a lack of knowledge about the underlying problems, which we're going to speak about.

DR. MACDONALD:

A. Yes, that's a fair statement.

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COFFEY, Q.C.:

Q. If we could, please, Registrar, Exhibit P-3485? This is just--if we could, please, yes, this is just an e-mail. Kind of going to pick up the trail, as it were, the beginning of July 2007, and there's an e-mail from Heather Predham, Mr. MacDonald, to yourself. I apologize, not July--well, in fact, the trail begins here in June. Well, you had sent an e-mail, I don't have the body, the rest of it here, but to her back on June 16th and "been reviewing the summary provided by Bev. Is this summary accurate?" and Bev would be who?

DR. MACDONALD:

A. That would be Bev Griffiths of the Department of Health and Community Services.

COFFEY, Q.C.:

Q. Department of Health. So you were getting information from them?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Initially. And then Ms. Predham is saying, two days later, in her response "I think it's pretty much accurate. I do have some changes

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as outlined below. I don't know how important they are to you," and she begins to talk about then some changes. The first bullet, fifth bullet, and "there are a few more changes that I have to follow up with Bev, but it's only clarification of wording. If you want to know, I can tell you, but it's not a really factual information." Now then you forwarded that on, on July 4th, to Dr. Reza.

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Now sir, I take it this would be early days, as it were, mid June, early--certainly mid June, early days in this?

DR. MACDONALD:

A. Yes, that would have been probably following our first meeting.

COFFEY, Q.C.:

Q. If we could look, please, at Exhibit P-3563? This is a document dated July 6th, 2007. It's entitled "Estrogen and Progesterone Receptor, ER/PR, Breast Cancer Testing Communication Event Database, Scoping document" submitted by the Research and Evaluation Department, NLCHI,

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July 6th '07. And Mr. MacDonald, what was this document?

DR. MACDONALD:

A. Following some initial meetings with Eastern and also with the Department of Health and Community Services, we were asked by the Department to put together a plan how we would approach the creation of such database and to outline any options which we feel may be relevant to the task.

COFFEY, Q.C.:

Q. And here, just to give the Commissioner some sense of the way, at least, this started out. There's a description here at the very beginning on page two of what ER/PR testing involves, and a very brief summary of it, and the second paragraph says "given the need to identify all patients who received ER/PR breast cancer testing at Eastern Health from 1997 to 2005 and to document relevant communication events following testing, staff of NLCHI met with the representatives of Eastern Health and the Department of Health on June 14th to discuss a framework for the database management process. The database

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would focus on when and how patients were contacted to inform them of the retesting, as well as when and how patients were informed of the subsequent test results. It is recognized that the database must establish the source of supporting documentation for any core fields included in the database. The database is to contain, but not be limited to the following core fields" and there is a listing of 12 of them.

And it continues on, "following subsequent meetings with Eastern Health officials and a preliminary review of available documents, it was recognized that the development of the database would be a complex undertaking involving a number of patient lists and data sources created by various agencies and individuals. While the number of sources adds to the complexity, they also provide a valuable tool for verification and quality checks. There are two main phases to the development of the database. One, identifying all patients diagnosed with breast cancer that had ER/PR testing carried out at Eastern Health; and two, provide all relevant

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communication event dates for patients tested at Eastern Health. The Centre proposes the following three options for creating a database of patient interventions and communications specific to Eastern Health's ER/PR breast cancer testing." And then there are options here. Phase one, options A, B, C, and then in particular, Option C has a number of steps.

Now, Dr. Reza, I understand that you were involved in kind of the nitty gritty of dealing with Eastern Health initially?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And as time went on?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. Could you tell the Commissioner, please, what you found in June and early July when you first got involved and kind of your sense of the challenges, as it were, that you faced?

DR. ALAGHEHBANDAN:

A. I guess the first thing I was trying to

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understand was what the issue is, and what is the magnitude of this issue and what are the components of the matter, so we could understand it before going and proposing a protocol to develop the database. So we met with Eastern Health officials and tried to gather some information and that information came to be quite useful to us in creating the scoping document and we proposed three options here, and we took it from here. At the time, the major challenge we learned was the fact that there are a number of sources that we had to consider before creating a database and that's why we proposed the options based on multiple sources, and we indicated in the scoping document that this undertaking is going to be not an easy task. It's going to be a complex initiative.

COFFEY, Q.C.:

Q. And why was it going to be complex?

DR. ALAGHEHBANDAN:

A. Because matter of fact is that you are going to bring together multiple sources from different parties and reconcile them, and that task is not always easy, and we learned early

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days that they were not in consistent formattings and that was the first and main point for us, that we had to standardize them. We had to basically in uniform format, make them look like each other, so be able to link and merge them and cross reference them.

COFFEY, Q.C.:

Q. When you say different source documents when you first got involved were in different formats, I take it some of them were in electronic format?

DR. ALAGHEHBANDAN:

A. That's right, some electronic, some hard copies, e-mail communications, notations, and notes. So different formattings.

COFFEY, Q.C.:

Q. And were they all in one centralized location though?

DR. ALAGHEHBANDAN:

A. That was another challenge. No, they were not actually. So we had to gather them from different places, different departments, different regions, and that was another challenge. It wasn't centralized.

COFFEY, Q.C.:

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Q. And were they even all located within Newfoundland Labrador or were some of them -

DR. ALAGHEHBANDAN:

A. No, one of the main sources that we were going to consider for creating the database was the Mount Sinai information about retesting results for all the patients who had been sent to Mount Sinai. So it was this source out of the province actually.

COFFEY, Q.C.:

Q. Now in relation to this matter then, I'm going to take you through then how, from your perspective, NLCHI's perspective, this unfolded. But Mr. MacDonald, I wanted to ask you first, so the Commissioner has some context to this, okay, the idea of information management as opposed to data creation or management, is there a difference?

DR. MACDONALD:

A. Yes, that's a good point. There is a distinct difference. The terms, there's various terms that are used. Information management is one term and database management, and they are two distinct activities. Database management is really the infrastructure put in place to

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support a business activity, okay. Information management is taking the data created in the database and creating information. I'll give you an example. If I sent around a piece of paper here today and asked everyone to put their age and gender down on it, and everyone did, and you presented it to the Commissioner, what would that be? Not a lot. It would be a bunch of numbers and letters, M and F's. That would be database management, okay, the activity of actually creating the data.

Information management would be taking that and saying the average age of females in the room is this, and the average age of males in the room is that, and then -

THE COMMISSIONER:

Q. The first being 29.

COFFEY, Q.C.:

Q. Certainly no more.

DR. MACDONALD:

A. And so that would be creating information from data, okay. So that's information management. Two distinct skill sets, two distinct areas of expertise. One, in the database management

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side, what we're talking about is--and I'm not an IT person, so please excuse, all my colleagues in that area, but we're talking about computers, technology, security, these types of things. So it's actually a physical creation of an entity that can store, collect and store data. The information management side then would take that as a tool to support the business of the organization.

I'm a strong advocate that there is a relationship between the two, but really--in my department, for example, all my colleagues, there's 27 researchers in the research and evaluation department. None of them are IT people.

COFFEY, Q.C.:

Q. What do you use for IT support?

DR. MACDONALD:

A. Well, I suppose, a big part of the infrastructure you would require for database management is a lot of the communication pieces. So for example, in research, we don't need to communicate between databases as such. Reza just spoke eloquently to the dispersion of data across the province and even in Mount

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Sinai that we had to bring together to create one database, but the database that we have at the Centre for Health Information, our ER/PR event communication database, does not talk to any other database. We don't need that additional infrastructure. So we actually have it in a package called Statistical Package for the Social Science, SPSS. That's a store-bought product. So we didn't need any database management IT/expertise because we just bought that from the store and created the database within it. So there is--there's more to the database management side than just creating the infrastructure for the data. There's a communication side to it. As I said, security is a big thing. It's creating information from data that is key to running the business of any entity.

THE COMMISSIONER:

Q. Mr. MacDonald, I'm not sure--I'm sorry, I got a chicken and egg problem here, in the sense of it seems to me that logically one would be interested in first determining what information you want and need.

DR. MACDONALD:

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A. Yes.

THE COMMISSIONER:

Q. And then going to look at what database is appropriate for supporting the information you need. Have I got the order of things right or should it go the other way?

DR. MACDONALD:

A. No, that's a good point, and you're correct. The activity of defining your business is left up to the organization, and at that point, IT does not come into play, into defining your business. Once you, as an entity, have defined your business, then you bring in the IT people to say "can you build the infrastructure to support my business?"

THE COMMISSIONER:

Q. So in my other life, I had occasion to be involved in the development of a product which was going to assist us in keeping records, which was very useful exercise actually because it forced us to examine every record we keep, why we keep it, and in effect, gave us an opportunity to determine whether or not it had any useful information any more, whether we really wanted to have that kind of

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information, and whether there were other kinds of information that was involved, and all of that had to be done before the IT people were in the position to be able to develop the tool to enable us to get the information out. So that's the kind of division that I'm thinking about.

DR. MACDONALD:

A. Yes.

THE COMMISSIONER:

Q. And is that right?

DR. MACDONALD:

A. And that is correct.

THE COMMISSIONER:

Q. So that if you really wanted to get into information management in the organization, that's a big investment in time and energy in terms of figuring out exactly what you do and what you want to do, isn't it?

DR. MACDONALD:

A. That's correct. You know, it's taken us many years, eight years to build capacity at the Centre for Health Information to support information management activities and we do that in support of policy. Obviously, we're

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doing it in collaboration with Eastern Health and the task force and the government in developing this database. There is not much expertise for capacity in this province around information management. We have database management capability. An example, of course, is the development of the electronic health record in our province. Even though those skillsets are hard to find, we do have somewhat capacity around that area. There was little information management capacity in this province until the centre was established in 1997. It's taken us almost a decade to get where we are now because we've had to home grow these people. It's difficult to put an ad in the paper to look for an information panellist. You will get a wide variety of applicants to that because really our university doesn't produce graduates that have the expertise to do what we do, which is the secondary use of administrative data, information management, these types of activities, but to ultimately get to the point where you have the best of both worlds is the marriage of the database management with the

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information management, but I have to be clear, it's the information management side which defines the business rules. The technology just comes in to support that. They should not be involved in defining your business.

THE COMMISSIONER:

Q. So having the technology side walk through the door and say you can't do that because our program doesn't allow you to do it is not right, you should be saying I want the program that allows us to do whatever it is we want to do, is that the -

DR. MACDONALD:

A. Yeah, I think the--the technology is there to probably support any business activity.

THE COMMISSIONER:

Q. Uh-hm.

DR. MACDONALD:

A. The more dangerous thing is when IT comes in and says this is what you need as opposed to you saying this is what I want, and they support that.

THE COMMISSIONER:

Q. All right, thank you.

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COFFEY, Q.C.:

Q. So now in terms of then--to put this in context, this is a scoping document we're looking at the beginning of July, 2007. Mr. MacDonald, did you understand that NLCHI's involvement in this was of the nature of a research project?

DR. MACDONALD:

A. No, Mr. Coffey.

COFFEY, Q.C.:

Q. You're nodding "no", and Dr. Reza too. Go ahead.

DR. MACDONALD:

A. We were clear on that because we are a research entity, there's no doubt about that, and we have relationships with several universities across Canada in doing research, so that certainly is our first expertise, you might say, but we also have expertise in database management, and when we were asked by Robert Thompson back in June of 2007 to undertake this, this was a database management activity. There was never, and still is not any intent of the Centre for Health Information to take this activity beyond

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creating what was needed for the Commission of Inquiry and the task force in support of Eastern Health.

COFFEY, Q.C.:

Q. And never set out to carry out an epidemiological research study here, that was never your intention?

DR. MACDONALD:

A. No.

COFFEY, Q.C.:

Q. Never asked to do it and it was not your intention?

DR. MACDONALD:

A. Our mandate, and still our mandate is to gather as much information as we can on the patients affected by the ER/PR testing and the communication events surrounding those.

COFFEY, Q.C.:

COFFEY, Q.C.:

Q. And if we could then, just looking at this, Phase I, development of patient list for ER/PR testing, Option "A", and this is page three of the document, it reads, "Option A, Eastern Health has already identified a list of 2760 original test cases for the period '97 to

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2005, with 939 of these having a negative ER/PR result. These negative results were subsequently sent to Mount Sinai for ER/PR retesting. A database of these 939 patients having some of the core fields identified for this initiative is available from Eastern Health. This database, N=939, can be used as the final ER/PR patient list, with additional data fields incorporated to reflect the requirements of Health and Community Services. Advantages, it builds on work already undertaken by Eastern Health, and, therefore, would be timelier and require significantly less resources to complete. Disadvantages, the Centre cannot confirm all patients impacted are included in the database as the primary source data was not utilized in building client listing". I'm going to ask you about that, Dr. Reza. I take it that you're the one who would have been on a day to day face to face involvement with this?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And the disadvantage here that's articulated

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here, why is it that you could not confirm all patients impacted, which I presume is all patients impacted by way of having--should have been retested, based upon the retest criteria, whatever they might have been. Did you have reason to doubt at that point that all patients had been identified to be retested?

DR. ALAGHEHBANDAN:

A. Well, I guess here we're referring to one source as the core source to build a database, and that was Eastern Health's database at a time they reported as 939, so we knew at the time that there were other sources available to us. One option was to just simply disregard the rest of the options, the sources, the just go with this one and build a database based on this. We also learned that from Eastern Health that 939, that it was reported, I believe, back in 2006 or 2007, was not really the case based on the database they had at the time. So the disadvantage was the fact that we were not going to be quite sure that this option would give us 100 percent accuracy in respect to patient listings.

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COFFEY, Q.C.:

Q. Because here it says, "As the primary source data was not utilized in building the client listing", I take it that's the client listing of the 939 that's -

DR. ALAGHEHBANDAN:

A. That was the client listing, yes.

COFFEY, Q.C.:

Q. And -

DR. MACDONALD:

A. If I might just interject for one second there.

COFFEY, Q.C.:

Q. Sure.

DR. MACDONALD:

A. I just want to get back to when you asked us whether it was intent to be a research project, but this is really a research activity and inherent in us researchers is we were--an option was to take what someone already created and we would not then be able to say that's--we did not create it, so we couldn't confirm that all the cases were there. So even--this report was written probably three weeks into our first foray into

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this activity. So even then we knew that without using a primary source, we couldn't say we had all the cases.

COFFEY, Q.C.:

Q. To go on then to Option B, which was, "The database be developed completely independent. The work carried out by Eastern Health to create the database containing N=939 patients, this new database would use as its main source a download from Meditech of all ER/PR testing carried out from '97 to 2005 from each of the four health authorities. Identification of those tests specific to breast cancer and confirmation of test results, positive/negative, this list would then be cross-referenced with Mount Sinai's list of all ER/PR testing and retesting for the province over the period '97 to 2005". Go back here just to show here, "The advantages are the Centre can confirm all patients impacted are included in the database as primary source data was utilized in building the client listing. The disadvantages, it would require significant resources and time to complete. It should be noted that ER/PR

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testing can be either interpreted based on laboratory guidelines or clinical criteria by an oncologist/pathologist. Thus, re-evaluating each ER/PR test as either positive or negative using Option "B" needs to be considered in the decision, given the subjectivity of the testing and the resources required to review all ER/PR test results". Could you elaborate a bit, Dr. Reza, on what the disadvantage here was identified with Option "B".

DR. ALAGHEHBANDAN:

A. So this is the second potential option that we proposed. So basically, go into Meditech and downloading the data that we wanted to use as the core of the database, and then going to Mount Sinai and bringing that data and merge with this. The first challenge was basically the timing and resources. We were under some certain timeline with respect to deliver the work, and going through this activity would require extensive time and also resources. We also said here that the interpretation of ER/PR scores and also the clinical criteria which were used by clinicians is something

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that we should be cognizant of, and--but again the main disadvantage as I mentioned was significant resources that we're going to basically consider for this option and that's why we came up with Option "C" as an alternative option to this one.

COFFEY, Q.C.:

Q. So Option "C" indicates, "The database could develop using a hard copy/electronic data of all positive/negative ER/PR testing results, N=2760, developed by Eastern Health laboratory ER/PR testing from Central, Western, and Labrador, Grenfell, and Mount Sinai's list of all ER/PR testing and retesting for the period '97 to '05. A step by step approach is provided below for Option "C", although many of these steps are also relevant to Option "B", and then there are a listing of steps; Step 1, Step 2, Step 3, and Step 4, and Step 5. "Following completion of Step 5, the database will contain: (a) all patients that had ER/PR breast cancer testing carried out at Eastern Health from May, 1997, to August, 2005; (b) all patients that had ER/PR breast cancer testing carried out by Mount Sinai from

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1997 to 2005 would include samples sent directly to Mount Sinai by-passing Eastern Health; (c) all patients that had ER/PR breast cancer retesting carried out at Mount Sinai from May, '97 to August, 2005; (d) patients that are deceased since 1997, and (e) data for some core fields, in particular", and they're spelled out here. The report then says--the scoping document says, "Of note, regardless of what option is chosen to develop the patient list for ER/PR testing, it will be necessary to identify how best to obtain a complete list of ER/PR testing/retesting conducted at Mount Sinai. It's understood that several lists of ER/PR testing and retesting already exists at Eastern Health, however, one of these lists has no dates included in the database, while a second is yet to be reviewed. It's possible a new list will need to be obtained from Mount Sinai", and then--now in relation to this, this would be under Option "C" after it says here at paragraph (a), all patients that had ER/PR breast cancer testing carried out at Eastern Health from May, 1997, to August, 2005. Now to this date, has that been done,

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that all patients who had ER/PR testing done, is it in the database?

DR. ALAGHEHBANDAN:

A. At the moment, no, it is not.

COFFEY, Q.C.:

Q. Yes.

DR. ALAGHEHBANDAN:

A. All original tests?

COFFEY, Q.C.:

Q. Yes.

DR. ALAGHEHBANDAN:

A. No.

COFFEY, Q.C.:

Q. Okay, and Mr. MacDonald, can you tell us why that is?

DR. MACDONALD:

A. Back when the scoping document was prepared, obviously we had some assumptions that the patients had been identified. As we've gone through the last sixteen months, even until today, we recognized that it's been a challenge to identify the patients for various reasons. So we were a bit naive back then to say that by doing this activity, we would gather all the patients.

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COFFEY, Q.C.:
Q. I take it you had started from the assumption that perhaps they were in electronic database at Eastern Health, all ER/PR tests or slides that had ever been produced, there would be a record of them there -
DR. MACDONALD:
A. We thought it would be -
COFFEY, Q.C.:
Q. In the database or elsewhere within Eastern Health?
DR. MACDONALD:
A. Yeah, we certainly thought it would be a lot more uncomplicated to gather the information we required.
COFFEY, Q.C.:
Q. To this day, have the patients who were originally reported as ER/PR positive, the group, and I understand there would be upwards of 1800 or so, give or take a bit, have they been entered in any database that you're aware of?
DR. MACDONALD:
A. Not that I'm aware of, no.
COFFEY, Q.C.:

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Q. And why was that?
DR. MACDONALD:
A. I'll pass that to Reza.
COFFEY, Q.C.:
Q. Sure.
DR. ALAGHEHBANDAN:
A. Let me just go back a few steps. Option "C" simply proposes that we go and take all multiple sources across the province, bring them together and merge them and reconcile them starting from all pathology reports being printed back in '05 at Eastern Health, and Mount Sinai, pathology reports from the regions, other sources available to us, such as mortality system, probably Meditech, and creating the database including all those patients who had an ER/PR test regarding their scores, whether negative or positive, or whatever the case may be. So initially we thought that would be the best option to go with with respect to creating a database. We started that activity back in June and started reviewing pathology reports, and after a few weeks we came to learn that the timeline that we proposed was a little underestimated with

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respect to the amount of sources that we had to go through, and the work that we had to do, and then we met with Mr. Thompson, the department rep at the time, and his group, and it was decided to redirect approach and mainly focusing on those patients who had ER/PR negative, and that was the main question that the Centre was asked to be basically creating a database based on that. So really the approach changed from collecting all positive and negatives to just focusing on negatives, and the reason was basically the timeline and the time required for that activity.
COFFEY, Q.C.:
Q. I take it, it was a combination of, well, the time within which it was desired that a database come into existence?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. A useful database come into existence.
DR. ALAGHEHBANDAN:
A. That's right, a functional database.
COFFEY, Q.C.:
Q. Functional--bearing in mind the amount of

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time. Do you recall what kind of time frame--well, actually, we'll see it here, I believe, actually. I'll come back to Phase 2 in a moment. Look here at page eight, the heading, "Timelines are estimated based on available information", would be available at that time. "A major contributor to length of time to complete the database will be the time required by the data holders in providing data to NLCHI", and Phase 1, which is Option "A", in effect, timeline for each Option, for Option "A" was then thought four to six weeks. Option "B", 12 to 16 weeks, and Option "C" was 8 to 12 weeks.
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And initially the choice was to go with which option initially?
DR. ALAGHEHBANDAN:
A. Initially with Option "C".
COFFEY, Q.C.:
Q. And then as you got into it and embarked on creating Option "C" or pursuing Option "C" with a view to having it completed within

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eight to twelve weeks, which would be two to three months -

DR. ALAGHEHBANDAN:

A. Just the patient listing, between four to six weeks.

COFFEY, Q.C.:

Q. And the--I'm sorry, the patient listing, and then the event fields which would be--I'll come back to that, but there's some indication which is the whole communications issue is described here at page six, as Phase 2, "Data specific to communication event fields. In Phase 2, additional data fields will be incorporated into the database to reflect the requirements of Health and Community Services. The purpose of this scoping document concerning communication event field is used and is considered a field in the database which contains data for a specific event that occurred along the patient's ER/PR testing time continuum. These would include", and there's a number of things. It begins with the date that the sample was obtained by Eastern Health, all the way down to verification that the doctor reviewed the

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results with a patient. It says, "In obtaining data for these event fields, several steps utilizing various data sources will be investigated", and there's Steps 1, 2, 3, and 4. Then you go on to refer to the core field, number 12, "Verification the doctor reviewed results with patient" as being identified as one that may be difficult to obtain supporting documentation. In order to verify that the physician reviewed results with patient, it may be necessary to contact each physician and/or perform a chart audit, and the timelines are set out here. So I take it, Option "C", the patient list was thought to be four to six weeks, and Phase 2 of the event fields was another four to six, adding up to eight to twelve weeks for Option "C"?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. That's the one that was initially chosen, and when you got into it, pursuing Option "C", the difficulty in relation to getting a patient list within four to six weeks was what?

DR. ALAGHEHBANDAN:

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A. Okay. So end of June, we were basically commissioned to develop this database by the Department of Health and Community Services. End of June up to early July that we developed this scoping document, we had so much time, probably ten days or less than two weeks to study what is the issue, what is the magnitude of the issue, and what are the sources, what are the components, what are the details of it that we had to consider before going and creating the database. Based on that assessment, we thought that, okay, here are the sources and probably this is the timeline and we're going to create a database. During the course of action, we came to learn there were more sources available to us that we were not aware of at the time, and that added to the whole thing, and that's why four to six weeks was not really the case at the moment, and that's why we brought it to Mr. Thompson's attention that these are the challenges, we have extra sources, we need extra time and there are more challenges, such as, as I said, different sources, different data were in different formatting, and we needed to

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reconcile them. For instance, one of the core data--one of the data sources that we were going to consider was Eastern Health's August 1st one, did not have MCP as identifiable information for us.

COFFEY, Q.C.:

Q. Sorry, the -

DR. ALAGHEHBANDAN:

A. I'm sorry, one of the data sources that we were going to use for creating the database was August 1st file at management risk department at Eastern Health, the data that we referred to as 939.

COFFEY, Q.C.:

Q. Okay.

DR. ALAGHEHBANDAN:

A. And that database did not have MCP. So we had to find patients names, match with MCP, be able to use that MCP for further linking, merges, and cross-referencing down the road. So as we move forward over next couple of weeks after we started the work, we learned these things, and that's why we had to redirect the approach from Option "C" to something much more, I guess, reasonable with

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respect to the task that we had been given.
COFFEY, Q.C.:
Q. And which was then to focus on those who -
DR. ALAGHEHBANDAN:
A. Were negative.
COFFEY, Q.C.:
Q. Negative.
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Or reported originally as negatives?
DR. ALAGHEHBANDAN:
A. Go into other sources and again try to reconcile them.
DR. MACDONALD:
A. And, Mr. Coffey, it's important to realize too back during the early days as we were all learning about what was needed with respect to this activity, and we didn't realize at the Centre--I don't think anyone really realized how much of this data is actually in hard copy form.
COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:

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A. We kind of said there, well, let's just go ask for the databases, we'll get our epidemiologist to link them together, we'll fill in the gaps, and we'll all go home.
COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:
A. It didn't happen. I would suggest that perhaps 80 percent of the data that is incorporated into the database today came from hard copy handwritten spreadsheets, not electronic.
COFFEY, Q.C.:
Q. Had to be--you read something handwritten on a spreadsheet, it may be typing, and something handwritten, or handwritten entirely, and someone would then have to take that--NLCHI would have to take that and put that in the appropriate field?
DR. MACDONALD:
A. We would have to create another database for that. I mean, just from a pragmatic perspective, I give you a list of 10,000 names, and I say--and it's not indexed, find Don MacDonald; how long is it going to take

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you to do that. Who knows? Put it in the database and ask the computer to search like your person here is doing for these items, very easy to do. We didn't even have that when we started.
COFFEY, Q.C.:
Q. Because it didn't exist -
DR. MACDONALD:
A. It didn't exist.
COFFEY, Q.C.:
Q. Within Eastern Health or elsewhere?
DR. MACDONALD:
A. That's correct.
DR. ALAGHEHBANDAN:
A. And to reconcile those data sources we had to have them electronically available. You could not bring hard copies and just simply manually cross-reference. I mean, that would have taken us forever. We had to convert them into electronic format.
COFFEY, Q.C.:
Q. Now if we could--and again--so do you recall when it was the decision was made by Mr. Thompson to focus on the negatives? Do you recall when that was?

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DR. ALAGHEHBANDAN:
A. I believe that was in July '07.
COFFEY, Q.C.:
Q. Sometime later on in July?
DR. ALAGHEHBANDAN:
A. That's right, after we reported to him the challenges we faced.
COFFEY, Q.C.:
Q. Dr. Reza, then I take it you--take up the account then, then what happened in terms of what did you do? Okay, you're told by Mr. Thompson, well, let's narrow it down. Was it still to be Option "C" focused on the negatives?
DR. ALAGHEHBANDAN:
A. It was just Option "C", excluding positives, and again I just want to mention that the question was to focus on those who were negative and were tested in Mount Sinai. So really we redirected the approach, but really we still were going to answer the same question, although we changed the approach. So it was Option "C", excluding the positives, meaning that we had to go to different sources, different data, inside the province,

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outside the province, and following the same process actually.

COFFEY, Q.C.:

Q. So identifying those who had been originally reported as negative and had been retested at Mount Sinai?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. Okay, so that's the initial approach?

DR. ALAGHEHBANDAN:

A. That's the initial.

COFFEY, Q.C.:

Q. So what then happened? Okay, that's your task. What did you do?

DR. ALAGHEHBANDAN:

A. So basically we started with what we called August 1st file from Eastern Health, and -

COFFEY, Q.C.:

Q. That's the day, August 1st, 2007?

DR. ALAGHEHBANDAN:

A. August 1st, 2007, was the day that we received that file from Eastern Health. We also had to review spreadsheet manual--spreadsheet written, and prepared by Mr. Gulliver,

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including all positives and negatives actually from '97 to 2007. We had to convert them into electronic format. They were in hard copies. We requested the regions to send us their pathology reports. At the same time, we asked the department to request copy of Mount Sinai spreadsheets from Mount Sinai. That also happened.

COFFEY, Q.C.:

Q. The regions were asked to send in pathology reports for all ER/PRs or just negative ER/PRs?

DR. ALAGHEHBANDAN:

A. Just negatives.

COFFEY, Q.C.:

Q. Negatives.

DR. ALAGHEHBANDAN:

A. And then--so we had to review all pathology reports from the region. We had to review spreadsheets created by Mr. Gulliver. We had to enter them into the database. We came to know that there were some sporadic, I guess, requests on some ER/PR testing in Central Mount Sinai, we called them--it was called consult at the time. We came to learn that

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some of them existed at risk management department with Ms. Predham and we also included them. At a later date, we learned that there were probably more than those at Dr. Cook's office at St. Clare's. We also had a copy of those reports, again there were reports and we had to enter them into SPSS program. And we received Mount Sinai files, so basically we were reconciling all those--within the province data and then cross-referencing it with Mount Sinai data and gave us a fairly concrete idea of what is the patient listings which respect to this issue. And we took it from there and we added the communication piece to the database. So the first phase was really getting a list of patients and once we had that, we could go on and look for communication piece and add it to each patient.

COFFEY, Q.C.:

Q. Now I'm going to come back to the patient identification issue, okay, but could you tell the Commissioner then, in a general way then, how the communications piece was approached? What did you do to -

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DR. ALAGHEHBANDAN:

A. With respect to communication piece, we--most of the work was done with Eastern Health actually and we also contacted the regions and asked them to send us their information and communications and they did. With respect to Eastern Health, specifically I worked with Ms. Predham and for each patient, we look at documentation whether that would be an e-mail, a phone call, a panel letter, whatever the case would be and then we enter it into the database. The components that we consider with respect to communication was basically two things: No. 1, whether the patient was communicated with respect to the retesting process. That means before we send a sample to Mount Sinai, did we call the patient and let the patient know that your sample is going to be retested. The second piece was when we received the information from Mount Sinai, did we communicate information with the patient. So retesting process and the results. And we did that with each region. More specific in detail who placed a call, when that call was made and from which region, was the content of

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the communications and with respect to, for example, panel letters, we had the date that patient was discussed at the panel, that letter was issued and there were a number of ways of communication, as I have said, some patients were contacted via panel letters, some patients were contacted by the regions, some by physicians and we gathered all this information for every patient after we completed the patient listings.

COFFEY, Q.C.:

Q. I take it then that you would look at, for example, if Eastern Health provided a sheet of paper with a number of names in a particular person's handwriting, I'll just say, for example, Nancy Parsons' handwriting, number of person's names and dates and you would be given to understand that on a particular day, that day, she contacted that patient and told that patient about the patient's retest results, that would be the sort of thing -

DR. ALAGHEHBANDAN:

A. That would be the documentation source.

COFFEY, Q.C.:

Q. And you would record Ms. Parsons' name as the

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contact person from Eastern Health.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. Ms. Parsons and the date.

DR. ALAGHEHBANDAN:

A. And the date and the communication contents.

COFFEY, Q.C.:

Q. And, then, of course, in relation to that particular patient.

DR. ALAGHEHBANDAN:

A. That's correct.

COFFEY, Q.C.:

Q. Now did you always take what was written at face value in the sense of assume that it was correct?

DR. ALAGHEHBANDAN:

A. Always because that was the source of communication for us and a health care professional recorded it, one would assume that that's accurate and valuable.

COFFEY, Q.C.:

Q. So there was no, I'm going to suggest to you there was no audit in the sense of having done all that, you didn't call and pick out every

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tenth patient and contact every tenth or twentieth patient yourself and say, well, we have this information -

DR. ALAGHEHBANDAN:

A. No.

COFFEY, Q.C.:

Q. - Ms. or Mr. So and So, is this -

DR. ALAGHEHBANDAN:

A. No, that type of audit form never happened at the time, it wasn't part of our mandate; however, Eastern Health performed that audit at a later time and they ensured that the patient was communicated that way.

COFFEY, Q.C.:

Q. And that later check by Eastern Health, audit in effect by Eastern Health, was the fact that that was done, was that recorded in the database?

DR. ALAGHEHBANDAN:

A. It is recorded in the database, it is in the database right now.

COFFEY, Q.C.:

Q. It was a subsequent -

DR. ALAGHEHBANDAN:

A. Absolutely, we added that field to the

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database.

COFFEY, Q.C.:

Q. Now in relation to the reliability of what was written down, what you were reading, did you ever have reason to come to question like the reliability of a date or a month?

DR. ALAGHEHBANDAN:

A. If I had that doubt in my mind, I would not have entered such information in the database and we were quite transparent in that manner. If and neither of our parties, that means the centre in Eastern Health or the regions were not sure about certain things, we would not have been entering the database.

COFFEY, Q.C.:

Q. Were there ever any instances where after data had been entered in the database it came to your attention that perhaps that's not accurate?

DR. ALAGHEHBANDAN:

A. I can't recall such an event off the top of my head.

COFFEY, Q.C.:

Q. There will be one, I'll just refer to it because it was referred to it yesterday.

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DR. ALAGHEHBANDAN:
A. Right.
COFFEY, Q.C.:
Q. Janet Henley-Andrews.
DR. ALAGHEHBANDAN:
A. Right.
COFFEY, Q.C.:
Q. There's been evidence, the Commission has heard that well, in fact, Ms. Predham told us yesterday that in fact what she had written down was just, you know, she said she was just mistaken and what she had written down -
DR. ALAGHEHBANDAN:
A. The earliest, the early time that we were involved with gathering the communication events and information, I did not encounter such experience. Later that we were more involved with communications and Eastern Health also throughout the regions, we were given updates on communications and as you mention, yes, at a later time we encountered such a -
COFFEY, Q.C.:
Q. And what would you do then if something was brought to your attention, would you change

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the -
DR. ALAGHEHBANDAN:
A. Oh definitely. We would change and we would update the database; however, we would always keep a copy of the old version of the database and that is a part of the database management.
COFFEY, Q.C.:
Q. Now in relation to that topic, now that you've referred to it, was a challenge encountered in this context in terms of when you were dealing with Eastern Health, like your approach at NLCHI is well, we keep copies and if we're going to change a particular entry, we keep a copy of what it was before we changed it and, of course, now we have the new version. When you were dealing with Eastern Health, what was the situation then as you got into this?
DR. ALAGHEHBANDAN:
A. One of the questions that government had for us, Mr. Thompson's school had for us was that can we go back to the database and revisit 939 and so that was the first--one of the first questions that we had--they had for us. Our understanding was that every time the database at Eastern Health was updated, it was

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overwritten, so it was not, a copy of--a previous version of the database wasn't kept and so it was impossible for us to go back and to retain that information based under that version of the database. So when on August 1st, 2007 we received a copy of the database, when we went through it and got the MCP numbers for all those patients and counted them, as a matter of fact, we came up with a different number as opposed to 939, so yes, again, the file was overwritten each time information was entered into the database and the database was updated.
COFFEY, Q.C.:
Q. So I take it that at least from the time you got involved, you were in a position where you weren't able to reconstruct the 939?
DR. ALAGHEHBANDAN:
A. No, it was not possible.
COFFEY, Q.C.:
Q. Because of this overwriting -
DR. ALAGHEHBANDAN:
A. Overwriting.
COFFEY, Q.C.:
Q. Well, the overwriting and a failure to keep an

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earlier copy of what had been overwritten.
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. It's the combination of the two.
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. There's nothing wrong with overwriting something as long as you keep a copy -
DR. ALAGHEHBANDAN:
A. No, you overwrite something, but you always keep a copy of your old file.
COFFEY, Q.C.:
Q. And again, perhaps an illustration for the Commissioner of what you encountered in the early stages, P-1064 please? Now, Mr. MacDonald, this is an e-mail from yourself to Mr. Thompson on August 17th, 2007 and you write, "We continue to work with staff at Eastern Health's lab to resolve discrepancies in patient listings, demographics and clinical entries for breast cancer patients, (1997--2005) who were sent to sent to Mount Sinai for retesting. Having first completed the

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straightforward cases, we were left with 50+ patient records that required further investigation. As of today, we resolved all but 19 of these 50+ records. It is expected that the majority of this work will become completed this weekend. But we received the file on ER/PR retesting from Newfoundland and Labrador breast cancer patients (1997--2005) from Mount Sinai on Thursday night." That would be, just presumably the Thursday before. "We have only just learned that individual samples sent for retesting were considered consults and as such, generated a full pathology report that was sent back to Eastern. They were not included in the Excel spreadsheet we have just received." Which is, I take it, Mr. MacDonald, the spreadsheet from Mount Sinai.

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. And, "We are following up with Mount Sinai to address this oversight; nevertheless, we have preliminary evidence to suggest that the number of patients sent for retesting at Mount

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Sinai may be less than 939. We have received information from Central, Western and Labrador Grenfell regarding communication events. Upon preliminary review, it appears that everything they have has been provided, however, some follow up will be required. Further communication with Rolf Pritchard will take place regarding documents previously sent to the department. Work begins with Heather Predham on Monday, August 20th to document communication events in Eastern Health." And just while we're at it, it says copied to a number of individuals, Dr. Reza as well as Michael Barron, who I take it is your CEO?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Dr. Reza, could you tell us then about your interaction with Ms. Predham in the later summer or early fall?

DR. ALAGHEHBANDAN:

A. So before August 20th, we had a list of patients that we thought that they were basically ER/PR negative and they were tested at Mount Sinai. So that was the time for us

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to start gathering communication information on those patients. On August 20th, Ms. Predham and myself started working on that, she provided me with source documents, we reviewed each patient one by one and entered the information into the database, and that actually started August 20th and continued on up to the end of the year, actually, with regard to whatever we already had in regard to some of the patients that she had to contact or she had to gather the information for us to be entered into the database.

COFFEY, Q.C.:

Q. If we could look, please, at Exhibit P-3495? This, Mr. MacDonald is a series of e-mail exchanges, August 27th, 2007 with Maria Mendes, who I take it works with Mount Sinai and there's a note--there's one here from her on a date to you, saying, "Hi Don, we received samples in June and July, but these were for QA 2007 cases. All cases for retrospective testing were received starting in August '07 and these results should start coming out in September '07. I think since the beginning of August '07, we have received about 79 blocks

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for testing." And just to put this in context here, what I'm going to do, actually, if I could Commissioner, I'm just going to go and follow this through because it will give you some sense of--the first e-mail here, page 3, at the bottom of page 2 of the exhibit, on August 16th, it's from Maria Mendes to yourself, Mr. MacDonald. You say "All information has been sent to you, the Excel chart was e-mailed and I have called and given you the password. The letter from Dr. Pritzker has been faxed. Please let me know if you require any other information." So I take it that by the middle of August, Mount Sinai had supplied in electronic format their database?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Such as that Excel spreadsheet with the retest results.

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. But it did not include, as you found out

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afterward, it did not include the consults.

DR. MACDONALD:

A. That's correct.

COFFEY, Q.C.:

Q. Individual consults.

DR. ALAGHEHBANDAN:

A. That's correct, yes.

COFFEY, Q.C.:

Q. And then, here then you wrote, getting back to her the same day, August 27th, saying, "Hi Maria, again, thanks for providing ER retesting database. I am now hoping you might answer a question for me. In our original request to Dr. Pritzker we asked for two specific date fields, namely two, the date the sample received at Mount Sinai and three, the date result sent back to the hospital/health authority. In the file you sent back, the only date included was ordered. Is this the date the test was ordered from Newfoundland or from your LIS system? Is it not possible to obtain the dates as per your request." And she came back to you, Mr. MacDonald, the same day saying "In regards to the two line items, date sample received, you can use the order

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date as the approximate date the samples were received from you. At the time we were not tracking the date received, only the order date. The date results sent back to hospital/health authority, we"--that is Mount Sinai--"were not tracking this information. Now we are. If this is required, perhaps Dr. Cook can help since all e-mail results went to him." And then the same day you went back saying "Thanks Maria. Do you know about when you started tracking the date results sent back? Was it this summer?" And she responds saying, "Yes, it was this summer." And then you went back to her saying, "Thanks, I will follow up with Dr. Cook on the date sent back. By the way, do you know when the retesting for samples sent up in July might be completed?" And then she refers to the fact that, well, "we hope to start to give those out in September", the e-mail I looked at earlier. A couple of questions about this, this grouping of 79 blocks for retesting, did you know what sorts of patients they were? Was this the deceaseds?

DR. MACDONALD:

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A. I don't know.

COFFEY, Q.C.:

Q. You don't--Reza, do you -

DR. ALAGHEHBANDAN:

A. I believe it's a group of deceased people that were sent in July '07 to Mount Sinai for retesting.

COFFEY, Q.C.:

Q. And I take it then, well you realized, Dr. Reza, that these were being sent for retesting, there would eventually be results.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And the plan was to incorporate them into -

DR. ALAGHEHBANDAN:

A. Absolutely, we were in touch with Eastern Health and we were just about to receive the results later.

COFFEY, Q.C.:

Q. Now here, Mr. MacDonald, this reference to you following up with Dr. Cook in the date sent back, okay, that is the date that Mount Sinai sent, I suppose the spreadsheets from time to time back to St. John's. How did that unfold

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afterwards, can you tell the Commissioner about -

DR. MACDONALD:

A. Well, one of the questions that we wanted answered certainly that Robert Thompson asked us to investigate was actually when the samples were sent to Mount Sinai and actually when they were returned, so what was the turnaround time and what was the action taken between the results being there and any action taken after results come in, so obviously it was important for those two dates. So we worked with Mount Sinai for a little while trying to figure that out and it's clear in the e-mail from Maria that they didn't collect that information, so basically the order of date, which she refers to in her e-mail, is the date that they actually ordered it in their own LIS, so she's assuming that as soon as it showed up in their lab, they will place an order and Dr. Mullen would do the testing. So there's an assumption right there. We went back to Eastern Health and asked them, okay, we can't get the date that it was returned because Mount Sinai doesn't capture that, but

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can you tell us when the files came in? And as I recall, we never were able to get those, the dates that the Excel spreadsheets were sent back. I don't know if they existed anymore, the e-mails might have been deleted but the files kept, there was some challenge I believe on that end and I'll ask Reza to correct me on that end, but the other challenge we had were the consults. So it's very simple actually. If two or three samples were sent up, blocks were sent up, it was considered a batch and it was included in an Excel spreadsheet, that's just the way they did it at Mount Sinai.

COFFEY, Q.C.:

Q. Yes. Sometimes the Excel spreadsheet might be too -

DR. MACDONALD:

A. Well, they'd add it all up. When we got ours, we asked them to create a new Excel spreadsheet right from their LIS. We didn't want anything that was done, we wanted to go primary into their database. But we also then had to add in the consults because they weren't a part of the spreadsheets, so when we

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asked--okay, well we need to find out then when the consults was sent back, which was basically your path report, they were faxed and the only way that we could have, and we couldn't--eventually couldn't even get that, was the date on the fax cover sheet and they were not kept. So we were never able to -

COFFEY, Q.C.:

Q. They weren't kept by Eastern Health or by the other authorities, I take it?

DR. MACDONALD:

A. No, not to my understanding.

DR. ALAGHEHBANDAN:

A. The majority of them were Eastern Health's, Dr. Cook's office at a time, probably sporadically what regions, but as Don said, they were just, you know, they were not a part of that batch, so they were not a part of the Excel sheet to come back to Eastern Health again.

COFFEY, Q.C.:

Q. Now in terms of this, the idea of trying to locate the electronic version of the spreadsheets that came from Mount Sinai from time to time, I take it as you got into this,

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you realized Mount Sinai has sent them in, in waves, as it were, they would send a spreadsheet with -

DR. MACDONALD:

A. That's right.

COFFEY, Q.C.:

Q. - five results or 150 results, depending upon which spreadsheet, you understood that.

DR. MACDONALD:

A. That's right.

COFFEY, Q.C.:

Q. Did you ever ask Eastern Health for their copy of those electronic--an electronic copy of those spreadsheets?

DR. ALAGHEHBANDAN:

A. Yes, we did and they had a copy of it in their e-mail accounts and I received a copy of that, but as Dr. MacDonald mentioned, we went to the primary source for Mount Sinai data. We also kept a copy of those Mount Sinai copies were sent to Eastern Health; however, we directly requested Mount Sinai for the original copies.

COFFEY, Q.C.:

Q. Yes, so in terms of have you been able to locate Eastern Health's received electronic

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version of, for example, the first reports? Do you have those?

DR. MACDONALD:

A. Yes, we do.

COFFEY, Q.C.:

Q. And when did you receive those?

DR. ALAGHEHBANDAN:

A. Early days actually, that was, I believe, in July/August, '07.

COFFEY, Q.C.:

Q. In terms of this, Mr. MacDonald, in terms of your dealing with Mount Sinai, as time went on in terms of that, Mount Sinai in the end referred you to Eastern Health to tell you look, they'll have it, presumably because we sent it to them?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. And that's what -

DR. MACDONALD:

A. That's--we pursued it from that end.

COFFEY, Q.C.:

Q. Have those dates been recorded in the database?

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DR. ALAGHEHBANDAN:
A. We do have the original copy of those files and they are e-mails, I never gathered the copy of the e-mails, but just the copy of the database, but the question was when we sent a sample and when we received it. So one of the sources we could consider for the date the sample was received was Meditech and because, you know, the results came back from Mount Sinai, it has to be assessed and studied by pathologists at Eastern Health before being entered into Meditech. And that could have, you know, taken, I don't know, one day or two days or more or less, and then a secretary had to enter into Meditech and that was another segment of time with respect to this matter. So we considered all this and with respect to these two dates, date sent and date received or we can't really say date received, date that data entered into Meditech, we do have some approximate dates on the patients in the database.
COFFEY, Q.C.:
Q. That's Dr. Cook's entry signing off in the database as to the retest results?

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DR. ALAGHEHBANDAN:
A. Or Dr. Carter or whoever the attending pathologist would be.
COFFEY, Q.C.:
Q. What about the date that the results were sent from Mount Sinai electronically to Eastern Health, do you have that recorded?
DR. ALAGHEHBANDAN:
A. Yes, we do have that.
COFFEY, Q.C.:
Q. Okay, so for example the first wave--and we know this because of documents we have, September 26th, 2005, there's an e-mail with an attachment.
DR. ALAGHEHBANDAN:
A. Yeah, that data exists but that data is not a part of the database.
COFFEY, Q.C.:
Q. Okay, and that's what I wanted to ask you about. Why is that?
DR. ALAGHEHBANDAN:
A. The question was when the data entered into a database and that was the most accurate data that we could gather from the Meditech source because we did not have a date received for

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all the cases because there was some consults, there was some spreadsheets, Excel files from Mount Sinai, some were received by Dr. Cook, some were received by Ms. Predham, so there was dispersed data information at the time, so we considered to go back to Meditech as a uniform source and gather that information solely from Meditech for all the patients if possible.
COFFEY, Q.C.:
Q. So the database wouldn't allow you, for example, to figure out for a Patient A, you might in looking at an electronic version, not in your database, but an electronic version of a file, Dr. Mullen's September 26th file that came with his e-mail, Patient A is there, so that's the day that it landed in St. John's, sometime that after--late that afternoon, Patient A. That is not recorded anywhere in your database?
DR. ALAGHEHBANDAN:
A. In the database, no.
COFFEY, Q.C.:
Q. If it was recorded there and, but you have recorded for Patient A when it was entered in

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Meditech?
DR. ALAGHEHBANDAN:
A. Definitely.
COFFEY, Q.C.:
Q. So whether it was entered--if for Patient A, September 26th was entered and then for Patient A you already have, for example, October 12th, one would be able to figure out that there was about a 16 day gap. I take it you would be able to figure how long it took Dr. Carter or Cook -
DR. ALAGHEHBANDAN:
A. Right, it depends on the case, actually. If it was an urgent case, as I understood, they would have signed out immediately. If it was not an urgent case, again, depends on the clinical situation of that patient, it could have been on the desk for certain--same time. It depends on, again, the clinical situation. I can recall a sample was not signed out for one week or two weeks or more or less, yet a sample was just came in immediately, was reviewed by pathologist, shared with oncologist and proceeded.
THE COMMISSIONER:

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Q. I'm sorry, I just want to make sure I understand, you're saying that in respect of the issue of when the information was received back from Mount Sinai, there were a number of different potential sources, some of which were clearer than others, for example, you could discover--you could find the electronic spreadsheets that came with each sending of a "batch" from Mount Sinai to Dr. Cook, but there were not electronic spreadsheets for every single case because of the complication of the consults?

DR. ALAGHEHBANDAN:

A. Well consult was an separate issue, even with respect to the batches they came, as I came to learn, some electronically, some were sent in hard copies from Mount Sinai to Eastern Health.

THE COMMISSIONER:

Q. So even that wasn't consistent.

DR. ALAGHEHBANDAN:

A. Even that wasn't consistent because they were sending some electronically and some as hard copies. Sometimes they sent electronically and hard copies.

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THE COMMISSIONER:

Q. Okay, so are you then saying for the purpose of consistency wanting to have one source of information for the data of when it came back, you chose to use Meditech?

DR. ALAGHEHBANDAN:

A. In consultation with the Eastern Health officials and the other matter was with respect to the hard copies spreadsheets they would receive from Mount Sinai. There was no date on those spreadsheets, so we could not really be consistently capturing the data with respect to that matter. We decided to go with the date the data is entered into Meditech.

THE COMMISSIONER:

Q. So for the purposes of material coming back, what we know is not necessarily when it actually came back, but when it got processed to the point that it was entered into Meditech?

DR. ALAGHEHBANDAN:

A. That's correct and that's what the database can speak to.

THE COMMISSIONER:

Q. All right, thank you.

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DR. MACDONALD:

A. And that is important, if you look at even coming from Mount Sinai, they told us we can't tell you when we got it, we can only tell you when it was ordered in our LIS. So it's the same situation when it came back. We can't tell you exactly when it came back, we can only tell you when it was entered in the Meditech. So at both ends, we didn't get the dates we wanted.

COFFEY, Q.C.:

Q. How about being sent off, were you able to tell when things left St. John's?

DR. ALAGHEHBANDAN:

A. The main source was Meditech, so if we sent a Reza sample to Mount Sinai within Meditech, we say sample on this block and the specimen number was sent on this date. Interestingly enough to know that that date was not captured consistently across the board for all patients. Sometimes they mentioned just the year, sometimes it was the year and the month and sometimes it was year and the month and the date.

COFFEY, Q.C.:

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Q. That they were sending it in '05 and '06?

DR. ALAGHEHBANDAN:

A. That's correct, so that was another challenge. We went back to Mr. Gulliver's office for clarification and we tried to improve the data, I guess the data quality of this field in the database, it had been improved since then. But that was a challenge at the time because in all, it said for some patients in Meditech was that the sample was sent in 2005 or this sample was sent in October '05, or this sample was sent in October 1st, 2005, so with respect to analysing it, standardizing it, that was a challenge because they were not consistently captured.

DR. MACDONALD:

A. And that's a database management issue, not a data technology issue.

COFFEY, Q.C.:

Q. So in terms of that, Dr. Reza, how far has that been able to be clarified, to what extent?

DR. ALAGHEHBANDAN:

A. Off top of my head, I can't give you a proportion, but I believe that has been

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significantly improved and just going back to Dr. MacDonald's comment, there was a field created within Meditech at Eastern Health, so it was given the date, by year, month and date, but it was just the staff who probably just entered the year or simply entered the year and the month or just, you know, the full date. And that unfortunately did not get entered in, as I said, consistently for every patient that was sent to Mount Sinai.

COFFEY, Q.C.:

Q. So approximately how--do you have any sense of how many -

DR. ALAGHEHBANDAN:

A. I'd have to check the database. I don't have a proportion, but as I believe it's been significantly improved.

COFFEY, Q.C.:

Q. Another aspect of this matter, if we could bring up, please, Exhibit P-3497? Now this is September, 2007, some e-mail exchanges between Ms. Mendes and you, Mr. MacDonald, it actually goes back to earlier September, but here September 4th, there's an e-mail from yourself to Maria Mendes saying, "We found a patient

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with breast cancer who apparently was retested at Mount Sinai. It's been entered into our Meditech system which is our hospital information system. We have been unable to find the hard copy of the Mount Sinai pathology report/consult for this particular patient. I wonder if you could check this patient in your LIS system and let me know whether she had an ER/PR test done at Mount Sinai and if so, could you provide me with a copy of the report." And then she came back to you saying, "I will check our records" and then on the 11th of September, she comes back to you saying, "I apologize for not having gotten back to you last week. I checked our system and what I'm finding is not consistent with the name you have below"--because you had provided a name and date of birth. "For case number SP-05-19151, the patient name is"--it's redacted, date of birth--"I've also checked the Excel spreadsheet that I sent you and the only names that I saw were"--redacted--RS and there's a SS2120 and another name and RS number--the RS number is there, but the name is redacted. I'm sorry, the RS number is

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redacted, the S number is there. "Don, I'm not sure if this information helps. If you need my help, call me"--on her mobile number. And then you go back to her the next day saying, "Hi Maria, mystery solved. The patient got married and that's why she had two last names. Sorry for bothering you with this." And she says, "Not a problem, glad it is solved." So I take it then that there were problems with the fact that people's names over time would change?

DR. MACDONALD:

A. The problem is that we didn't use--Mount Sinai didn't our unique identifier MCP number, nor would they, there's no need for them to do it. If there was seven Don MacDonalds in St. John's alone, imagine. If you don't have a unique identifier, you have to do a lot more investigation to find out if it is the same Don MacDonald we're talking about, complicated further by when there's marriage, so the name changed and without a unique identifier, we basically, the system saw it as two different people. So Reza's team actually had to get together and try to make sure that this was

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the actual lady we were talking about that had been married. We talked about some of the earlier challenges when we were creating our database and Reza alluded to the original file from, the August 1st file from Eastern Health not having a MCP number. There was over 900 names that we had to reconcile with other systems to actually find their MCP number and this was just one case.

COFFEY, Q.C.:

Q. Now on that, Dr. Reza, how did you go about that, the reconciliation with MCP numbers?

DR. ALAGHEHBANDAN:

A. It was, we put extensive effort into that, I must say. We had to consider different sources to find MCPs for those patients. One was just a MCP registry file that we maintain at the centre on behalf of the ministry. The other source was Meditech. Meditech is a great source for that and we used Meditech for that matter. Once we had all the MCPs for those patients, we could simply go and link and cross-reference and merge them with other data sources and we learned sometimes even in Meditech, patient name--as here we can see a

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patient got married and the last name got changed--the first name sometimes, for example, Cathy with "C" and with "K", we had, you know, this difference between one patient and--reading one patient or between one and two patients, the MCP was the key for us to identify unique patients, not name or anything like -

COFFEY, Q.C.:

Q. Now, in terms of MCP numbers, I take it that, of course, that relies upon the number actually being accurately recorded. If it's not recorded accurately, then--maybe transposed, for example two digits.

DR. MACDONALD:

A. It is 12 digits long.

DR. ALAGHEHBANDAN:

A. It is.

COFFEY, Q.C.:

Q. Did you ever run into a situation where the same patient apparently had two MCP numbers?

DR. ALAGHEHBANDAN:

A. No, I didn't, but I can recall sometimes we had an NL resident, Newfoundland and Labrador resident who must have had a valid MCP, yet

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the patient had what we call pseudo MCP, let me give you a scenario here, a patient was sent from Western Memorial to St. John's for ER/PR retesting. For some reason, they forgot to mention the MCP for that patient, so once we received that patient in here, in St. John's, the Meditech system automatically generates a pseudo MCP number for that patient, so that's one of the challenges that we had, so we captured that pseudo MCP from Meditech, yet we had to go back to MCP registry to find the proper MCP number for that patient so we'd be able to do the rest of the cross-referencing and linkages down the road. That was one of the challenges that we had.

COFFEY, Q.C.:

Q. Just on this August 1st database, I'll refer to it as, to use your terminology. You say that did not have any MCP numbers in it?

DR. ALAGHEHBANDAN:

A. No.

COFFEY, Q.C.:

Q. Did Eastern Health provide you with anything that actually had the MCP numbers in it?

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DR. ALAGHEHBANDAN:

A. Yes, Mr. Gulliver's spreadsheets contained all MCP numbers for those patients and those are basically coming from original pathology reports that he reviewed, I believe 26 or 2700 including all positives and negatives. So he reviewed all of them, he created the spreadsheets, he logged them on into the spreadsheets, including their MCP numbers.

COFFEY, Q.C.:

Q. And these were handwritten -

DR. ALAGHEHBANDAN:

A. Handwritten, so the challenge was to convert them into electronic format.

COFFEY, Q.C.:

Q. Did Eastern Health provide NLCHI with an electronic database identifying patients by MCP numbers, that you recall?

DR. ALAGHEHBANDAN:

A. Two main sources that we received from Eastern Health was August 1st file, which was in electronic format, but did not have MCP.

COFFEY, Q.C.:

Q. No MCP numbers.

DR. ALAGHEHBANDAN:

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A. And then spreadsheets handwritten by the lab which included MCPs but it was not in electronic format, so I'm sure you can appreciate the challenge that we face in terms of marrying this to, and bring them under one roof and basically reconciling them.

COFFEY, Q.C.:

Q. So they did not have--at least, you were not made aware of Eastern Health having an electronic database for the patients that contained--identified the patients by MCP number, an electronic one?

DR. ALAGHEHBANDAN:

A. Not that I'm aware of to state.

COFFEY, Q.C.:

Q. Now with respect to--you referred to this before. Mr. Gulliver, you understood--you saw he had spreadsheets, handwritten, that recorded the patient's name, I take it, amongst other things, the patient's name and the patient's MCP number?

DR. ALAGHEHBANDAN:

A. That's correct.

COFFEY, Q.C.:

Q. And that was for all patients who were

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negative?
DR. ALAGHEHBANDAN:
A. And positives. I'm sorry, just the negatives and he called them "weak positive", the second group.
COFFEY, Q.C.:
Q. Weak positives, okay, but not the positive/positives?
DR. ALAGHEHBANDAN:
A. No.
COFFEY, Q.C.:
Q. He didn't record those.
DR. ALAGHEHBANDAN:
A. He reviewed them, but he did not record them.
COFFEY, Q.C.:
Q. Yes, we've seen some of the--we've seen some of his spreadsheets there, perhaps all of them, but the negatives and the weak positives?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. We've looked at those, but the idea--a listing of all the patients, including all the positives, handwritten, that didn't exist?

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DR. ALAGHEHBANDAN:
A. No.
COFFEY, Q.C.:
Q. Okay. If we could bring up, please, Exhibit P-1016. Here just before I get into this, i wanted to ask you about this. Dr. Reza, we've heard evidence that there was a distinction made, depending upon which Health authority you were speaking about, or which institution, between ER and PR tests done on breast--primary breast tissue, as opposed to other types of ER/PR tests done for other types of bodily tissue, and how did that work, what do you recall about what you were told about that?
DR. ALAGHEHBANDAN:
A. As you know, ER/PR is a test, and that test can be done for different tissues and samples because that receptor exists in certain tissues within the body. It could be done ER/PR on a breast sample, it could be on an ovary, uterus, or could be liver, lung, depends. So at the beginning, I understood that the issue is focusing on ER/PR testing only for breast samples, and that's what we

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started to work on.
COFFEY, Q.C.:
Q. Okay, and did you ever encounter information on patients whose tissue samples were, in fact, retested, but they were not breast tissue?
DR. ALAGHEHBANDAN:
A. They were not breast tissue primarily, however, they were related. I can give you a case scenario here. A patient had been diagnosed with breast cancer in 2001, and a sample was taken, primarily breast. In 2004, we have a lymph node and that lymph node been removed and tested for ER/PR and came back, for example, positive or negative, or whatever the case might be. So we included that case within the database because it was related to breast because breast was the primary tissue and the metastases was basically happened, so that lymph node got involved. So that was part of our database.
COFFEY, Q.C.:
Q. Did you ever become aware of any distinction made between the health authorities outside St. John's, that they sent all the ER/PRs for

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retesting, or some of them did, to St. John's only concentrated on primary breast?
DR. ALAGHEHBANDAN:
A. I believe they were just told to send breast samples or related breast samples, and I never came across any non-breast samples in this regard.
COFFEY, Q.C.:
Q. Now if we could then, looking at this exhibit, P-1016, this is an e-mail, Mr. MacDonald, on September 19th, 2007. It says attached is the--it's to Robert Thompson, and it says, "Attached is the interim report which outlines the approach used in developing the database, the data dictionary, and recommendations for the maintenance and development of the database interface. As noted in my earlier e-mail, work continues on adding to the database as new information becomes available, however, we are in a position to begin providing you with preliminary data analysis. I also have attached a copy of the letter I'll be sending to Pat Pilgrim tomorrow. This letter came out of last meeting. It took some time to put together, given the number of patients

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involved. Once we hear back from Eastern Health on our request, there will be further updates to this database". You copied it to Dr. Reza and others. So here on the second page of this exhibit, Mr. MacDonald, is what's referred to as an interim report, dated September 19th, 2007. Now what was this report related to?

DR. MACDONALD:

A. Going back to our scoping document, which we've already spoken to, we did tell the task force that we would have a functional database ready within eight to twelve weeks, which brought us into sometime in September, given the June or July creation of that. So we were really putting a lot of resources towards the database during these three months to provide the task force with at least some foundational activity around the database and particular analysis. So on this particular date, on this report we were providing a report to the task force which outlined our activities to date with the creation of the database and informing them perhaps--I'm not really intimate with what's in the report at this

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particular moment, but I would say informing them of some of the challenges and limitations we would have in doing an analysis, but basically saying we are now ready to begin trying to answer some questions.

COFFEY, Q.C.:

Q. And here then there's a table of contents, and the project background is there, and here toward the bottom of that section, you say, "For the purpose of this report, the resulting database is called the "ER/PR patient listing and communication events database".

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. And, Dr. Reza, you're nodding. I take it that's the title?

DR. ALAGHEHBANDAN:

A. Yes, but just let me go back with regard to this report. As Dr. MacDonald mentioned, the purpose of this report was to document how we created the database. So down the road, if someone take the database and wants to use that, that person would know what steps we took to create the database and what are the

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components and elements and variables within this database, and what is the definition of each variable and what are the values of each variable within this database. Within this report, we also indicated what criteria was considered before creating the database, original criteria, revised criteria, and this is all going back to database management, and this is a database management piece. Whatever you create, whatever you do, you have to basically document it, and this report is about it. So the name of the database, "Patient listing and communication events" simply describes the fact that this database has two components into it, patient listing, demographic and clinical information to a certain extent, plus the communication events.

COFFEY, Q.C.:

Q. The sentence following that says, "The aim of this report is to describe the methodology used to develop the database and present a description of the variables within the database".

DR. ALAGHEHBANDAN:

A. That's right.

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COFFEY, Q.C.:

Q. The selection criteria noted here, "The following criteria were initially used to develop the ER/PR patient listing and communication events database", and they are listed here as a number of bullets, okay, and the--on September 11th--it continues on saying, "On September 11th, 2007, a meeting between the Department of Health and the Centre resulted in the original criteria being revised", and then there are revised criteria, and there's one through four, or one through three.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And here when we look back at this, at the top of the page five of the exhibit, there's a reference to original ER testing, either negative or positive done in Newfoundland and Labrador and retested at Mount Sinai, okay, and that was originally what you set out to do, include all the ER positives as well, but as well positive or negative and they ended up being retested in Mount Sinai, include tissue

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other than breast at the time, and include DCIS, insufficient tumour for ER testing at Mount Sinai, include deceased patients who had been recently sent for retesting, include all originally negative ER done in Newfoundland and Labrador, but not retested in Mount Sinai, include all ER tested in Mount Sinai, but no original ER testing in Newfoundland and Labrador and called in and asked to be tested at Mount Sinai, but did not meet the eligibility criteria, and then under the revised criteria, you've written, "Had original ER test done in Newfoundland; two, had original ER test for sample related to breast cancer, example, breast, lymph node, chest, etc; three, had original ER test between January '97 and August '05; four, had original ER test done prior to January of '97 and sent to Mount Sinai for retesting; had original--negative original ER test result or had positive original ER test result and sent to Mount Sinai for testing, and then there's a larger "or", which is had sample taken in Newfoundland related to breast cancer; two, had sample taken between January '97 and

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August '05, or had a sample taken prior to '97 and sent to Mount Sinai for testing, and, three, had no original ER testing in Newfoundland, but sample sent to Mount Sinai for testing". It goes on with another proviso, "In addition, if an individual met the above criteria, he or she would not be excluded based on any of the following criteria. Sample not retested at Mount Sinai due to DCIS, sample not retested at Mount Sinai due to insufficient tumour for ER testing, and patient is deceased", and then there's a description of the data sources spelled out here. This goes on and it's quite detailed. I'm not going to take you all the way though it. I'm going to ask you, Mr. MacDonald, was this the approach adopted? Perhaps Dr. Reza actually -

DR. ALAGHEHBANDAN:

A. I'm sorry, I missed your question.

COFFEY, Q.C.:

Q. Was this the approach adopted then?

DR. MACDONALD:

A. Well, I might just start by we're still basically still in our infancy and still

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learning, and even today, as we already recognized, the database still gets updated. So at this particular time, as you can see by the criteria by inclusion into the database it had gotten, even at that point a year ago, quite complex. Our original mandate, as asked by the task force in Administrative Health, was original negatives and sent for retesting. We then found out that some positives had been sent for retesting, so that didn't really meet our criteria, so then there was much discussion over, you know, retro convertors versus convertors. Then we started to identify patients that were missed. So it got very complex as to what we would include and not include in the database. I can tell you today that there's many different cohorts in our database and when you go into our database, you have to really understand it to select those patients you're actually interested in. So your question as to is this what we ended up with, I can say with comfort this is what we started going with, but I think it was certainly an iterative process because there was always nuances always being

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found as we went forward that really didn't fit the criteria as we had originally thought it would, so we had to fit it in somewhere. So I would suggest that through evolution, that probably changed also.

COFFEY, Q.C.:

Q. Here when we look at page 15, under action items, it says, "Database maintenance and analysis implications. The Centre is currently maintaining the ER/PR patient listing and communication events database on behalf of the Department of Health. It is recognized that it will require ongoing maintenance and updating for several months as more data becomes available". So this is in mid September you realize, look, at least until the end of 2007 perhaps, several months at least?

DR. MACDONALD:

A. This particular context was really--originally we were to create the database and give it to the task force and they would do their analysis, and a few months in, I think we all recognized that it was a very complex undertaking and that it would be best

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undertaken by the Centre, so--actually that's the way it still exists today, the task force has never received a copy of the database, we do the analysis on their behalf.

COFFEY, Q.C.:

Q. Now there's a reference on the last page of this exhibit to having Eastern prepare the interface, "It has the advantage of having significant resources with expertise in the area of database interface development. The disadvantages are that; one, Eastern may not be able to access some data in the database, negate them accessing the full database for developing the interface; two, having Eastern develop the interface would require that they maintain it. Having one agency responsible for the data, another responsible for the interface, is not good database management practice. Having the Centre develop the interface has the disadvantage that we do not have extensive development resources or expertise compared with that of Eastern Health. The Centre has the advantage of keeping all interface maintenance and updating activities located at one source. It is

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recommended the Centre develop the interface. Protocol database access--protocol will need to be put in place to transfer the database to the Commission of Inquiry, and if possible, to the Eastern Health Authority". So what was decided then in terms of the interface?

DR. MACDONALD:

A. And just to explain what we meant by the interface because we've spoken to the various diverse and dispersed databases that actually came together to create this, at the Centre for Health Information we did that in the Research and Evaluation Department, so we would get the Excel file from Mount Sinai, we would get the hard copy spreadsheet from the lab, we would have the August 1st file from Eastern Health, and we would--our epidemiologist would actually basically by hand bring all that together. So that was the interface. We had the human interface between the dispersed databases and the creation of the ER/PR database. What Eastern Health was proposing, and I was not comfortable with from the start, was to do that electronically, to create a layer on a software platform called

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"COGNOS" that would interface with MCP, with mortality, with all the different databases to funnel down in or filter down into the database. I did not recommend that because I didn't have a level of comfort that--this is again the bringing together of database management and information management. Given the complexity and sensitivity of this data, I didn't feel a level of comfort, so I recommended to the task force that we do not go with Eastern Health's proposal coming from their IT Department. It was welcomed, but it was just something that I decided against.

COFFEY, Q.C.:

Q. And what was the result? Did they go with your advice?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. They accepted your approach. If we could, please, Exhibit P-3498. Now there are a number of these letters. I'm not going to take you through--for the other health authorities, but this is a letter of September 20th, 2007, to Pat Pilgrim at Eastern Health,

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Mr. MacDonald. It's from--at the very end there, you can see it's from yourself, and you've written to Ms. Pilgrim saying, "Find attached five separate lists of breast cancer patients for which the Centre is asking for assistance in determining their status. Were possible, we ask that Eastern Health provide the Centre with (1) documentation that addresses the request noted for each table; (2) confirmation that the patient specimen in question was the responsibility of Eastern Health, but no documentation is available to address the Centre's request; or (3) the patient specimen was not provided to Eastern Health and is the responsibility of the health authority listed for the patient, and then there's a description of the lists. It's a heading "Lists". For the eight breast cancer patients provided in List #1, the Centre has documentation that specimens for these patients were sent for retesting, however, there was insufficient material to test, and the request is documentation that a second specimen was sent for retesting. I take it this was up to this point in time, Dr. Reza

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and his colleagues had identified people who fell into that category?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. In fact, the regions in question, Western, Central, St. John's, Carbonear. So they were from various hospitals throughout the province, and the original ER and the original PRs are noted there. So I take it, this was ensuring that a patient who had been identified as originally a negative, or falling into the negative category--well, it's hard to tell with that '02 one, 25 to 30, would have been the positive--would have fallen into the positive category, we'll talk about that, but the point being that there are a number of these, eight of them here, that you wanted confirmation--the Centre wanted confirmation from Eastern Health, or confirmation that they couldn't give it to you, documentation that would prove that samples for them were sent for retesting?

DR. MACDONALD:

A. Yes, I mean, one of the sources that we did

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have was obviously we've asked all the authorities to send in the original--copies of the path reports for their ER breast cancer patients for testing. So we actually had what the authorities had sent in, we had what Mount Sinai sent back, and so when we started consolidating all this information, we had to reconcile some of the things, so in this particular case we probably, if I'm not mistaken, would have a path report that Mount Sinai said insufficient tumour.

COFFEY, Q.C.:

Q. Yes.

DR. MACDONALD:

A. And there was no amendment to it. So we would go back to Eastern Health and ask for further information.

COFFEY, Q.C.:

Q. What happened with that patient?

DR. MACDONALD:

A. Yes, exactly.

COFFEY, Q.C.:

Q. Here on the second page, it says "for the 60, 6-0, breast cancer patients listed in--provided in list number two, the Centre has

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been provided documentation by the three health authorities other than Eastern indicating an ER/PR of less than or equal to 30. However, the Centre has no documentation that these patients had specimens retested at Mount Sinai." You "request confirmation that a specimen was sent for retesting or if not, the reason why the specimen was not sent. Note: If a specimen was not sent to Eastern for retesting by the health authority identified in the list, please report same." And there's a listing of these. A number of them are Western. There's a Central, another Western, Grenfell has some and then Carbonear has a whole list.

Dr. Reza, I'm going to ask you here, in terms of list number two, in the main, what were they comprised of?

DR. ALAGHEHBANDAN:

A. I'm sorry?

COFFEY, Q.C.:

Q. In the main, what was list two comprised of?

DR. ALAGHEHBANDAN:

A. We reviewed pathology reports from the regions and we came across some patients who were--who

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had ER/PR scores less than 30, regardless of the year, and at the same time, cross referenced this list against Mount Sinai and other sources that we had and we couldn't find them there. So the question was have these patients been sent to Mount Sinai in a different method, such as consult that we don't have, because we received from Mount Sinai just Excel spreadsheets, so they were not in that file. The question was whether they had been sent or not, because in our understanding, they were somehow negative and they might have been considered for the ER/PR recall, and you could see a number of them from different regions.

COFFEY, Q.C.:

Q. In particular, there are quite a number from Western.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And then there are quite a number from Carbonear. Do you recall anything about the Carbonear ones?

DR. ALAGHEHBANDAN:

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A. We received, as I said, reports from the regions, including Carbonear. Carbonear is a part of Eastern Health, but at the time, we received reports from Carbonear and also Clarenville as a part of Eastern Health. Reviewed the pathology reports and came across these patients, as you can see the list here, and noted that we can't find them in Mount Sinai's file. So that was the point for us to notify the regions.

COFFEY, Q.C.:

Q. The next page says "for the 22 breast cancer patients provided in list number three, the Centre has been provided documentation by Eastern Health indicating an ER/PR of less than or equal to 30. However, the Centre has no documentation that these patients had specimens retested at Mount Sinai." And the request is "documentation that the specimen was sent for retesting or if not, the reason why." So again, Dr. Reza, what was this about?

DR. ALAGHEHBANDAN:

A. The same thing again. We came across these patients, same story, less than--ER/PR less

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than 30 actually and again, the question was posed to Eastern Health is whether they had been tested, retested or not at Mount Sinai because we were not able to track them down in Mount Sinai file.

COFFEY, Q.C.:

Q. I take it here, these were--this was based upon information you'd received from Eastern Health itself?

DR. ALAGHEHBANDAN:

A. That's correct.

COFFEY, Q.C.:

Q. And do you recall what, in the main, what the explanation was?

DR. ALAGHEHBANDAN:

A. Well, some of them basically, the patient had one sample being tested and the other sample wasn't, so that could have been one of the main reasons for this table actually.

COFFEY, Q.C.:

Q. And then it says "for the four breast cancer patients provided in list number four, the Centre has been provided documentation by Eastern Health indicating the patient had more than one sample originally tested. The

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specimens provided in the list below were not sent for retesting. Request documentation as to why these specimens were not sent for retesting." And then final page, "for the 17 breast cancer patients provided in list number five, the Centre has been provided documentation by Eastern Health indicating that the patient is deceased and have been sent for retesting in the summer of 2007. The specimens provided in the list below were not sent for retesting. Request documentation as to why these specimens were not sent for retesting."

DR. ALAGHEHBANDAN:

A. Again, the same thing, but for the deceased group.

COFFEY, Q.C.:

Q. I take it, Mr. MacDonald, as well there were other similar letters sent to the other regions or certain of the other regions?

DR. MACDONALD:

A. There was always initially certainly a bit of confusion as to who was responsible for some of the tests.

THE COMMISSIONER:

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Q. In what way?

DR. MACDONALD:

A. We would basically ask--for example, ask Western for this particular type of information, and obviously not these specifically. This is obviously to Eastern. But they would say "well, we've given that to Eastern. They would know." So we would go to Eastern as the primary source for retesting. That was the position taken by the authorities.

THE COMMISSIONER:

Q. So if you went to question an authority outside of Eastern regarding a particular file, if they had sent it in, they would say "go ask Eastern Health"? Is that it?

DR. MACDONALD:

A. In most cases, yes. They would say "we've already given that to Eastern Health. We don't know if they sent it or not, perhaps, so go to the source."

THE COMMISSIONER:

Q. Okay.

DR. MACDONALD:

A. So most of our work was with Eastern Health

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around the clinical side of things. More work with the other authorities on the communication side.

THE COMMISSIONER:

Q. Okay. Was there ever any point along the way where Eastern Health indicated that for some reason certain specimens were not sent on, other than the one that's been referred to by Dr. Reza, i.e. we sent another specimen, not the one that you're looking for?

DR. ALAGHEHBANDAN:

A. I'm trying to understand your question.

THE COMMISSIONER:

Q. Well, I'm wondering whether or not there was any culling of specimens that came from outside of St. John's at Eastern Health itself to say, for example, "this doesn't meet our criteria. We're not sending it," or were they just sending on -

DR. ALAGHEHBANDAN:

A. Right, this is my understanding from this exercise. The samples came in from the regions to Eastern Health. Clinical chief, pathology, at the time, reviewed the blocks and the slides and decided which ones should

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go, with respect to appropriateness of that sample and which one probably may not be appropriate for that purpose. That was all on my understanding. However, I don't have a list of those that were not sent based on that exercise back in August '05.

THE COMMISSIONER:

Q. Okay. So your--we've had some various evidence on this, not all entirely consistent, but your view was that what the pathologists locally did vis-a-vis those samples that came in from outside was to try to choose the best block to send on to Mount Sinai, effectively so you wouldn't have to resend because you had sent perhaps a less than best example of -

DR. ALAGHEHBANDAN:

A. At least a sample, and I believe that at each region, a responsible pathologist also looked at those blocks and the slides before shipping them to Eastern Health.

THE COMMISSIONER:

Q. All right, thank you.

COFFEY, Q.C.:

Q. Just before we break, Commissioner, just looking at this, I wanted to ask you about

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this because it's going to come up on an exhibit I'll refer you to after the break. Look at this letter. See at the top of page two here, it says "for the 60 breast cancer patients provided in list number two, the Centre has been provided documentation by the three health authorities indicating an ER/PR of less than or equal to 30." See that?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And then there's, at the top of page four, a listing provided of 22 patients provided by Eastern Health indicating an ER/PR of less than or equal to 30, and why 30 at that point, at this point in time?

DR. ALAGHEHBANDAN:

A. Our understanding always has been that there was clinical criteria set out by clinicians with respect to offering treatment. The cut off point was, again this is my understanding, less than 30 for '97 up to 2000 and from 2001 onward, was less than ten. So the cut off point changed with respect to that clinical ER/PR scoring. In this letter, we chose to go

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with 30, just to be on the safe side, although we understood that there are some specimens who were coming from years after 2000, yet ER/PR score was greater than ten. But again, for the sake of clarity, we put that there and for some of those, of course, we received same answer, that because they were greater than ten, they were not sent to Mount Sinai.

COFFEY, Q.C.:

Q. As an example here, just looking at page three of this exhibit, 3498, under the Carbonear Listings. For example, yes, I got the cursor on S564-2002, Carbonear. ER/PR is 15 to 20 and, sorry, ER is 15 to 20, the PR is 60 to 70.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. So that would not have met the retest criteria?

DR. ALAGHEHBANDAN:

A. Obviously not.

COFFEY, Q.C.:

Q. Okay. But at the time -

DR. ALAGHEHBANDAN:

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A. We considered it as a part of the letter for the sake of clarity.

DR. MACDONALD:

A. You know, and on that one too, Mr. Coffey, I mean, that was just basically from a database management perspective to be more encompassing. When we're going to the regions, we didn't want to have to go back. Another example with that, originally the retesting time frame was somewhere April 1997 to July 2005 and we recommended to the task force that we include all of 1997 and all of 2005, just again to be more encompassing as we go out. We don't want to have to go back again. So it's just being a bit more cautious in what we ask for.

COFFEY, Q.C.:

Q. In that regard, if I could, Commissioner, Exhibit P-1022? These are two e-mails. One is October 25 from Dr. Reza to a number of individuals within Eastern--within NLCHI, I'm sorry. You write, "in follow up to our meeting with Robert on Tuesday, please see below a summary of the process used to select breast cancer patients for retests at Mount

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Sinai by Eastern Health. Later today, I will be sending a further note re: Meditech search for ER/PR pathology reports." But the original e-mail that you were forwarding was from Terry Gulliver to yourself, Dr. Reza, July 24th '07. The subject is ER/PR clinical cut off points, and he says "Reza, as per your request, here is a summary of the guidelines/process used from July 2005 onwards to select patients for possible retest at Mount Sinai." And then there's a fairly detailed description here, ten numbered paragraphs and other things, okay.

So you had known about this, this 30 and 10 issue and cut offs, clinical cut off points, dating back to late July, and the document we just looked at is, I believe, September. The letter to Ms. Pilgrim is toward the end of September. You refer to this 30 at the time, you're using the 30 to be careful. Did you, at that time, by the end of September, did you have any reason to believe that some authorities might have been using less than 30 all along?

DR. ALAGHEHBANDAN:

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A. Yeah.

COFFEY, Q.C.:

Q. And St. John's was using 10 and 30?

DR. ALAGHEHBANDAN:

A. I appreciate your question. ER/PR is a subjective test.

COFFEY, Q.C.:

Q. Yes.

DR. ALAGHEHBANDAN:

A. And we all know that, and the clinical guideline is not a concrete guideline. It's a controversial guideline. Some centres go by ten, 30, zero, one. This is the information that I received from Mr. Gulliver, who is not a clinician, and I appreciate that he received this information from either oncologists or pathologists. Relying on this information, we decided to be on the safe side, just to basically going by less than 30, regardless of the year. So as Dr. MacDonald mentioned, that was mostly for, I guess, not underestimating as opposed to overestimating here in this matter. That's why we chose 30, as opposed to being much more precise, saying that for this time period, less than ten, for the other time

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period, less than 30.

COFFEY, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. I'm missing a step here. I'm not sure how they got on your list in the first place if a source of your list was either Mr. Gulliver or Ms. Predham. So how did they get there? Presumably, Mr. -

DR. MACDONALD:

A. We had all the pathology reports sent in from the authorities as another source.

DR. ALAGHEHBANDAN:

A. From the regions.

THE COMMISSIONER:

Q. So you would have, in making up--in establishing your list, you would have done an independent look at all of the pathology reports?

DR. ALAGHEHBANDAN:

A. That's right, from the regions.

THE COMMISSIONER:

Q. From the regions, okay, but not within St. John's?

DR. ALAGHEHBANDAN:

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A. Not within St. John's.
THE COMMISSIONER:
Q. Okay, thank you.
DR. MACDONALD:
A. Actually, St. John's wouldn't have those pathology reports.
THE COMMISSIONER:
Q. Because of their method of putting it on -
DR. MACDONALD:
A. Because it would be the pathologists in the regions interpreting the slides.
THE COMMISSIONER:
Q. Yes.
COFFEY, Q.C.:
Q. See, here, when we get to the page two of this e-mail in July from Mr. Gulliver, page two, he says, paragraph eight, "each batch received"-- well, I'll just go back a bit. "While Barry and I were doing all this for St. John's patients, Dr. Cook had written all the other pathology labs in the province informing them we were going to retest all the province that had test performed at the Health Sciences Centre lab. In Dr. Cook's letter, he outlined the guidelines used by St. John's to determine

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if a patient needed to be retested. He asked that the pathologists/technologists in each lab review all of their ER/PR results and send to Barry Dyer and myself. We received batches of patients and their original block slides and control slides every week for a couple of months."

Paragraph eight, "each batch received by Barry and I, we then made a retesting spreadsheet for the referring site, example, Western Memorial, by year. This was exactly the same as we did for St. John's patients. This process of logging and documenting the out-of-town patients took until about the end of October 2005. Remember that Mount Sinai by then had already received hundreds of blocks for retest and were starting to get results back from the St. John's patients and still packing up out of town blocks and sending."

Number nine, "the out-of-town patients were reviewed by the pathologist from the referring site to determine the clinical cut off results as provided by the oncologists. The block slides were reviewed by our pathologists to ensure that we had a good

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block for retesting. We discovered, after the out-of-town results started to come back, that they did not review their patient list and remove patients that were deceased. Hence the reason why we have about 175 deceased patients retested."

Number nine, "once results started to come back, they were reviewed by our pathologists and then the new results from Mount Sinai were added to the patients original report in our LIS Meditech system and a new report generated with both the original and new results."

So did you understand that there was any filtering going on in St. John's from the out-of-town -
DR. ALAGHEHBANDAN:
A. Before the sample is being sent to Mount Sinai.
COFFEY, Q.C.:
Q. You understood there was?
DR. ALAGHEHBANDAN:
A. Yes.
COFFEY, Q.C.:
Q. That they were, they were pulling out the

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deceased, if they knew about it, if they knew -
DR. ALAGHEHBANDAN:
A. If they knew about it, yes.
COFFEY, Q.C.:
Q. And other than that, they were -
DR. ALAGHEHBANDAN:
A. Checking the appropriateness of the blocks.
COFFEY, Q.C.:
Q. Appropriateness of the blocks.
DR. ALAGHEHBANDAN:
A. If the sample was enough there for retesting.
COFFEY, Q.C.:
Q. How about the 30, 10 issue? If, for example, Carbonear sent--not Carbonear. Say Western sent one--better still, I'll use Central. Central sent one that was 20 in 2002, for retesting. Did you have any understanding -
DR. ALAGHEHBANDAN:
A. We learned from Carbonear that Carbonear initially sent only the zeros, technical negatives, and not clinical negatives, and obviously at the time probably they were looking at it, but not from that point of view that looking at it from clinical, you know,

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cut off point.
COFFEY, Q.C.:
Q. Did you have any understanding, ever get any understanding that in St. John's, the lab, someone in the lab, connected with the lab, was screening out patients for retesting, out-of-town patients, out of St. John's patients, screening them out for retesting based upon the fact that they didn't meet the ten or 30 criteria?
DR. ALAGHEHBANDAN:
A. I'm not sure about that.
COFFEY, Q.C.:
Q. Okay. The suitability of the block is referred to here, yes.
DR. ALAGHEHBANDAN:
A. Definitely.
COFFEY, Q.C.:
Q. But you'll notice here that Mr. Gulliver says that he told you that the out-of-town patients were reviewed by the pathologists from the referring site, the out-of-town site, to determine the clinical cut off results as provided by the oncologists. So the assumption was -

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DR. ALAGHEHBANDAN:
A. It was a screen at the primary site and then being sent to St. John's.
THE COMMISSIONER:
Q. You would have had, I assume, the communication from Central to Mr. Gulliver or Dr. Cook, or whoever it was that they sent it to, saying "here is my list of patients for retesting"?
DR. ALAGHEHBANDAN:
A. Plus the original scores.
THE COMMISSIONER:
Q. Yes.
DR. ALAGHEHBANDAN:
A. I came across -
THE COMMISSIONER:
Q. So would you have--are you confident that, in terms of the list that came from Western or Central or wherever it came from, somewhere along the way, by the end, you had a retest result for all of those patients?
DR. ALAGHEHBANDAN:
A. If it happened back in '05, yes. If it happened, for example, in '07, we would have basically waited to hear back from Mount--from

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Eastern Health and then from Mount Sinai. For instance, the deceased group, where it was sent in August, in July '07.
THE COMMISSIONER:
Q. Um-hm.
DR. ALAGHEHBANDAN:
A. And we indicated to Eastern Health that we understand that this batch has been sent in '07, July, and please inform us as soon as you receive the information back, so we can update the database. So it depends on the timing.
THE COMMISSIONER:
Q. All right. So if it was sent in 2005 from Central and you had that list, you know that on your database, each of those names is reflected and there is a retest result from Mount Sinai?
DR. ALAGHEHBANDAN:
A. We could cross reference them.
THE COMMISSIONER:
Q. Yes.
DR. ALAGHEHBANDAN:
A. Because we had the pathology reports from the regions and that was one of our ways to go and cross reference making sure that those who

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were negatives from the region had been retested at Mount Sinai.
THE COMMISSIONER:
Q. Okay.
DR. ALAGHEHBANDAN:
A. That was made possible.
THE COMMISSIONER:
Q. Thank you. Do you want to take the morning break?
COFFEY, Q.C.:
Q. Yes, if we could, please, Commissioner. Thank you.
THE COMMISSIONER:
Q. We'll take 15 minutes.
(BREAK)
THE COMMISSIONER:
Q. Please be seated. Mr. Coffey?
COFFEY, Q.C.:
Q. Thank you, Commissioner. Exhibit P-1019? Dr. Reza, this is an e-mail of October 19th, 2007 to Mr. Thompson and others. You say "please find attached a revised copy of the PowerPoint presentation containing new analysis based on questions generated at the October 17th meeting." And it's copied to Mr. MacDonald

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and others, and this is a presentation, at least a draft of a presentation entitled "Database Development, Patient Listing and Communications Events, ER/PR Retesting, Preliminary Results. Presentation to the Department of Health and Community Services, October 19th, 2007."

There are here, just a couple of things I wanted to ask you about, just to comment upon. Here under the heading, it says, "preliminary"--it's page five of the exhibit, "preliminary analysis as of October 19th, 2007," and there's certain numbers given for the total number of records and the total number of unique patients and broken down by gender. Total number of deceased are--I apologize. I apologize, there it is. Apologize, it's page six. I apologize, Commissioner. Total number of deceased is 296 based on the mortality system as of June 2007. I wanted to ask you about this.

I take it that NLCHI, when you got involved in this, did hook--as you got your database up and fronting, did connect it or did access the Provincial Mortality Database?

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DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. Electronically, you could do that?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And in the course of your involvement in this matter, did you come to learn anything about whether or not Eastern Health had ever used it?

DR. ALAGHEHBANDAN:

A. No, I believe they don't.

COFFEY, Q.C.:

Q. Here, just looking at this, this is October 19th, 2007 that you're presenting a draft of your presentation. It says "based on the mortality system as of June 2007." So how up to date, in your experience, is the Mortality Database?

DR. ALAGHEHBANDAN:

A. I'm just going to pass it on to Dr. MacDonald because that's his expertise.

COFFEY, Q.C.:

Q. Yes.

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DR. MACDONALD:

A. Currently, we're usually only a couple of months behind now before they get entered in and quality assurance put on it.

COFFEY, Q.C.:

Q. So it's about a two-month lag?

DR. MACDONALD:

A. Two or three month lag.

COFFEY, Q.C.:

Q. Two or three month lag time, and here, Dr. Reza, you've written, "for the purpose of analysis, looking at unique patients, an assumption was made that if a patient was tested, retested at Mount Sinai more than once and had a status change, example, from negative to positive, only the worst case scenario was retained." What does that refer to?

DR. ALAGHEHBANDAN:

A. Let me just give you an example. We had--we have a patient here who had two specimens being sent to Mount Sinai for retesting, for example. Mount Sinai reported it back, on the first one, a changed result; on the second one, no changed result. For the purpose of

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this analysis, we used the one that had a changed result.

COFFEY, Q.C.:

Q. Okay, for dealing with that particular patient?

DR. ALAGHEHBANDAN:

A. For that particular patient. So we were dealing with a unique patient as opposed to number of records, because a patient may have had more than two records.

COFFEY, Q.C.:

Q. Yes, so in terms of the unique patients, if the patient had more than one retest, then the worst case one, which is the conversion, as it were -

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. - and I'll use that phrase advisedly, the changed result would be the one that you would record for that unique patient?

DR. ALAGHEHBANDAN:

A. For the purpose of the analysis, that's right.

COFFEY, Q.C.:

Q. But your database kept track of, for unique

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records -
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. - of any particular block that did or didn't have a change in results?
DR. ALAGHEHBANDAN:
A. Correct.
DR. MACDONALD:
A. And that was another database management property of the database, whether we're talking about tests or unique patients.
COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:
A. So we always had to be--we would qualify this, because we're talking about, in this particular context, the deceased, we have to talk about the individual and therefore we had to separate those individuals who had more than one test.
COFFEY, Q.C.:
Q. And here, one thing I wanted to ask you, Dr. Reza about is this, is in the course of your involvement in this matter, did you ever

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become aware of situations where a patient had been ER/PR tested years ago, back, I'll just, I'll pick say in 2002, and had a negative result and then in 2003, you know, pick a year, was retested, same sample retested, and the result was positive?
DR. ALAGHEHBANDAN:
A. On the same sample?
COFFEY, Q.C.:
Q. On the same sample.
DR. ALAGHEHBANDAN:
A. I can't recall that, but probably on a separate tissue sample, yes.
COFFEY, Q.C.:
Q. Okay, no, on the same sample was retested, and the issue of whether or not that patient or that patient's samples were ever retested at Mount Sinai. You recall I said 2002 and 2003 and of course, Mount Sinai is '05 and '06.
DR. ALAGHEHBANDAN:
A. Right.
COFFEY, Q.C.:
Q. So was it ever brought to your attention that, in the course of originally identifying patients, that those patients were weeded out,

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as it were?
DR. ALAGHEHBANDAN:
A. No, but I just want to clarify here. First of all, I never came across such a patient, but if we came and if we knew that the patient was tested and again retested in house, yet our assumption would have been that this patient must have been sent to Mount Sinai, no matter had the patient got retested once or twice in house. But matter of fact, I never come across any of those patients.
COFFEY, Q.C.:
Q. In terms of actually retested in house before 2005?
DR. ALAGHEHBANDAN:
A. Before 2005.
COFFEY, Q.C.:
Q. Because there were a number of them retested in house in '05.
DR. ALAGHEHBANDAN:
A. Right.
COFFEY, Q.C.:
Q. And ended up at Mount Sinai as well.
DR. ALAGHEHBANDAN:
A. That's correct.

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COFFEY, Q.C.:
Q. But retested before '05 in house, you didn't come across?
DR. ALAGHEHBANDAN:
A. No.
COFFEY, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. Dr. MacDonald, on the point of the use of the Provincial Mortality Database, is there any impediment to Eastern Health having easy access to that?
DR. MACDONALD:
A. No, they wouldn't have access to the provincial database. They would certainly have, in their own Meditech system, those patients that they were interested in who had died in hospital. 99 percent of the people do die in hospital. So for their own region, yes, they would have access to the deceased record. But this is a provincial database and only the Centre has access to the provincial database.
THE COMMISSIONER:
Q. So it would not have been--I'm just thinking

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in terms of--one of the problems we've been told in this whole process was the matter of the ability to identify exactly who was deceased, and I'm not talking about necessarily what they did in respect, as I understand it, to the concern about recent deceased was check obituaries and that kind of thing, but it wasn't just confined to the last month or two. So I was wondering if, outside of what was contained within the institution, there was another way of checking with the provincial database as to whether or not specific patients might be alive or not. But that wouldn't have been easily done?

DR. MACDONALD:

A. Not--oh, it certainly would have been easily done if they had asked.

THE COMMISSIONER:

Q. Okay.

DR. MACDONALD:

A. The database has been around for many years. We were not asked.

THE COMMISSIONER:

Q. So, okay, if the hospital had that kind of problem, then do I take it had they made the

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contact with the appropriate officials, there might have been a way of determining whether or not the people on the list, in fact, had died?

DR. MACDONALD:

A. Yes.

THE COMMISSIONER:

Q. All right, thank you.

COFFEY, Q.C.:

Q. Look at, just to go a bit further through this, in relation to this, page 11 of the exhibit, and within the database, how many of the negatives were deceased. In other words, you've written here, "as of February 2006, using the updated criteria, 237 negative patients were deceased. 248 patients were deceased in total. As of November 23rd, 2006, using the updated criteria, 264 negative patients were deceased. 281 patients were deceased in total." The choice of November 23rd, 2006, why that date? Is that the date that the -

DR. ALAGHEHBANDAN:

A. I believe -

COFFEY, Q.C.:

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Q. That's a briefing note?

DR. ALAGHEHBANDAN:

A. That's correct, yes.

COFFEY, Q.C.:

Q. Provided to -

DR. ALAGHEHBANDAN:

A. The Minister.

COFFEY, Q.C.:

Q. - Minister Tom Osborne.

DR. ALAGHEHBANDAN:

A. I can't recall who was the Minister at the time, yes.

COFFEY, Q.C.:

Q. And as of May 18th, that would be the date that Mr. Tilley held a press conference?

DR. ALAGHEHBANDAN:

A. I believe so.

COFFEY, Q.C.:

Q. Okay. These dates, were they ones that you came up with or were you asked to -

DR. ALAGHEHBANDAN:

A. We were asked.

COFFEY, Q.C.:

Q. Mr. Thompson asked that -

DR. ALAGHEHBANDAN:

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A. By Mr. Thompson.

COFFEY, Q.C.:

Q. - as of those dates?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. Here in this, question 4A poses "how many of the patients sent for retesting had ER status changes and how many did not have ER status changes?" and I should actually, perhaps before I get to that, Commissioner, I wanted to have Dr. Reza clarify something here, in terms of the context here, because by the time you're involved here now. You've noted on page five of this slide presentation that "Eastern Health had reported way back there were 939 negative ER patients retested at Mount Sinai, November/December '06. 176 reported as deceased. The existing database, NLCHI, does not match with the 939," and then you've noted on the next page here, page six, "preliminary analysis as of October 19th, 2007, the total number of records is 1,195. The total number of unique patients is 1,032."

DR. ALAGHEHBANDAN:

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A. That's right.
COFFEY, Q.C.:
Q. So 939, you've identified a not insignificant number more than 939 by that point?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And then here then, apologize, here in page 12 of this, question 4A, and I appreciate again this is as of that date, "how many of the patients sent for retesting had ER status changes and how many did not have ER status changes? 392 patients sent for retesting had ER status change. 504 patients sent for retesting had no ER status change." This is, it was just ER?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. This doesn't include someone who, for example, went from an ER negative PR positive to an ER negative PR negative?
DR. ALAGHEHBANDAN:
A. We did not consider PR here.
COFFEY, Q.C.:

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Q. Yes.
DR. ALAGHEHBANDAN:
A. We just considered ER.
COFFEY, Q.C.:
Q. And this would be then, these numbers here were based upon, as they existed at the time, I take it, the results from Mount Sinai?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Mount Sinai results. And now status change, at that point, you were defining status change as what?
DR. ALAGHEHBANDAN:
A. If you go back to previous slides, it's been noted as less than 30 up to 2000, less than ten after 2000.
COFFEY, Q.C.:
Q. So that's the critical--the clinical criteria?
DR. ALAGHEHBANDAN:
A. Clinical time line.
COFFEY, Q.C.:
Q. That Mr. -
DR. ALAGHEHBANDAN:
A. Was defined.

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COFFEY, Q.C.:
Q. - Gulliver had sent to you back in July, in terms of their criteria for retesting?
DR. ALAGHEHBANDAN:
A. And we confirmed it with other parties as well.
COFFEY, Q.C.:
Q. So sir, I'm going to ask, please, Registrar, you bring up Exhibit P-1025. Now this is--the first page of this is an e-mail from Mr. Thompson to Mr. MacDonald here, October 27, 2007, draft notes, and he says "Reza, these are my draft notes on this morning's meeting. If you have time, could you give them a scan to see if they reflect your understandings as well. If so, I'll base my communications with Louise to tell her the outcomes and with the other CEOs accordingly." Look at the very next page. It's a draft of some notes of a meeting of October 27th 2007, meeting regarding outstanding ER/PR data retest and communications issues at Department of Health and Community Services boardroom. Attendance are Ms. Jones, Mr. Gulliver, Ms. Pilgrim, Ms. Predham, Dr. Reza and Mr. Thompson in his

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capacity as DM for the Department of Health. There's a number of--I just want to ask you to kind of look through this, Reza, Dr. Reza, and tell us, please, what you recall, from your perspective, at the time, kind of the purpose of this meeting at that time was?
DR. ALAGHEHBANDAN:
A. If you go back to the first page of this note actually, it's been stated by Mr. Thompson that the purpose of the meeting was to have a clear understanding between Eastern Health and the Department with respect to outstanding information and how that activity has to be followed up by the Centre and other parties. So we discussed a number of documents, such as the letter that we viewed earlier this morning, and discussed the tables and the meaning of each table and where we are with those tables and outstanding information.
COFFEY, Q.C.:
Q. And here, Mr. Thompson had written--well, he sent it to Mr. MacDonald. I take it that's as a conduit to yourself, Dr. Reza, through Mr. MacDonald. Saying "Mr. Thompson summarized the objective of the meeting: to discuss the

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continuing activity directed at identifying patients that have not been retested or, if retested, have not yet been communicated with by Eastern Health. The plan is to discuss each list that has been prepared by NLCHI, some of which have been previously sent to Eastern Health and to ensure there's clear understanding between Eastern Health and the Department as to what each list represents and the next steps that are to occur. NLCHI is represented in the meeting to ensure clarity on how the lists were assembled. The plan is also to have a general discussion on communications." And then it goes on from there.

Now Mr. MacDonald, when you saw this, and from your perspective then coming out of this, what was your understanding then of NLCHI's role?

DR. MACDONALD:

A. It certainly--as we've already stated, our mandate from the very start was simply to identify patients who had originally tested negative for the ER/PR test and been retested at Mount Sinai, but because of our

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investigation in the creation of the database, we did come across some cases that needed further work by Eastern Health and the other authorities. For example, the potential for patient with an original ER negative not sent for retesting. We would need clarification as to why that didn't occur. So I think as we've already established, Mr. Coffey, the Centre's role in creating the database really expanded and got very--and the database became very complex, and I think that's reflected in our scope where we originally thought, based on our mandate, eight to 12 weeks, and here we are 14 months later still perhaps not with a full complete database. So I can't even tell you today that our role might not change.

COFFEY, Q.C.:

Q. And if we can go to the last--again, at page four and five, page four there's a paragraph entitled communications. I'm not going to take you through all the details of that because it's self--in some ways self explanatory, but the note here at the end is to the effect that "Eastern Health acknowledge in a public communications effort parallel to

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the direct contact with living patients is necessary. Their communications director is currently planning an approach and will be in touch with the Department. Though the communications from other regional health authorities may be needed as well, further checking with them is necessary, first to determine whether any of the cases noted above are truly 'missed'--'missed cases' or whether they were not sent for retesting based on valid reasons. As well, the list of October 26th, cases for which patient contact is unknown, may contain some cases from the other regional health authorities. Until we know from Eastern Health which of these cases were not contacted by Eastern Health, we will not know which cases to send to the other regional health authorities with the same question."

So I take it that at the time, Mr. MacDonald, was it your understanding that they were trying to straighten out--Mr. Thompson was trying to straighten out with Eastern Health as to kind of who's responsible for what here? If you, for example, NLCHI identifies patients who haven't been retested

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and who arguably, perhaps, should have been.

DR. MACDONALD:

A. Yes, that's -

COFFEY, Q.C.:

Q. What role you--what role, if any, you'd have.

DR. MACDONALD:

A. Yeah, we did play somewhat of an expanded role beyond database management, and in particular on the communications side, but there was also, at the time, around the communication to the patient on the results as to Eastern, to my understanding, would be communicating results to the patient if in fact there was a change, and the other authorities only if there was no change. So we were involved in that, to a certain extent, and there was certainly a difference of opinion as to how that would unfold. So we kind of played the role of--if there was a particular case that we needed to investigate, we would--we would go to Eastern Health first and then if we had to, we'd go to the authorities and try to iron it out. So we kind of played intermediary, I suppose, to a certain extent.

COFFEY, Q.C.:

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Q. I take it in identifying--investigatory identifying role and then an intermediary role, if necessary, between the authorities?
DR. MACDONALD:
A. Yeah. We were in the best position to know what the question was and try to get the answer, and we would go to the sources and sometimes we would bounce around a bit until we actually found the source.
COFFEY, Q.C.:
Q. If we could, in relation to this, P-1026, please, 10-26? This is an e-mail of October 27th from Mr. Thompson to yourself, Mr. MacDonald. Subject is draft notes and he says "Don and Reza, I need to know when you were first advised that the Carbonear specimens had indeed been sent for retesting. The October 24th spreadsheet says they were sent to Mount Sinai on September 27th. Was this spreadsheet the first time we knew? My reason for asking is that I'm puzzled why Eastern Health is only now contemplating making phone calls to these people and did not do so at the same time as samples sent to Mount Sinai. My question does not reflect upon you at all. I just want to

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know the chronology. Thanks, Robert."
Perhaps I'll ask you, first of all, Dr. Reza. In relation to Mr. Thompson's query about was this spreadsheet the first time we knew about the Carbonear cases that had been missed, was that -
DR. ALAGHEHBANDAN:
A. Just let me go back to your steps here. So we investigated it and we started to review the pathology reports from the regions. We learned that some Carbonear cases, negatives, clinical negatives, were not sent to Mount Sinai because we did not have documentation to support it. Then we sent a letter to Eastern Health asking them whether these patients have been retested or not, and obviously following to that, Carbonear, I believe in coordination with Eastern Health, actually sent those cases to Mount Sinai, and the spreadsheet that Mr. Thompson is referring to is a list of those patients who were compiled by Mr. Gulliver at a time at Eastern Health's lab and they were sent to Mount Sinai. So that was the first time that we learned about the fact that that spreadsheet was basically the patients were

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sent to Mount Sinai.
COFFEY, Q.C.:
Q. There were certain patients, which may have included them and others, that you had queried? You kind of queried about what's the status of this, and then eventually, because we saw that, I believe, in a September 20th letter to Ms. Pilgrim.
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And then eventually, you got an October 24th spreadsheet which listed a bunch of patients and their specimens which Mr. Gulliver had just forwarded to Mount Sinai for retesting?
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. And that you became aware of then?
DR. ALAGHEHBANDAN:
A. That's right.
THE COMMISSIONER:
Q. Sorry, just going to make sure I'm following. Do I take it that on the basis of the pathology reports from Carbonear, which you

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had all gone through, you discovered that there were patients who A. were not on your list, and B. would seem to meet the criteria for retesting?
DR. ALAGHEHBANDAN:
A. That's correct.
THE COMMISSIONER:
Q. So you asked the question as to what happened to these folks?
DR. ALAGHEHBANDAN:
A. That's correct.
THE COMMISSIONER:
Q. And learned that it had been -
DR. ALAGHEHBANDAN:
A. Following to that letter, they basically compiled the list and sent them to Mount Sinai.
THE COMMISSIONER:
Q. Okay. That was the order. It was not that they were just late doing them.
DR. ALAGHEHBANDAN:
A. No.
THE COMMISSIONER:
Q. It was on the basis, it was your letter -
DR. ALAGHEHBANDAN:

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A. The letter generated -
THE COMMISSIONER:
Q. - that moved people to ask questions about these particular individuals and, in fact, take the action of sending the -
DR. ALAGHEHBANDAN:
A. The letter prompted the action actually.
THE COMMISSIONER:
Q. Thank you.
DR. ALAGHEHBANDAN:
A. You're welcome.
COFFEY, Q.C.:
Q. Now just, because again, so in respect of when I say non-Eastern Health, I mean, non St. John's, okay, for all the hospitals outside St. John's, and I'll come back to Clarenville eventually, remember to do that, but for Carbonear, for Gander, Grand Falls, Corner Brook and St. Anthony, you got, you understood, all of the pathology reports, positive and negatives?
DR. ALAGHEHBANDAN:
A. Negatives.
COFFEY, Q.C.:
Q. Negatives. Did you ever get the positives?

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DR. ALAGHEHBANDAN:
A. No, we didn't ask for positives. We asked for negatives.
COFFEY, Q.C.:
Q. Negatives. And do you define what negatives were in asking for them?
DR. ALAGHEHBANDAN:
A. I'm just trying to think when we requested that. I think we requested that through the Department of Health back in July '07 asking for all pathology reports with ER/PR negative, negative ER/PR. I'm not sure if we--in that e-mail, we defined negativity per se, but I can recall that we requested that through the Department, asking for all negative ER/PR pathology reports from the regions.
COFFEY, Q.C.:
Q. So have you ever looked through the St. John's pathology reports?
DR. ALAGHEHBANDAN:
A. The answer is yes and no.
COFFEY, Q.C.:
Q. I mean, on -
DR. ALAGHEHBANDAN:
A. I have to explain.

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COFFEY, Q.C.:
Q. - I appreciate you've looked at individual particular ones.
DR. ALAGHEHBANDAN:
A. Right.
COFFEY, Q.C.:
Q. But I'm talking about like en masse.
DR. ALAGHEHBANDAN:
A. No.
COFFEY, Q.C.:
Q. Okay.
DR. ALAGHEHBANDAN:
A. However, I have to correct myself here. For majority of those cases within the St. John's region, we went into Meditech and we looked up their ER/PR original scores within Meditech to ensure the quality of the data that we received based on August 1 file, but the answer, the quick answer is no, we did not look at it, as you mentioned, as a mass, going through all pathology reports, hard copies from St. John's region, negatives.
COFFEY, Q.C.:
Q. And for the out of St.--from outside St. John's, you've gone through all the pathology

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reports that they've sent in to you?
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. And you had asked for all of the ER negative patients?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. All the pathology reports.
DR. ALAGHEHBANDAN:
A. All the negative reports, yeah.
COFFEY, Q.C.:
Q. If we could, just again on--I got to have something clarified here, if I can. Exhibit P-3498? Page--this is that September 20th letter of 2007 to Ms. Pilgrim. Page three, please. Just looking down through this, get down into the--well, into the page here, you get, for Carbonear, there are a long listing for Carbonear, actually begins almost at the top of the page and continues on, and some of them certainly are, up above, you know, 2000 is a five to ten ER, 2000 and ten to 15, a '99 a ten, 2000 a one to five, a '99 a negative,

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'99 negative, I'm sorry, a five, an '05 a negative, an '04 a negative, a '99 a 10 to 20, and we get further down though, you get into like 2003, a 20 to 30. A 2004 case, a 20 to 30; a 2003 case, 20 to 30. Just wondering, if you asked that people send you the negatives -

DR. ALAGHEHBANDAN:

A. We did.

COFFEY, Q.C.:

Q. Why were you getting all these 20s to 30s?

DR. ALAGHEHBANDAN:

A. I don't know. It was basically sent to us. I don't know what criteria they chose to select their pathology reports, but we simply asked for negative ER/PR pathology reports.

COFFEY, Q.C.:

Q. Now up until September, and you're involved in this exercise with Ms. Pilgrim, were you aware of any patients having self-identified up to that point?

DR. ALAGHEHBANDAN:

A. I was aware of the fact that there were a number of patients who called in and self-identified themselves to Eastern for the matter of retesting, and that group of people,

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their samples were sent to Mount Sinai, if I'm understanding it correctly--if I recall it correctly, back in July '07. There were a number of patients, I would say less than ten patients, during the course of ER/PR, I recall, after August '05, up to that point.

COFFEY, Q.C.:

Q. Did you say '07 or--the self-identified ones, '08, actually?

DR. ALAGHEHBANDAN:

A. '07, July, '07, their samples were sent to Mount Sinai because there were two sets of self-identified patients. One set between '05 and '07.

COFFEY, Q.C.:

Q. Okay.

DR. ALAGHEHBANDAN:

A. And then we had a group of self-identified patients in '08. I'm speaking to the first group.

COFFEY, Q.C.:

Q. Yes.

DR. ALAGHEHBANDAN:

A. We were not involved with that. That occurred prior to July '07.

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COFFEY, Q.C.:

Q. Did you get an explanation as to how they had been missed?

DR. ALAGHEHBANDAN:

A. I spoke to Mr. Gulliver and the main reason was that ER/PR entry code was not basically entered into that appropriate box within Meditech when the test was ordered, however, the test was performed, yet the test was not ordered technically within the Meditech system.

COFFEY, Q.C.:

Q. So really in '07--when you first got involved, really in the first two months, you realized speaking to Mr. Gulliver that not all the time that an ER/PR test was actually done, was the appropriate box checked in Meditech?

DR. ALAGHEHBANDAN:

A. That's correct.

COFFEY, Q.C.:

Q. And if it wasn't checked in Meditech, he hadn't found it?

DR. ALAGHEHBANDAN:

A. Because he searched by ER and PR procedure codes, so he would not have been able to

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capture them through that exercise.

COFFEY, Q.C.:

Q. And so you understood that back -

DR. ALAGHEHBANDAN:

A. That was a limitation back then.

COFFEY, Q.C.:

Q. Limitation back then.

DR. ALAGHEHBANDAN:

A. Yes.

COFFEY, Q.C.:

Q. And that has resurfaced again now in 2008.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And we'll talk about that a bit. Was it pursued any further at the time in 2007? I mean, that limitation--I mean, if Mr. Gulliver is telling you, look, Dr. Reza, I got about ten or so patients who somebody didn't check the right box, therefore, I, Mr. Gulliver, didn't find them, was that pursued any further at that time?

DR. ALAGHEHBANDAN:

A. I believe--well, first of all, I shared that with Mr. Thompson's group, and also I believe

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Mr. Gulliver shared that with his group at Eastern Health. So that's something wasn't unknown to anyone, it was known. As you mentioned, again it resurfaced and prompted us to a new search.

COFFEY, Q.C.:

Q. At the time, I take it, initially it wasn't pursued, at least in '07?

DR. ALAGHEHBANDAN:

A. That's correct.

THE COMMISSIONER:

Q. Can I take it that Meditech does not have one of those irritating little systems that refuses to take any information unless you fill in all those boxes?

DR. ALAGHEHBANDAN:

A. I understand that's a fairly accurate statement. As a matter of fact, if you don't fill that ER/PR procedure code, it wouldn't give you an alarm, for example, window saying that, okay, you can't proceed because you haven't entered it into that system, and that's how we have some basically self-identified new patients because they were not captured at the beginning through that ER/PR

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search strategy.

DR. MACDONALD:

A. It is a limitation to the lab system. We had spoken to Eastern Health about that, that they can actually enter a pathology report without an order being included in the Meditech. They recognize that now as a weakness.

COFFEY, Q.C.:

Q. So we've heard from a patient named Elizabeth White as having been a person who self-identified from Carbonear in the summer of 2007. Were you aware--were you made aware of her at that time, in the summer of 2007, do you recall?

DR. ALAGHEHBANDAN:

A. If we were notified of that individual, definitely the patient would have been--the patient's information entered into the database, but I just don't have the detailed recollection of that specifically.

COFFEY, Q.C.:

Q. Your memory of Carbonear, such as it is, is that when Carbonear sent you a listing of pathology reports, as we can see here, you noticed, well, I don't have any retest results

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for a whole bunch of these?

DR. ALAGHEHBANDAN:

A. That's correct.

COFFEY, Q.C.:

Q. And made the inquiry.

DR. ALAGHEHBANDAN:

A. And prompted us to write that letter.

COFFEY, Q.C.:

Q. So in coming--if we could look, please, at Exhibit P-1028. Actually, no, I apologize. Go right to P-1032, please. This is a letter of October 29th, 2007. It's to Boyd Rowe, CEO, Labrador Grenfell. It's from Mr. Thompson, but I take it that in effect, Mr. MacDonald, and Dr. Reza, this is--these are questions that your organization wanted answered? Mr. Thompson wanted them answered too, but, in effect, you posed the questions?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And here then you have a List One attached that you want answers to, and a List Two as well attached, and there are people fall into different categories there. I'm not going to

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take you--take the Commissioner through those here in detail, but there are certain things or information that you needed clarified or provided from Labrador Grenfell. If we could look at Exhibit P-1033. This is a letter of the same date, October 29th, 2007. It's to Karen McGrath, the CEO in Central, and again a similar sort of exercise, a set of lists, and questions associated with them.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. That NLCHI needed information for. Exhibit P-1035, please. Here is a letter of the same date to Ms. Susan Gillam, the CEO of Western, again the same thing, lists one and two attached, and questions posed for information. Just here, and I'll just use this one as an example, at the bottom of the first page here on your List One, this list contains patients who were identified by Western to NLCHI as having negative ER/PR results from '97 to '05 and also sent for retesting '05/'06. NLCHI has been unable to find information with Eastern Health's information systems, or in a

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separate data file provided by Mount Sinai Hospital to verify these cases had been retested. "Therefore, we ask you to determine from your information system or files whether you can verify that these cases have been retested. If so, please forward us the following information in each case", and you've got a list of information you want. "If any cases have not been retested, please inform us on a case by case basis if there was a valid reason that a retest was not requested. If there are cases for which retesting should have been completed, including deceased cases, please take the necessary action to forward these cases as consults to Mount Sinai Hospital as soon as possible. You should also prepare to communicate with the patients' families regarding these retests, and we will be pleased to discuss with you the timing and approach that might be taken", and it's signed by Mr. Thompson, as the Acting Deputy Minister of Health. This is a question for you, Mr. MacDonald, I appreciate that this was--Dr. Reza, you had provided the names?

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DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. That you wanted information in relation to.
DR. ALAGHEHBANDAN:
A. After we had the database, we could cross-reference and link with other sources, so we could compile this list as whether they had been retested or whether they had been communicated with.
COFFEY, Q.C.:
Q. And then, Mr. MacDonald, your organization then was letting Mr. Thompson know there are certain patients that we've identified that we can't find any record that they were retested or whatever, if they were communicated with, and so on--I mean, there's a number of different questions, particularly they weren't tested or whether they were tested, retested, whether they had been told about it. You provided that to Mr. Thompson?
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. And the idea that--because here he is, in

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effect, saying--he says, in fact, "If there are cases for which retesting would have been completed, please take the necessary action and forward these cases". That's Mr. Thompson speaking as Acting Deputy Minister. From NLCHI's perspective, were they involved in directing anybody to do anything other than requesting that information be provided?
DR. MACDONALD:
A. No. Obviously, this is a patient care issue.
COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:
A. It's not a database management issue, albeit through our activities we did identify particular cases that probably would require follow up from the health system to ensure that proper patient care had taken place. It was our--in working with Mr. Thompson and the task force, we felt that best be conveyed through his office, not the Centre, because our mandate was really the creation of the database.
COFFEY, Q.C.:
Q. And, Dr. Reza, did you get responses then?

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DR. ALAGHEHBANDAN:
A. Yes, we did receive responses from the regions.
COFFEY, Q.C.:
Q. Yes, and addressing, I take it, whatever the particular question was for particular patients?
DR. ALAGHEHBANDAN:
A. We received responses from the regions. We reviewed the responses. If we had questions, we went back to the regions to clarify them. Once we were comfortable with the information, then we entered them into the database.
COFFEY, Q.C.:
Q. Now you recall we looked at September 20th letter to Ms. Pilgrim, which again had five lists on it. What happened with respect to the response to that?
DR. ALAGHEHBANDAN:
A. We had that meeting that we just reviewed.
COFFEY, Q.C.:
Q. October 20th.
DR. ALAGHEHBANDAN:
A. We basically discussed the tables, and we wanted to make sure that everyone understands

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what these tables are about and everyone is on the same page, and there was further discussion as how to proceed with the process.

COFFEY, Q.C.:

Q. And did you ever receive a response?

DR. ALAGHEHBANDAN:

A. We received a response from Eastern Health as well.

COFFEY, Q.C.:

Q. And in relation then to the September 20th letter, were all of those--eventually all of those matters dealt with one way or the other between yourself and Eastern Health?

DR. ALAGHEHBANDAN:

A. That's correct. If there was a matter of clarity, again as I mentioned, we had to go back to Eastern Health, to certain individuals, to confirm or clarify the matter.

COFFEY, Q.C.:

Q. Okay. Mr. MacDonald, from your perspective then, after that--when we get into late October, 2007, from your perspective as the director, how did this unfold? What's kind of your next involvement in this?

DR. MACDONALD:

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A. With respect to the expanding role of -

COFFEY, Q.C.:

Q. Yes.

DR. MACDONALD:

A. We were asked to actually take a bigger role other than just create the data, and we certainly saw that we could provide that expertise to both the task force and the ministry, so--as I've said a couple of times, it certainly--our role did expand and evolve beyond just the creation of the database where we became more, in some cases, a conduit to the system, to make sure appropriate patient care had been provided in some cases that may have been missed, or certainly we would investigate further with the system to ensure that there was a valid reason why a person wasn't tested. So it was expected that we would do that, and we did it.

COFFEY, Q.C.:

Q. If you could look, please, at Exhibit 3499. Now this is a document entitled "Interpretation of statistical tables from ER/PR database", draft, January 28th, 2008, and then it's an introduction; total cases,

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there's a comparison of Eastern Health's November 23rd, 2006, briefing for the Minister with the new database results, there's at paragraph four, a time frame for retesting, including the number of cases by year of original test, and I take it this was the draft and you can see somebody has marked up parts of it, handwriting. Paragraph five, positivity rates, and then there's a table there, and--Table A, B, C. Paragraph six, changes in ER/PR scores after retesting. Table D, Table E, change rate by region, and then changes by site, paragraph seven, and then it's a Table G. I may have skipped some of the tables here, and then there's an addendum with variation between reported data and NLCHI database, the positivity rate, and false negatives. Sir, what was going on here, Mr. MacDonald, what was the reason for this document being prepared, at whose request, and who prepared it?

DR. MACDONALD:

A. The Centre's role in this document was to provide the task force with an analysis. So basically our role stopped after we provided

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the task force with the tables. We were asked to review some of the content prepared and to provide comments back, but this was an initiative undertaken by the task force, and my understanding is that it will be provided to the Commission.

COFFEY, Q.C.:

Q. So the tables--Dr. Reza, you're nodding. The tables were prepared at the request of the task force, like, if they ask for a table of whatever?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Of a particular type, "x" versus "y" or whatever the data was. Asking for a particular--something that could be provided in a table.

DR. MACDONALD:

A. Yeah, and really it kind of grew, a few questions, a few tables, okay, let's do these tables, so we didn't really get a specific--here's one stop shopping, do all that, it was kind of an innovative thing that went back and forth between us and the task force.

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COFFEY, Q.C.:
Q. But the editorial--I shouldn't say editorial, the text comment here, was NLCHI involved in that? Like, for example, introduction, this note provides a summary interpretation of statistical tables from NLCHI ER/PR database, the tables address clinical issues only, communications data will be forthcoming, and it goes on from there. Would NLCHI have prepared this?
DR. MACDONALD:
A. No.
COFFEY, Q.C.:
Q. That's just something that the--in your understanding, the task force -
DR. MACDONALD:
A. We would certainly have reviewed it, but it would have been written by the task force, and we would have certainly--we wouldn't approve it now, but we certainly would have reviewed it before it went out.
COFFEY, Q.C.:
Q. And if you were asked to review and make--asked for your input or commentary upon it, you would have provided that?

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DR. MACDONALD:
A. Oh, yes.
COFFEY, Q.C.:
Q. Okay, and it's apparent when we look at this, that some people have marked it up with handwriting and so on. If we could look, please, at Exhibit P-3500. This is a document entitled "Interpretation of statistical tables from the ER/PR database, draft, January 31st, 2008", and again just looking at this, for example, this particular copy printed out has the tracking changes. You can actually follow it because of the way it's printed out here. So--and it's got--now utilizing footnotes. If we can go then, please, to Exhibit P-3501. This is again an interpretation of statistical tables from ER/PR database, draft, February 4th, 2008. This particular one, at page two of it, you'll notice there are a number of footnotes. See that, numbers one to four, and number four footnote is the definition of negative between '97 and 2000. It gives the cutoff score of 30 percent, and after 2000, it gives a cutoff score of 10 percent. "This is consistent with the letter, September 6th,

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2005, from Dr. Cook to lab directors and medical directors throughout the province, in which instructions were given for the selection of samples for retesting at Mount Sinai. It's also consistent with Dr. Khalifa's proposed cutoff as communicated in his letter to pathologists on February 16th, 1998". I'm going to ask you, both of you, for example, that sort of comment here on footnote four, would NLCHI have provided that?
DR. ALAGHEHBANDAN:
A. We -
COFFEY, Q.C.:
Q. I'm not suggesting it's not accurate. I'm just asking if you provided it.
DR. ALAGHEHBANDAN:
A. No, I understand your question. With respect to this specific footnote, I believe this is backed up by the letter from Dr. Cook to the regions. We were asked about this--if we were asked about this, probably we would have provided the task force and Mr. Thompson's group with e-mails and communications and information that we received from Eastern Health or other individuals. So--and we were

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basically, I guess, supporting the document or providing input for the document--to the document.
COFFEY, Q.C.:
Q. Exhibit P-3502, please, and there's an interpretation of statistical tables from estrogen receptor database, draft, February 5th, 2008. Now here if we could look, please, at page seven, there are a series of appendices and tables here, and this particular one, for example, Appendix I, results tables, based on NLCHI database results in Appendix 3. So Table "A", entitled "Number and percentage of original negative ER tests and cases by year". So this is a sort of data or data table that NLCHI would have provided, Mr. MacDonald?
DR. MACDONALD:
A. That's correct.
COFFEY, Q.C.:
Q. And this would have been based upon, presumably, a printout of what was in the, as it then was, the SPSS database?
DR. MACDONALD:
A. Yes.

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COFFEY, Q.C.:
Q. And Table "B", the positivity rate for ER testing by year is there. Table "C", positivity rate for original ER testing by cutoff point by year. Table "D", change rates of original negative ER tests as compared to Mount Sinai results by year. Table "E", change rates of original negative ER tests as compared to Mount Sinai results by cutoff point and by year. Table "F", retest results and change rate of ER negative patients by time period by region. Table "G", change rate of ER negative patients by site of original test, and then Appendix 2, variations between reported data and the NLCHI database. This is an analysis, I take it, or a comparison of certain documents that Eastern Health had utilized before the Commission was established or before NLCHI ever got involved, and things that you were finding in your database?
DR. ALAGHEHBANDAN:
A. I'm sorry?
COFFEY, Q.C.:
Q. This is a comparison -
DR. ALAGHEHBANDAN:

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A. This comparison is based on Mr. Gulliver's calculation of positivity, and the other one, I believe that comes from another individual, and these numbers are not coming from the database.
COFFEY, Q.C.:
Q. Okay, these are not from--yes, these are May 10th, 2007, data from Eastern Health, and May 16th, 2007, data from Dr. Hutton, and there's a reference to false negatives. it goes on then at some length with a number of other tables. Now the request then for these particular tables originated with whom?
DR. MACDONALD:
A. The task force.
COFFEY, Q.C.:
Q. Which would be Mr. Thompson, I take it?
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. Or somebody on his behalf?
DR. MACDONALD:
A. Yes. I would like to point out, though, that myself, Reza, and Tracy Chislett, another epidemiologists that worked closely on this,

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worked very closely with the task force and we had many meetings, so a lot of questions would have been generated out of our joint discussions. I don't want to give the impression that the Centre was just doing--just doing the doings. We were actively involved in trying to figure out how to answer some questions that are being posed by government, and again that gets into the database management, information management, and epidemiology, trying to answer a question that probably is not very clear. So we played an active role in trying to refine questions and support analysis for it.
COFFEY, Q.C.:
Q. Mr. MacDonald, what did you understand in really a summary form the questions that were sought to be answered? What was your understanding?
DR. MACDONALD:
A. Well, ultimately what we really wanted to answer, and as you noted, tables go on at length, and I suppose at that point we're probably just looking under a whole bunch of different rocks trying to answer the ultimate

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questions, have we identified each and every patient affected by this testing, and have they been communicated with, and has proper treatment; if it had not been provided, is it being provided now. Those were basically what--the whole mandate we evolved towards. So whether there was 20 different questions coming out of those, those were the main ones.
COFFEY, Q.C.:
Q. Now there are tables, we've heard just in passing, to comparisons of, for example, retest results by region.
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. At times, I take it, there were questions raised about, well, is this confined to a particular region in particular time periods?
DR. MACDONALD:
A. The question or whether it was systemic across the system or whether it was focused in on a particular area had come up, yes.
COFFEY, Q.C.:
Q. And you've had, I take it, a fair amount of time to consider various tables and so on.

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DR. MACDONALD:
A. There's been considerable analysis done, yes.
COFFEY, Q.C.:
Q. Was it confined to any one point in time, first of all, any one point in time?
DR. MACDONALD:
A. I don't think we have a definite answer for that. I think that question has been raised now as to points along the continuum of '97 to 2005, there were some pinnacle points along that line, and that it is possible that some decisions made at certain points may have impacted on what we're finding today. I don't think we have an answer to that yet. We haven't really delved into that analysis. That's one of the things Eastern Health has asked us to look at.
COFFEY, Q.C.:
Q. How about the regions, any particular--the same question in relation to the regions?
DR. MACDONALD:
A. I don't think that has had the same focus as the time continuum. We haven't really concentrated much on the regional perspective at all.

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COFFEY, Q.C.:
Q. And although there are certainly tables created -
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. Early in 2008.
DR. MACDONALD:
A. I would suggest that our preliminary analysis didn't really show anything that required something to expediate any type of analysis.
COFFEY, Q.C.:
Q. And was that because there was no one region that was particular better or worse than another? Worse, in the sense of retest results.
DR. MACDONALD:
A. From our position, from an epidemiological position, because sometimes a particular area of the province may have a very high rate of let's say, positivity or negativity, for that matter, or change in results, but the sample size was so small, it was more a reflection on just the small number of cases. Five out of ten is 50. It's just the same as 500 out of

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1000 is 50. We would be concerned with the 500 out of 1000. So we didn't really have numbers to substantiate some of the results we found.
COFFEY, Q.C.:
Q. You might be into a situation, I take it, to use the vernacular, that the sample size in a particular region was so small that it wouldn't be necessarily representative of the quality of the work or the quality of the output?
DR. MACDONALD:
A. And certainly, you know, we also--it's not really a sample--it is a sample because we didn't look at positives, and that's certainly a limitation to our database. We've only looked at negatives. So we do have a population of negatives to the extent that we are moving towards identifying each and every patients. So in that sense, it's not a sample. So from a pure statistical sense, people would suggest you're using a census, not a sample, and, therefore, what you find is what you find, but nevertheless, because of the small number of tests being performed in

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certain areas of the province, it didn't--you know, you can't base any conclusions on just the number of test results for five patients, for example.
COFFEY, Q.C.:
Q. Now in relation to that, while we're on the topic, just before lunch, Commissioner, from your perspective, Mr. MacDonald, what if any are the implications of a original positive not having yet--at least as of yet, anyway, been entered in the database, or for that matter, even identified, frankly -
DR. MACDONALD:
A. Yes -
COFFEY, Q.C.:
Q. To be entered in the database?
DR. MACDONALD:
A. And that's a valid point, and we've already discussed some of our earlier work, that that was certainly something that we could have looked at, but given or timing and resources, we decided to try to approach it from a different lens. The main impact on not having positives in the database, or not including positives in our analysis, is that we don't

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have a clear denominator. We don't have something--what's the total number of cases. I just mentioned that we have the total population of negatives, but we don't have the total population of ER/PR. So we've only got a sample of the ER/PRs, albeit the population of the negatives, if you can understand my train of thought there.

COFFEY, Q.C.:

Q. Uh-hm.

DR. MACDONALD:

A. We don't know what the false negative or false positive rate of the positives are and how that would relate or correlate to the false negative and positive of the negative, ER negative. So it's--we don't have the complete picture.

COFFEY, Q.C.:

Q. And I take it, at least up to this point in time, I take it that's--well, amongst perhaps other reasons, that's because you were never asked to generate it?

DR. MACDONALD:

A. We certainly had some early discussions.

COFFEY, Q.C.:

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Q. Yes.

DR. MACDONALD:

A. But we -

COFFEY, Q.C.:

Q. Just chose, for practical reasons -

DR. MACDONALD:

A. It was--a pragmatic decision was made.

THE COMMISSIONER:

Q. Mr. Coffey, we are going to have to take that luncheon break now.

COFFEY, Q.C.:

Q. Yes, thank you, Commissioner.

THE COMMISSIONER:

Q. We'll met again at ten after two. Thank you.

(LUNCH BREAK)

THE COMMISSIONER:

Q. Mr. Coffey.

COFFEY, Q.C.:

Q. Thank you, Commissioner. Welcome back, gentlemen. If we could look, please, at Exhibit--I believe we've done P-3503. If we could look, please, at Exhibit P-3505, 3505. Gentlemen, this is entitled "Technical brief on statistical tables from estrogen receptor/progesterone receptor ER/PR

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database", draft, February 29th, 2008, and again I take it that this is one of--one of the copies of an evolving document. Dr. Reza, the Commissioner has heard testimony concerning the conversion rate in the sense of how it was talked about publicly, particularly going back to May of 2007 before you were ever envisaged being involved, and the rate talked about publicly and through some of the documents here, is 40/42 percent, depending upon which one you look at. Bearing in mind these tables, and the data in the tables, and your overall knowledge of this, that 40/42 percent figure, did you come across that figure at times, you know, when you were doing your calculations?

DR. ALAGHEHBANDAN:

A. We were asked by the task force office to create those tables and present them with numbers, and based on the calculation, that was our understanding at the time.

COFFEY, Q.C.:

Q. In terms of--I take it that that figure--and I appreciate it's off by at times a fraction of a percent and so on, but 42 percent, give or

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take a little bit, for the province was the conversion rate using 30 and 10 cutoffs?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. For the time period--that's the rough rule of thumb?

DR. ALAGHEHBANDAN:

A. Based on the what the database contained.

COFFEY, Q.C.:

Q. And that's based upon the database, such as NLCHI developed it finally. It's about roughly just over 40 percent of the samples that were retested had -

DR. ALAGHEHBANDAN:

A. Had the changed result.

COFFEY, Q.C.:

Q. Had a changed result based upon the 30/10 cutoff?

DR. ALAGHEHBANDAN:

A. That's correct.

COFFEY, Q.C.:

Q. Okay. So, in effect, really you -

THE COMMISSIONER:

Q. Changed results are?

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DR. ALAGHEHBANDAN:

A. Changed results means--let me just go back a few steps here. I want to make this point here clear that the database was created for the purpose of having a list of those patients who were tested originally here and retested at Mount Sinai. That was the first question. The second question, has this patient been communicated with. So something such as conversion rate, something like change in results, right, or whatever we call it, false negative, false positive, these are the terms that basically we've been trying to see whether the database could give us further information in addition to the two main objectives of the database that at the beginning we were planning to work on it. So basically we started compiling data and tables for the task force and see what are the other things that we probably could get from out of this database. However, it's important for all of us to understand that this database, the purpose of the database was to answer those two questions. So whatever comes out of this database besides those two questions

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should be seen carefully and interpreted carefully because there are multiple factors involved with respect to a change results. It could be a clinical condition situation, it could be technical condition situation, and so on and so forth. So the database does not include clinical components and data, does not include technical data, and that's what we have to be aware of before putting any context around it. So when we say, yes, there was a conversion of about 40 percent across the province, that's just a raw number, that number may not tell us a lot, but that's what we can get out of database, but again how that can be seen, I mean, it's a different--it's a separate story.

COFFEY, Q.C.:

Q. And just as an illustration of this, in this exhibit, if we could look at page nine, please. Actually--yes. This is a heading, "Change Rate False Negatives, See Tables F to I", and then there's a summary of ER/PR, Mount Sinai retest data, and change rates, 1995 to 2005 by cutoff point, and there's a row entitled "Cutoff points percentage, 30/10",

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which I take it is using a 30/10 cutoff as of December 31st, 2000, and then cutoff point using 10 percent, and a cutoff point using 1 percent. Then we look, the text below reads, "Using a clinical cutoff of 30 percent/ 10 percent, the number of original ER negative tests between 1997 and 2005 dropped from 1089 to 623 after being retested at Mount Sinai Hospital. Thus the change rate was 43 percent of the total ER negative tests for the whole period. Removing the ER negative/PR positive tests from this group and assigning them as ER/PR positive, the change rate was 33 percent. In other words, even though the proportion of false ER negatives was 43 percent, a more inclusive definition of positive, incorporating the ER negative/PR positive tests, means that the false negative rate from a clinical perspective was 33 percent". That's the way the text reads, and then you go on to talk about a 10 percent cutoff and a 1 percent cutoff.

DR. ALAGHEHBANDAN:

A. Uh-hm.

COFFEY, Q.C.:

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Q. You can see that on the screen there now. In terms of a false negative rate from a clinical perspective being 33 percent, okay, I take it that that--the underlying assumption there is that a person who is ER negative/PR positive, as long as the PR positivity was over the cutoff point, using that cutoff of 30 and 10, as long as there was PR--number was higher than 30 at one point, or higher than 10 at another, that the conversion or change rate, of course, would change, and it did change.

DR. ALAGHEHBANDAN:

A. It did change, yes.

COFFEY, Q.C.:

Q. It went from 43 to 33. Did that mean, in effect, Dr. Reza, that there were a number of patients for whom the original tests were ER negative, PR positive, and on retest, there was a not inconsiderable number that were ER positive, PR positive?

DR. ALAGHEHBANDAN:

A. So basically that's what exactly it says. It says that from ER negative, considering PR as positive, they changed to ER positive.

COFFEY, Q.C.:

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Q. There were -
DR. ALAGHEHBANDAN:
A. And that's what basically the sentence is--and this is coming from the database, and the database can only describe what it is, and doesn't put reason behind it why that happened. So my point being, yes, it says that 33 percent, one third of that whole cohort, changed from ER negative, while being positive for PR, to ER positive.
COFFEY, Q.C.:
Q. And we've heard a phrase used by one of the witnesses here, I believe an oncologist, to describe it "saved by the PRs" was the way that it was--something that she and her fellow physicians apparently had a phrase they used to describe the situation when it became--the results started to come back and they realized what had happened, which is that an awful lot of people were already on Tamoxifen because of the PR results, original PR results, and that was consistent with here, this 33 to 43 percent change.
DR. ALAGHEHBANDAN:
A. My understanding is that--again it depends on

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the clinician and the way they basically perceived this and the way they take it into account. Probably some clinicians just give more credit to ER, some people say that, no, this is a hormonal pathway regardless of whether being ER or PR, and there is a change, then probably we have to take that into account. In addition to that, there are other factors involved, such as patient's age, other comorbidity associated with, so again my point being one-third or 33 percent being noted here is just simply describing that some patients who had ER negative, while being PR positive, changed to ER positive, and that's all it says. So that's why we have to be careful with using the database for purpose of interpretation.
COFFEY, Q.C.:
Q. And but in terms of this notion that the change rate for at least ER negative tests upon retest was--the database says it was 43 percent for this -
DR. ALAGHEHBANDAN:
A. And obviously there was a 33 percent change.
COFFEY, Q.C.:

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Q. And that, I take it, is this figure, in effect, right here, the 42.8? That's -
DR. ALAGHEHBANDAN:
A. ER negative change rate.
COFFEY, Q.C.:
Q. That's that 42.8 is the 43 percent you're -
DR. ALAGHEHBANDAN:
A. I was not in charge of developing this specific table, and we provided task force office with raw numbers. I believe Mr. Thompson himself created a table and calculated rates.
COFFEY, Q.C.:
Q. And now, Mr. MacDonald, let me ask you, because you referred this morning to the fact that NLCHI has epidemiologists available to it and, in fact, working for you?
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. For your Centre. Were there epidemiologists involved in this?
DR. MACDONALD:
A. No.
COFFEY, Q.C.:

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Q. And why is that?
DR. MACDONALD:
A. This is not epidemiology. This is just straightforward math.
COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:
A. You know, we certainly work with the task force in the analysis, as I mentioned earlier, but there was--there was some numbers that were generated from the task force for their own purposes included in the report that we were not involved in.
COFFEY, Q.C.:
Q. And was it your understanding because, of course, you interacted with the task force personnel, that they have epidemiologists involved?
DR. MACDONALD:
A. The task force?
COFFEY, Q.C.:
Q. Yes, did you understand that they did or didn't?
DR. MACDONALD:
A. Oh, that they didn't.

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COFFEY, Q.C.:
Q. They did not. Can you tell the Commissioner why NLCHI did not utilize any epidemiologist in this?
DR. MACDONALD:
A. It wasn't a task for an epidemiologist. It's straightforward calculations. What an epidemiologist tries to do is--in the research arena is try to link--especially in our area of expertise, which is population based, is to link interventions to an outcome. So, for example, the implementation of a policy or program, what impact that have on health and population. So there's many tools available to an epidemiologist, many statistical tools, test of association, cause and effect, to some extent, surveys are used quite a lot in epidemiology, focus groups, interviews. None of these tools are employed in this particular exercise we see here with this report. This report is basically just taking some numbers and giving a percent or an average. So there was no need to bring in epidemiologists to actually generate these tables. This is a straightforward math exercise.

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COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:
A. We're not trying to find out--epidemiology would try to find out why, in fact, there was a change.
COFFEY, Q.C.:
Q. Yes. Now, Dr. Reza, in looking at the data, and again based upon some tables and spreadsheets that the Commissioner has seen in exhibit that were prepared very early on by Mr. Gulliver, for example, okay, there's some exhibits the Commissioner has seen, the positivity rate, at least as Mr. Gulliver at the time calculated it, changed significantly I'm going to suggest--at least changed, you know, in 2003, 2004--2004/2005, like, that idea that it went from a lower number to a relatively speaking higher number, went into the 80s, okay. Were you ever aware in looking at the data over the time frame that the positivity rates changed in the original data?
DR. ALAGHEHBANDAN:
A. You see, my main responsibility and my main role and concern was to develop the database, to ensure that we build a database that we can answer those two initial questions that we had.
COFFEY, Q.C.:
Q. Uh-hm.
DR. ALAGHEHBANDAN:
A. Yes, I was aware of the positivity rate, but it wasn't part of my role to interpret that, and I never had enough expertise in order to be able to make an interpretation of that.
COFFEY, Q.C.:
Q. If we could, just looking at page 12 of this exhibit, this is a table, Table "E", original ER/PR test results at Eastern Regional Health Authority on positivity rates, 1997 to 2005. Now would this be just Eastern Health, or would this be the entire province?
DR. ALAGHEHBANDAN:
A. The total number is 815, I believe -
COFFEY, Q.C.:
Q. Yes, total ER negative -
DR. ALAGHEHBANDAN:
A. That says that Eastern -
COFFEY, Q.C.:
Q. Actually, I'm going to go up because that's a different cutoff than the one I want to refer to. This is just a -
DR. ALAGHEHBANDAN:
A. The number is high. Seems to be for the total province--for the entire province.
COFFEY, Q.C.:
Q. Okay. In any case, looking at it, and I appreciate it wasn't your job, but when you looked at the kind of output that you were seeing from creating these tables, was there the--you did notice a particular point in time where the positivity rate kind of--it stands out it changes?
DR. ALAGHEHBANDAN:
A. That's right. Yes, I noticed that and I became aware of that, but again you had to put it into context whether there was a technical reason behind it or clinical reason behind it. I didn't have enough--it wasn't, you know, my expertise to make an interpretation of that, or I didn't have enough resources and tools to be able to assess that.
COFFEY, Q.C.:
Q. If we could, please--Commissioner, I'm going to ask that a new exhibit be entered. It's P-

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3565.
THE COMMISSIONER:
Q. Entered.
EXHIBIT P-3565 MARKED AND ENTERED
THE COMMISSIONER:
Q. Is there another one?
REGISTRAR:
Q. There is one, 35 -
THE COMMISSIONER:
Q. 3559 perhaps?
COFFEY, Q.C.:
Q. Yes, please.
THE COMMISSIONER:
Q. All right, they're both entered.
EXHIBIT P-3559 MARKED AND ENTERED
COFFEY, Q.C.:
Q. 3565, please. Now this is a letter dated March 14th, 2008. It's addressed to myself and Ms. Chaytor. It's from Mr. Thompson. It says, "Please find enclosed a draft copy of the technical briefing on the ER/PR database. The report is a short order review of key results and methodological issues. The main report consists of appendices which contains statistical tables provided by NLCHI based on

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a request from this office. The tables do not necessarily address all possible combinations of data within the database, and in particular, the report does not include tables on communications, but we expect that to be available in a short time. This report is a draft report and we continue to examine it for editorial changes", and if we just look then--this is 103 pages long. The second page of the exhibit is "Technical brief on statistical tables from estrogen receptor/progesterone receptor database, draft, March 11th, 2008". It's described as an internal working document of the Office of Secretary to the Cabinet on Health Issues. Then there's what I'll refer to as seven pages of text comment, and including one on page seven on the report itself, a portion referring to calculating a change rate, and--now in relation to this particular portion of this right here, and there's an explanation, I appreciate that, as to what in the context a change rate might mean, and it points out that--generally here is a statistical approach as opposed to a clinical one, but it ends here by saying,

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"It's important to bear in mind that out of 317 patients that had "change results" as reported by Eastern Health to the Minister on November 23rd, 2006, 117 were recommended for a change in treatment".
DR. ALAGHEHBANDAN:
A. Uh-hm, that's right.
COFFEY, Q.C.:
Q. Now has it ever come to your attention that that 117 figure -
DR. ALAGHEHBANDAN:
A. I'm sorry?
COFFEY, Q.C.:
Q. Has it ever come to your attention that that 117 figure is probably not accurate?
DR. ALAGHEHBANDAN:
A. It was accurate based on what we had in the database, and this report is--has been prepared based on the database. So having that in my mind, I was fairly confident that 117 is a confident--I'm confident that 117 is an accurate figure, given the fact that whatever data we had at that time.
COFFEY, Q.C.:
Q. The 117, how were they identified--how did you

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identify who the 117 were?
DR. ALAGHEHBANDAN:
A. The main source for identifying those patients were panel letters, actually.
COFFEY, Q.C.:
Q. Uh-hm.
DR. ALAGHEHBANDAN:
A. So if a patient had a change in results, automatically went to the panel tumour board, and tumour board reviewed the whole medical chart and decided whether a treatment change--a treatment being offered or not, and we used those panel letters and generated this number for this report.
COFFEY, Q.C.:
Q. And based upon the panel letters?
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. That you had copies of?
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. Now what about a panel letter that said that a patient had a retest result, the result

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changed, there was a changed result -
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And spelled out 0/0, say, to 50/50, say, but the patient has already been dealt with by their physician and, therefore, no treatment change is recommended by the panel?
DR. ALAGHEHBANDAN:
A. We also did have of those examples of a change in results, however, the patient already been on Tamoxifen, or appropriate treatment. So this figure of 117 does not cover that group.
COFFEY, Q.C.:
Q. Doesn't include them, but how about--and that group, I take it, though, was comprised of two groups really, which would be those who were on Tamoxifen before any retest ever occurred?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Primarily, based upon the PR result, the original PR result.
DR. ALAGHEHBANDAN:
A. Or any reason.

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COFFEY, Q.C.:
Q. Yeah, or for other reasons, but certainly that one, and were you aware of a second group that they ended up on Tamoxifen because of a changed result on the retest, but it occurred before the panel ever dealt with them? Were you aware of anybody who fell into that category?
DR. ALAGHEHBANDAN:
A. We objectively reviewed panel letters. So if the panel letter indicated that the patient is already on Tamoxifen, it could have been yesterday, it could have been a year ago, we wouldn't know basically reviewing the panel letter, and if that occurred, as I said, we wouldn't know, but this 117 simply means patients who had change in results, went to the tumour board, and offered new treatment.
COFFEY, Q.C.:
Q. There's something in the letter that says something about new treatment?
DR. ALAGHEHBANDAN:
A. I'm sure you've seen the letters. The letters are basically generally stating that this is the clinical situation of the patient, this is

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the original score, this is the retested score, and here what we offer--recommend.
COFFEY, Q.C.:
Q. So that in this context here, and I appreciate you may not have actually drafted the wording, but to be precise, they would be 117 were recommended the physician review panel to have a change in treatment?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Not that 117 people had a change in treatment as a result of the retests? Do you understand the distinction, because you here--Ms. Predham was here in the past couple of days.
DR. ALAGHEHBANDAN:
A. Right.
COFFEY, Q.C.:
Q. And she's told us--told the Commissioner that there were some patients that she was aware of that the panel did not recommend treatment change because a day before or a week before an oncologist had already changed the treatment.
DR. ALAGHEHBANDAN:

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A. We would not have been aware of that.
COFFEY, Q.C.:
Q. So you weren't aware of that.
DR. ALAGHEHBANDAN:
A. No.
COFFEY, Q.C.:
Q. So, therefore, when one says 117 were recommended for a change in treatment, in your world you're telling the Commissioner, I'm satisfied that having reviewed all those panel letters -
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. I can create a pile for you that has 117 in it, or at least say treatment change recommended?
DR. ALAGHEHBANDAN:
A. Treatment change offered, yes.
COFFEY, Q.C.:
Q. By the panel?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Okay, but that's not the same thing as saying

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there's only 117 people as a result of this whole process who had their treatment changed?

DR. ALAGHEHBANDAN:

A. No, it's based on panel letters, it's based on tumour board review.

DR. MACDONALD:

A. The panel letter played two roles here, and it gets back again to how the database was created and why it was created, and we saw the panel letters as another source. One was it was our only source of any treatment change had occurred because we did not do a chart review, so it's important to recognize that. So from the database perspective, the only really practical source for us to even look at a cursory level at treatment was the panel letter, and so--as Reza just mentioned, that it would recommend a treatment change based on the panel would recommend that. Another piece to the panel letter that we used was if, in fact, the panel letter was generated, we would assume that it went to the physician and the physician had met with the patient to discuss the results. So we used it also as a communication source, but it does have

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significant limitations with respect to the clinical side.

THE COMMISSIONER:

Q. I'm sorry, that last point, you're saying that if a panel letter went out, you accepted that as more or less proof that the patient in question had been communicated with?

DR. ALAGHEHBANDAN:

A. As a mode of communication, actually, one of the modes of communication. That means--the way we have said it in reports, we said that a panel letter was sent to the most responsible physician.

THE COMMISSIONER:

Q. Uh-hm.

DR. ALAGHEHBANDAN:

A. Not saying that the patient was notified of the results via panel letter. What we said, that the most responsible physician was notified via panel letter.

THE COMMISSIONER:

Q. Okay.

DR. ALAGHEHBANDAN:

A. And one would assume that every health care professional would share the results with the

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patient once they receive them.

THE COMMISSIONER:

Q. Okay.

COFFEY, Q.C.:

Q. Did you ever become aware that that wasn't always the case, that, in fact, for some patients, they didn't get told at least -

DR. ALAGHEHBANDAN:

A. Right, being in charge of creating a database, we had to be quite objective in this matter, and then as I mentioned, all we could say at the time that a letter was issued by the tumour board, sent to the physician. The rest of it, we wouldn't know for sure whether that occurred between that most responsible physician and the patient, but at a later time Eastern Health actually did a audit review, and then clarified that matter as well.

DR. MACDONALD:

A. We did come to the conclusion that we could not guarantee the patient had been contacted just because a panel letter had been generated.

COFFEY, Q.C.:

Q. And that's really what I was--and as this

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evolved more and more, you came to that conclusion?

DR. MACDONALD:

A. But we still used it as one of our sources of communication, but it certainly wasn't--wouldn't be what we would call a gold standard.

COFFEY, Q.C.:

Q. Now if we could, please--and that is--that database is kind of, and report, as it were, that database, the report is mid March. If we could look, please, at Exhibit P-3508. Now this is an e-mail from Ms. Chislett, Tracy Chislett. She is -

DR. MACDONALD:

A. An epidemiologist in the department.

COFFEY, Q.C.:

Q. In your Centre?

DR. MACDONALD:

A. Yes, yes.

COFFEY, Q.C.:

Q. Okay, and it's dated April 7th, 2008, and it's to Deborah Gregory and Robert Thompson. Who's Ms. Gregory?

DR. MACDONALD:

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A. Works in Robert Thompson's office, senior researcher.

COFFEY, Q.C.:

Q. And copied to both of you gentlemen. "Patient who"--the subject is "patient who self-identified." She begins, "Debbie, as per our discussion. Patient who self-identified late March which led us to meet regarding how to ensure that we have all," and all is italicized and bolded, "patients will not become part of the database. Because the patient was originally negative, she should have been part of the recall, but because in Meditech the order was not entered, she was missed when Eastern did their review. This patient will not become part of the database as of now because she has not been sent to Mount Sinai for retesting. Had she been sent for retesting, she would have been part of the database and the number would have changed. But because Eastern Health decided to retest the patient on Ventana and not send for retesting to Mount Sinai, she will not be included in the database. If you have any questions, please let me know."

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Now perhaps I'll ask you, Mr. MacDonald, if you know. Well, how then did this evolve? How did this come about and then how did it evolve?

DR. MACDONALD:

A. Well certainly, it was still around those days, and this is fairly recent, where the criteria for inclusion/exclusion into the database was still evolving. We were still--there was many different caveats as to the criteria around exclusion and the main one was that you retested at Mount Sinai. So this particular case was brought to the attention of the Task Force because, in fact, it didn't meet one of the main criteria of being retesting, but it was certainly a patient of interest from the database perspective.

COFFEY, Q.C.:

Q. And then what--what then happened with respect to whether or not the patient, that patient and there'll turn out to be others as we get into this, did they end up in the database eventually?

DR. ALAGHEHBANDAN:

A. If they were retested at Mount Sinai, they would have, and if they didn't, then they would have been separately identified in a separate set. But as a core set of the database, we would include only those who were retested at Mount Sinai. This specific individual was identified and, self-identified and then tested in house. That's why she did not meet the criteria.

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COFFEY, Q.C.:

Q. And Dr. Reza -

DR. MACDONALD:

A. Actually, these are too, Mr. Coffey, that earlier in our testimony we noted that there's many different cohorts in the database. So you would actually--when we were talking about its complexity, that you would actually have to know which actually patient cohort you want to select. I would suggest this lady is in our database, but you have--you would have to select a particular criteria to segregate her out from the main core, because she was not tested at Mount Sinai.

COFFEY, Q.C.:

Q. And I take it, Dr. Reza, if at some point she was retested at Mount Sinai -

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DR. ALAGHEHBANDAN:

A. She would have been -

COFFEY, Q.C.:

Q. - and NLCHI found out the results -

DR. ALAGHEHBANDAN:

A. She would have been a part of the core set, yes.

COFFEY, Q.C.:

Q. Okay. But if she wasn't retested at Mount Sinai, she would end up in the database, but not in the retest Mount Sinai database?

DR. ALAGHEHBANDAN:

A. The core set, yes.

COFFEY, Q.C.:

Q. Okay. If we could go to, yes, 3506, please? Now Ms. Chislett had referred to events in the latter part of March. Here, there's an e-mail from yourself, Dr. Reza, to Mr. Thompson and Mr. MacDonald, copied to a number of individuals, March 28th, 2008. Meditech search for missing patients. And you begin by saying "hi all. Terry, Tracy and I met this afternoon to discuss potential options for identifying missing breast cancer patients with negative ER/PR who may not have been

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retested. Terry has performed various search protocols in the Meditech system for the year 2002, searching approximately 90,000 specimens, and below is a summary of them for your consideration. One, using Snomed terminology, the code for breast was searched. 776 pathology reports related to breast specimens were captured. This means that pathology reports were either directly related to breast patients or indirectly related. For instance, a lymph node or a skin biopsy was taken and potential primary breast involvement was mentioned in the pathology report."

And then it goes on, "A. this has been further searched based on tumor markers. This means only breast specimens that were coded as cancer would be captured. Out of 776 breast related specimens, 282 of those recorded as breast cancer."

There's another paragraph, two, "Searching the pathology module for the word 'breast' 1,027 pathology reports were identified in which the word 'breast' had been mentioned in the report. Regardless of whether or not it was--regardless of whether

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it was in the clinical history or even statements such as 'not primary breast'. Paragraph A. this 1,027 was further searched using tumor markers for breast cancers. 370 pathology reports were identified." And then little i, "this 370 was even further searched using 'ER/PR ordered' 161 were captured." And then "B. the 1,027 was searched again using 'ER/PR ordered' 178 were identified."

Paragraph three, "Searching the pathology module for all tumor markers. This means all cancers were captured regardless of their original. The total number captured was 3,720."

You go on to write then, "please note that this is a preliminary search analysis for 2002 and that each option has its own advantages and limitations. For instance, using option two, breast as a key word will give us the most comprehensive list of breast related specimens in the pathology module. On the other hand, there may be a significant proportion of them not related to the purpose of the exercise. It is believed that any of these options may still not provide us with

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100 percent confidence that every ER/PR negative specimen would be found. For time line purposes, it is estimated that one could review a pathology report with an average speed of three minutes per report. This may be an underestimation as the reports are not consistently formatted. Further, additional time would be required to organize, count, and cross reference them against existing sources, such as NLCHI ER/PR database. Also, please note that in 2005, the original search used by Terry was done using 'ER/PR ordered'. It came up with 189." Signed Reza.

So I take it then that, Dr. Reza, that this is your at least initial inquiry and thoughts following this one self-identified patient in March?

DR. ALAGHEHBANDAN:

A. Right. So basically, Eastern Health knew that there was an issue ER/PR ordered entry and they had a number of patients back then, back in '07, and I became aware of it in early days of getting involved with this exercise and that became a part of the knowledge that I had, which I shared that knowledge later in

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early 2008 with Mr. Thompson's group, and this e-mail and the exercise that we performed with Mr. Gulliver and Ms. Chislett came after the fact that there was another case who basically self-identified herself and we look at the reason for that matter and the reason was the fact that ER/PR test was performed. However, the code or the procedure code was not ordered. Therefore, in 2005, when Eastern Health performed their search, they could not capture this individual through their exercise.

We look at a number of options here and I basically categorize them in three groups. Number one, using Snomed. Snomed is a terminology, quite extensive, having about half million terms in an environment of all medical terminologies and using that, we basically came up with a certain number. It had its own limitations and advantages as well.

Then we use only word 'breast'. That means searching the pathology module, searching for breast. So it could have been this phrase in the pathologist saying that not

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primarily breast. So that means, for example, the sample was not really breast. So you would have captured a number of pathology reports. Some may not have been really related to breast, but again, you would have had a comprehensive list.

The third one was basically looking at tumor markers. As you know, a sample could have been malignant or benign, and so if the tumor or the sample was benign, then it would not get that tumor marker code assigned to it, and if it had, then it would have.

Going through this and for each option, searching them down by, for example, Snomed and then going to tumor marker and then going down further, search by ER/PR entry code, we concluded that it would be better to go with word "breast" for the search strategy. Yet we indicated it in the e-mail that even this would not give you 100 percent level of confidence that you would basically pick up all the patients through this exercise. And also, coming out of this, we identified the fact that after searching, one has to go through a manual review and search basically.

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You search the Meditech system. You print them all and go one by one. So there are a number of steps into this exercise when someone has to go to do it.

COFFEY, Q.C.:

Q. And here, in fact, Mr. Miller, Wayne Miller, on March 28th, sent an e-mail to Pat Pilgrim. He says "this"--in commenting upon your e-mail we just looked at, "this is still a manual process. It is different than doing a word search," and he's described as the Senior Director, Corporate Strategy and Research, Eastern Health. So have you had dealings with Mr. Miller yourself?

DR. ALAGHEHBANDAN:

A. I'm sorry?

COFFEY, Q.C.:

Q. Have you had dealings in connection with this with Mr. Miller yourself?

DR. ALAGHEHBANDAN:

A. I'm sorry, I didn't hear.

COFFEY, Q.C.:

Q. Have you had dealings with Mr. Miller?

DR. ALAGHEHBANDAN:

A. With this exercise?

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COFFEY, Q.C.:

Q. Yes, or any other.

DR. ALAGHEHBANDAN:

A. In the past, on a number of occasions on different items, yes, with respect to ER/PR.

COFFEY, Q.C.:

Q. Okay, and so the idea of him describing it as a manual process, I take it is--it would involve -

DR. ALAGHEHBANDAN:

A. Well, as a matter of fact, first it's a technical process. Then you had to print all those pathology reports and go through them manually. So it's not purely manual. It's a combination of both technical IT and then manual.

DR. MACDONALD:

A. I think this is important to understand, at this point in the development of the database, we came to a point where "where do we stop doing the database management and do the information management?" and if I might just clarify where this e-mail is coming from. We were proposing that the most comprehensive search that--when we talked to the people in

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the lab that you search for breast and then you do a manual search on all those pathology reports to identify those that had an ER/PR test. So that would be the first filter. All breast, then who had ER/PR done.

On the IT side, they were--they felt that you could use more filters. So that's what Mr. Miller is getting to, in that it's still a manual search. But we had decided that that's--we felt really more comfortable doing a manual search than asking Meditech to say first search breast, then search tumor breast or tumor marker, then search this. So the computer would actually be doing a lot of the filtering, and ultimately, at the end of the day, from 3,000 pathology reports, you would end up with 185 ER/PR breast tests, and we didn't feel that--we didn't feel comfortable going down that road. We felt we were--it should be breast and then we'd do a review of the hard copy reports. So that's what Mr. Miller is stating there around it's still a manual process. He was stating the obvious.

COFFEY, Q.C.:

Q. And now, Dr. Reza, as you indicated to the

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Commissioner, you first became aware of this back in July of 2007.

DR. ALAGHEHBANDAN:

A. That's right. Probably -

COFFEY, Q.C.:

Q. August.

DR. ALAGHEHBANDAN:

A. - August.

COFFEY, Q.C.:

Q. August, okay, some time in the summer.

DR. ALAGHEHBANDAN:

A. In summer '07.

COFFEY, Q.C.:

Q. Yes. Did you bring that to Mr. Thompson's attention at the time?

DR. ALAGHEHBANDAN:

A. Well, at the time, we didn't, and that happened in early '08.

COFFEY, Q.C.:

Q. Okay, so around the time of this?

DR. ALAGHEHBANDAN:

A. Probably.

COFFEY, Q.C.:

Q. Okay, so this problem or potential problem with the search approach used by Eastern

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Health internally using Meditech -

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. - they hadn't checked the particular work order. You're aware of it. You understood a number of patients had self-identified back in the summer of '07. Why didn't you pursue it further at the time?

DR. ALAGHEHBANDAN:

A. At the time, our first priority was to capture a list of all those patients who were retested at Mount Sinai. We were still struggling with that. We had a number of sources. We had a great challenge in terms of reconciling all those data sources. So that was our priority, as opposed to going and doing further search, because yet we didn't know what we have in house.

COFFEY, Q.C.:

Q. Now when Mr. Thompson was told, in early 2008, about this -

DR. ALAGHEHBANDAN:

A. We had a discussion regarding this around probably earlier than this e-mail. I don't

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know, a week or so.

COFFEY, Q.C.:

Q. When this patient had first -

DR. ALAGHEHBANDAN:

A. Right.

COFFEY, Q.C.:

Q. - self-identified.

DR. ALAGHEHBANDAN:

A. Yes.

COFFEY, Q.C.:

Q. And what do you recall about what Mr. Thompson's response was?

DR. ALAGHEHBANDAN:

A. He was quite concerned and he asked us to basically investigate the matter in the sense that what would be the best option in terms of capturing missing patients within Meditech, and his comment prompted us to go with Mr. Gulliver and Ms. Chislett to basically perform this exercise.

COFFEY, Q.C.:

Q. This meeting that's referred to here came out of that?

DR. ALAGHEHBANDAN:

A. That's correct.

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COFFEY, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. Do I take it from what you're saying that in 2007, you were concentrating on the people who have been retested -

DR. ALAGHEHBANDAN:

A. And also -

THE COMMISSIONER:

Q. - following them through the system?

DR. ALAGHEHBANDAN:

A. That's right.

THE COMMISSIONER:

Q. Those who'd gone to Mount Sinai.

DR. ALAGHEHBANDAN:

A. The Mount Sinai and their communication.

THE COMMISSIONER:

Q. They were your--yes, and following them through from results coming back to being retested, and the self-identifiers were not in your current group. They might be a problem, but they were not in the group that you were assigned to follow?

DR. ALAGHEHBANDAN:

A. Well, the missing patients who--the self-

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identified patients, let's put it this way, the first group and the second group. First group, those that were self-identified themselves in '05, '06 and '07 to Eastern Health. They were a part of--always a part of the database and there was no question about it.

THE COMMISSIONER:

Q. But because of the way that they were dealt with?

DR. ALAGHEHBANDAN:

A. That's right. They became a part of the database. They were counted and with regard to their communication, we always had them equally treated, equal to other group. That means those that we captured them through the exercise. With respect to this patient and this group of patients that came later actually, that's what, you know, basically prompted us to go and do this exercise with respect to see what would be the best option to capture those potential missing patients in the system.

DR. MACDONALD:

A. The fact that we had identified the patients

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was the core. The fact that they were self-identified wasn't really core at the time.

COFFEY, Q.C.:

Q. In the early stages for you.

DR. MACDONALD:

A. In the early stages, yes. I mean, obviously then as time went on, we thought that this might be an issue that actually we had to address in more detail than what we had originally done in our searches.

COFFEY, Q.C.:

Q. And we're going to see now in P-3511, please? 3511. 3511, thank you. We haven't--mercifully, we may never make it to 35,000.

REGISTRAR:

Q. Too many numbers.

COFFEY, Q.C.:

Q. This is a series of e-mails. Mr. MacDonald, the first of them is from yourself to Mr. Thompson and others, including Dr. Reza, on May 9th, 2008. You write "Robert, Terry mentioned to Reza and Tracy yesterday," which would be Thursday, "that some new cases had been recently sent to Mount Sinai," MS Mount Sinai. "Positives and possible newly

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identified. I have left a phone message with Pat's secretary and sent her an e-mail in an effort to confirm that this is in fact the case. I've yet to hear from Pat, but if confirmed, the database will need to be updated to reflect these new cases." And then he responded, Mr. Thompson responded, he is saying "thanks, Don. Please advise as soon as you know."

So Mr. MacDonald then, if we look then at P-3512? This is an e-mail from yourself of May 14th, 2008 to Mr. Thompson, again copied to a number of individuals, including Dr. Reza. You write "I spoke with Pat and it appears there are a few new cases to consider. Pat has asked Heather for a list of all individuals identified since the end of October. This work is expected to be completed by the end of the week. The Centre will be provided a copy of this list when complete."

Now, I take it then that--do these e-mails reflect then when this became really kind of to the fore with NLCHI?

DR. MACDONALD:

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A. I think this is when this would certainly be the genesis of more than just one patient, yes. At a meeting into my previous e-mail that we had been attended to, Terry Gulliver had indicated that there had been some new patients and the reason I would go back to Pat is because there were so many players involved, both involved in development of the database. Pat and I were basically the conduit by which information flowed between Eastern and the Centre. So that's why I wanted confirmation from her.

COFFEY, Q.C.:

Q. Yes.

DR. MACDONALD:

A. I think it's a fair comment to say that this was really, I would think, the start of really realizing that we had to do a further look at our search.

COFFEY, Q.C.:

Q. If we could, please, Exhibit P-3513? This is a couple of e-mails. One, Dr. Reza, from yourself to Mr. MacDonald on May 23rd, 2008. The subject is list of self-identified patients. You write "Tracy and I reviewed the

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list of self-identified breast cancer patients, N equals eight, sent by Eastern Health. It appears that two of these patients had been retested on Ventana at Eastern Health. Therefore, they would not meet the inclusion criteria to be included in the database, and the other six, the info provided is not clear for two patients." Their names are redacted. For one of them it states that "Dr. Neil following up to see if this patient requires retesting" and for the other patient, it says that "'Dr. Neil states that this was done in April 1997 and outside the testing period and will not be retested.' I think further clarification is needed before we process this information." And then Mr. MacDonald, having received that, you sent--forwarded it to Mr. Thompson, same day, saying "for your information. We will be following up on this on Monday."

First of all, Dr. Reza, I take it then by May 23rd, it was eight people?

DR. ALAGHEHBANDAN:

A. We received a letter from Eastern Health including eight people and we reviewed the

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information and for further clarification, we had to go back to Eastern Health to clarify on those two patients and the comments that were made. We were not able to make a conclusion for those two patients. So this is a follow up with regard to the meeting that we had with Mr. Gulliver.

COFFEY, Q.C.:

Q. Now, I'm going to ask you this, Mr. MacDonald, the reference here to "Dr. Neil states this was done in April '97 outside the testing period."

DR. MACDONALD:

A. Um-hm.

COFFEY, Q.C.:

Q. And you referred to that earlier, the idea of January '97, January 1/97 onward as opposed to April or May or May 1st, 1997 onward.

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. You had, I take it, yourself initially cautioned or put forward the suggestion that the database go all the way back to the beginning of '97?

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DR. MACDONALD:

A. January.

COFFEY, Q.C.:

Q. January 1st.

DR. MACDONALD:

A. And to the end of 2005.

COFFEY, Q.C.:

Q. And sir -

DR. ALAGHEHBANDAN:

A. August 2005.

COFFEY, Q.C.:

Q. August, yes. So with respect to this, whichever of you is the most knowledgeable perhaps can answer it, what happened with respect to those first four months of 1997?

DR. MACDONALD:

A. I'll try to answer that first and certainly Reza can add to it. Certainly we did look at the April 1997 to August 2005 time frame originally and that had been communicated, I believe, to the authorities from Eastern Health in respect to the delivery of specimens. When we went back and we got involved, we kind of--Robert's office, the Task Force, on a communication to the regional

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authorities for some further information, requested that the time change now and they go back to January, and I believe I recall this one was--this particular e-mail with Dr. Neil was solved fairly quickly because it went--reiterated it is part of the continuum we were looking for. So yes, in the initial stages of some of the activity in Eastern Health, it was April. When we got involved, we went back to January. So there was a bit of an over--or a time when there was a bit of miscommunication of what the time frame was.

COFFEY, Q.C.:

Q. I take it that was followed up with, to your understanding, with the health authorities?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. Exhibit P-3516, please? Actually, if I could, I apologize, 3515, page two of this? It's an e-mail from Tracy Chislett of July 22nd, 2008 to yourself, Mr. MacDonald, and copied to you, Dr. Reza. She writes "Don, we had a phone call from Dr. Somers, a pathologist from Central. She was reading some testimony from

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the Inquiry and wanted to let us know that they had a patient originally negative and on retest was found to be positive. She wanted us to know this information. During the same phone call, I received a call from Sherry Freake from Central as well. I suspect that she is calling to give us this updated information."

So I take it then that, Mr. MacDonald, that as May became June became July, there were other patients or at least some patients self-identified not only from St. John's, but elsewhere, or that you became aware of?

DR. MACDONALD:

A. If I'm not mistaken, I believe we had to do some further work to see if these patients were actually included in the original eight.

COFFEY, Q.C.:

Q. Okay.

DR. MACDONALD:

A. I think there is some correspondence where Tracy clarified that. Reza?

DR. ALAGHEHBANDAN:

A. Yes.

COFFEY, Q.C.:

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Q. And what I'm getting at is this, and I'm not going to trace through every individual patient, because we'll be here a long time.

DR. MACDONALD:

A. Oh no. No, no, I understand.

COFFEY, Q.C.:

Q. But in terms of as anything came up, I take it, it was addressed? It was kind of inquired into and you were satisfied one way or the other?

DR. MACDONALD:

A. Yeah, each and every case that came across to us, we fully investigated to the satisfaction of what our mandate was.

COFFEY, Q.C.:

Q. Again, I started to refer to Exhibit P-3516, please, and this is, again, a couple of e-mails of July 23rd, 2008. The one at the bottom of the page here is from Dianne Smith, Eastern Health, of July 23rd, to yourself, Mr. MacDonald. It says "response from Pat Pilgrim." She says "Hi, Don. Spoke to Pat yesterday afternoon and her answer to your question is yes, the four patients recently identified from Central as being missed will

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be included in the update she will be sending to NLCHI." So again, that's just an example of, I take it, some patients being added into the database.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. Now in relation to this idea of doing this search and Dr. Reza, your e-mail had referred to three possible ways of doing it, to try and identify patients who should have been retested perhaps. Mr. MacDonald, how did that then play itself out in the spring of 2008? The proposal was there. Dr. Reza had put forward the proposal.

DR. MACDONALD:

A. The three search?

COFFEY, Q.C.:

Q. Yes, how did that then--what happened then with respect to that?

DR. MACDONALD:

A. Well, I'll try to recollect now what happened. I remember having a meeting at which Robert had proposed a comprehensive search using breast, and representatives from Eastern

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Health were there, many, about six or seven from Eastern Health, and I think Robert strongly recommended that they undertake that particular search because of the eight patients that had been--had forthcoming, because there was one point where there was only one and well, we could probably live--you know, that was probably acceptable given the amount of data we had gone through. Although when eight or nine had come forward, we kind of recognized there was a limitation in our original search and a more comprehensive one was required, and Eastern Health felt that there wasn't really much opportunity to gain anything by doing an extensive search, which would require a significant time and resources. But as I said, more people started coming forward and I think the position of the Task Force was then well, this has to be done. So it was an evolving issue and recognizing too that this is--the database was still being created. We were still working on the existing cases. So there was three or four activities being done on the database at the time and this was one of them. But I think

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back in the spring and the summer, even though things slowed down a bit in the summer normally, there was a recognition that a further search would be required.

COFFEY, Q.C.:

Q. And I'll be coming a bit more to that shortly. Exhibit P-3517, please? Now this is an e-mail from yourself, Mr. MacDonald, July 24th, 2008 to Mr. Pritchard. It's copied to Mr. Thompson and others. It's involving the NLCHI database. You say "there have been some very minor updates to the information since the last update on when/how the patient was contacted on the retest results. We estimate these changes at about one percent of what was previously provided. However, we are expecting a set of data from Eastern on Friday," which is then tomorrow, "that has major updates to contact information for patients currently in the database, information on the DCIS patients, and number equals 52, information on the 'no tumors' and information on approximately 12 positives who called in and requested that they be retested." And you write "perhaps Sandy may

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wish to wait until this data is received and entered," and this had arisen out of a request for information from Ms. Chaytor?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. So Dr. Reza, what had happened then with respect to this DCIS patients? How had they been dealt with initially?

DR. ALAGHEHBANDAN:

A. I believe Eastern Health decided to review those patients with diagnosis of DCIS and then to basically identify whether they were initially diagnosed properly or not and that was one of the initiatives that Eastern Health was undertaking. The second one is no tumors. Those are the patients that basically did not have sufficient sample on their blocks and again, the question was whether we can go back to original slides and determine whether there is any change to results or not. For example, we could have just simply destain and stain the original slides, given the fact that there was not much tumor left on the blocks.

With respect to the first item, Eastern

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Health decided to go and do an extensive audit with respect to contact information. So basically, they started chart reviewing, going to physicians and finally to the patients, whether they could find any information on that within the chart, or the second level would have been contacting the most responsible physician, and if not, they finally basically contacted the patient. So that was a way of ensuring that everyone had been communicated with regarding the results.

THE COMMISSIONER:

Q. That was the people they knew about.

DR. ALAGHEHBANDAN:

A. I'm sorry?

THE COMMISSIONER:

Q. That was the people that were known about.

DR. ALAGHEHBANDAN:

A. Right.

COFFEY, Q.C.:

Q. And in the meantime, I take it back in May or June, Mr. Thompson, the time you watched Mr. Thompson make a pitch, as it were, or suggestion, a strong suggestion to Eastern Health about trying to identify all the

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patients through this usage of the term breast that Dr. Reza had referred to?

DR. MACDONALD:

A. As I see -

COFFEY, Q.C.:

Q. So these are kind of going on simultaneously, I take it. There's a suggestion out there about breast, and had not been acted upon. I'm correct on that?

DR. MACDONALD:

A. Only to the extent that we felt it was the most comprehensive search that we could do.

COFFEY, Q.C.:

Q. Yes, but it had not been acted upon?

DR. MACDONALD:

A. No, it has not.

COFFEY, Q.C.:

Q. And in the meantime, there is new data coming in and you've described, Dr. Reza, that this is here, plus there had been some self-identified patients who are being retested and that data is coming in as well.

DR. ALAGHEHBANDAN:

A. So the issue basically resurfaced and that prompted basically to go and perform the new

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search.
COFFEY, Q.C.:
Q. Now if we could look, please, at Exhibit P-3520? This is an e-mail of August 6th, 2008 from Deborah Gregory to Mr. Thompson, but it's copied to Dr. Reza and Mr. MacDonald here. "Chronology of events. New patients in ER/PR database." And she writes "Robert, I compiled a chronology of events related to 'newly identified patients' since March 2008. Added/to be added to the ER/PR database. If anyone has anything to add to the table, please forward the information to me and I will insert the additions. I have also compiled a chronology of events related to 'newly identified patients' since October 2007 when this became a concern of ours. I will forward it if you think it will be helpful set in the context for the management of newly identified patients. You will note that I have started to address the questions put forward by Sandra Chaytor, but I would prefer confirmation from you/NLCHI that I have not omitted any relevant details, e-mails, telephone conversations, etcetera." So I take

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it you were asked for input then into this spreadsheet that Ms. Gregory was preparing?
DR. ALAGHEHBANDAN:
A. Dr. Gregory created this chronology events and basically she compiled them, and what she's asking here is that whether you have anything else extra to what I have already compiled, so we would have a comprehensive documentation with regard to newly self-identified patients.
COFFEY, Q.C.:
Q. If we could, please, look at Exhibit P-3336? So I take it then, Dr. Reza, that you were asked for your input to review this chronology and if you had anything to add to -
DR. ALAGHEHBANDAN:
A. That's right, from my e-mails or notes or handwritten or anything.
COFFEY, Q.C.:
Q. And, Mr. MacDonald, you were asked the same?
DR. MACDONALD:
A. I was on vacation.
COFFEY, Q.C.:
Q. Okay, and here this particular document, the first page of it says, "Newly identified ER/PR patients' chronology of events initiated

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August 5, 2008, revised on August 21, 2008." It's entitled "Newly identified ER/PR patient's chronology of events." It begins March 27th, 2008 at 11:15 a.m. And then continues, if we could go, please, to page 36, continues for some 36 pages and concludes August 21, 2008 at 9:21 a.m. with an updated briefing note. So, I'm not going to take you through all of this and Dr. Reza, I take it at the time when you reviewed it, in terms of its account of your involvement, you found it to be accurate, in terms of your own involvement?
DR. ALAGHEHBANDAN:
A. That's right, it is pretty accurate.
COFFEY, Q.C.:
Q. And if one takes the time to sit and read through it, you can kind of follow the whole scenario -
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. - as one goes through it.
DR. ALAGHEHBANDAN:
A. Dr. Gregory has done a great job here.
COFFEY, Q.C.:

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Q. Now, just a moment please, Commissioner, thank you. If you look, please, at Exhibit P-3528? And here there's an e-mail from Ms. Chislett, August 12th to Ms. Gregory and yourself, Dr. Reza, saying "There are seven patients in the database that we know of that were missed because ER/PR was not ordered in the order entry window. As of the eight in list, plus two from Central, we are unable to determine if they were missed due to the same reason. As discussed, this will be a question for Terry or Barry. We can discuss the search strategy at 1:30, is that time okay for you." And as well, if we could then look at exhibit P-3529 and this is--well actually two e-mails, one is at March 28th, 2008 from--one from Dr. Reza that we looked at earlier about the Snomed, and other search approaches, and then there's an e-mail of Dr. Reza from yourself of August 12th to Terry Gulliver and others, saying "Hope all is well, this is in follow up to our previous discussion about searching Meditech for those missing patients whose ER/PR was not ordered. Since the number of self identifers is increasing, we've been

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asked by Robert Thompson to look into the matter of various search strategies, perhaps initially doing a small pilot concerning one of the below options and assessing whether we are able to capture known self-identifiers. I understand you are on vacation, but I would appreciate it if you would give me or Tracey a call to discuss this in further detail." And so, Dr. Reza then, what happened with this at that time?

DR. ALAGHEHBANDAN:

A. So basically we had a number of newly self identified patients. The question was, the search strategies that we proposed back in, back in March, whether those search strategies could capture one of these patients as an example as a pilot and we tested that pilot, we took one of the patients, I think from 2002 and used those options, search strategies we proposed and the patient basically could have been found every time using each of those, you know, options. So all of those options simply worked.

COFFEY, Q.C.:

Q. If we could look, please, at Exhibit P-3534?

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This is an e-mail of August 14th, 2008 from yourself, Dr. Reza, to Mr. Thompson and others, saying "Tracey and I met with Barry this morning and performed the pilot using various search strategies. We searched for one of the patients who was on the list of eight patients recently sent to us by Eastern Health. Using the following search strategies, the self identified patient from the Health Sciences Centre from the year 2000 was found: One, searching pathology module using Snomed; two, searching pathology module using tumour marker; three, searching the pathology module using the word "breast". In speaking with Barry, he indicated that using the word "breast" may be one of the most comprehensive search strategies with a high level of certainty in capturing breast cancer patients at each LIS." And what is a LIS?

DR. ALAGHEHBANDAN:

A. Lab Information System.

COFFEY, Q.C.:

Q. Okay. "Please note that any of the above options requires a manual review of the path reports." So that's the meeting or the

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searches activity that you just referred to.

DR. ALAGHEHBANDAN:

A. That's right. So we examined all these options against that case and every time she could have been found, so she was found through each of them.

COFFEY, Q.C.:

Q. And what then happened? So you figured out that it might work -

DR. ALAGHEHBANDAN:

A. So this pilot was suggested by Mr. Thompson and we performed the pilot, we reported it back to Mr. Thompson and then we had a discussion as to what would be the next system. So the next system was decided to be for the centre contact in the regions and asking them what was the search strategy they used back in 2005 in terms of identifying their breast cancer patients to be a part of the ER/PR recall. Then we created basically a questionnaire and Mr. Thompson contacted the CEOs in the regions and we had either in person or on the phone interview with the most responsible individuals at the regions and documented what and how they performed their

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searches and some other questions again related to this matter.

COFFEY, Q.C.:

Q. Now, do you have any understanding, Mr. MacDonald that Mr. Thompson has pursued this further in the sense of with the CEO's of these health authorities?

DR. MACDONALD:

A. Yes.

COFFEY, Q.C.:

Q. And Mr. Thompson, I tell the Commissioner, of course, Mr. Thompson will be here tomorrow and I will say right now, Commissioner and let counsel know that, although before when Mr. Thompson was last here, I had actually concluded my questioning, there's a fair amount that has happened since, including since the day he testified, and there's certainly, in terms of taking up chronology as to what's happened, I'm going to ask leave of yourself tomorrow to ask him some questions about what's happened since, in terms of -

BRAZIL, Q.C.:

Q. I'm sorry, did you say you were going to question him or you were going to ask -

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COFFEY, Q.C.:
Q. No, I'm going to ask the Commissioner leave for me to -
THE COMMISSIONER:
Q. He said he was going to ask for leave to question him on the events that occurred since he was here.
BRAZIL, Q.C.:
Q. Right.
COFFEY, Q.C.:
Q. So with that -
THE COMMISSIONER:
Q. I doubt it's going to come as a big surprise to Mr. Thompson.
BRAZIL, Q.C.:
Q. It's not a surprise.
COFFEY, Q.C.:
Q. She just mis-heard me, she thought I was -
BRAZIL, Q.C.:
Q. No, I thought that if we were going back to Ms. Pendergast (phonetic) -
COFFEY, Q.C.:
Q. No, no, not at all. Mr. Thompson will be here because I've asked--the Commissioner has asked him to come. So I appreciate I will be asking

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Mr. Thompson a little bit more about this tomorrow, but in terms of, you understood, I take it, Mr. MacDonald that Mr. Thompson has pursued it with the CEO since?
DR. MACDONALD:
A. Yes, he has asked the centre, following the interviews that Reza has noted that the Centre did with the authorities, we prepared a summary of those interviews with some options as to how to address the issue of missing applications.
COFFEY, Q.C.:
Q. And I'm going to take that up with Dr. Reza because he actually was involved, I think, in the interviews.
DR. ALAGHEHBANDAN:
A. Sure.
COFFEY, Q.C.:
Q. But again, while that's going on, in the meantime, if we could look, please, at Exhibit P-3539? Actually go to page two of it, there's an e-mail there of August 15th, 2008 from Dr. Reza to Mr. MacDonald and others and Mr. Thompson is saying, "Wayne Miller and Dr. Denic called today and requested information

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on IC, internal control and F/P, fixation and processing from Mount Sinai's spreadsheet, Excel file, to be added to the ER/PR database. Eastern Health wants to perform analysis on frequency of internal control and fixation and processing by site/facility/years, as well as examining the relationship between internal control, fixation and processing with the conversion rates. We told him that an official request needs to be sent from Pat or Louise to the Centre re: this request. Estimated timeline for this piece of work is to be determined by us. Commission of Inquiry will also receive a copy of the database once the new information is included. Please let me know if you have any questions." Now, Mr. MacDonald, what happened then with respect to this?
DR. MACDONALD:
A. Louise Jones, CEO of Eastern Health, sent a formal request to, I believe to me, I'm not sure, asking that this work be carried out.
COFFEY, Q.C.:
Q. And what was utilized then--perhaps I'll ask you, Dr. Reza, what actual electronic data was

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utilized and what then happened?
DR. ALAGHEHBANDAN:
A. So in middle of August, '08, I received a call from Mr. Miller and Dr. Denic and they're simply requesting for a comparison between internal control and fixation status from Mount Sinai spreadsheet and I'm going to speak to that, with the, basically, analysis, I'm sorry, another comparison. Our understanding at the time was the fact that these are the ones that have been captured and reported in original Mount Sinai file back in 2005 and '06. Later we learned that pathologists at Mount Sinai was asked to review the original slides and comment on internal control and fixation and processing. At the time that we received this call, we did not have that information, we were not possession of that information, so our understanding was that they're referring to the retesting, actually internal control and fixation process retesting, not original testing. We performed and we did the request for them and we sent it to Eastern Health. I believe Dr. MacDonald later contacted them and informed them that we

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are now in the position of this data, we received it from the Commission of Inquiry and now we -

COFFEY, Q.C.:

Q. That's the data, Dr. Mullen's data from April of 2008?

DR. ALAGHEHBANDAN:

A. That's right and we received the data from the Commission's office and incorporated with the database and we'll be doing that for Eastern Health and this e-mail is about that.

COFFEY, Q.C.:

Q. So the request that Ms. Jones had forwarded along, now that you have the actual -

DR. ALAGHEHBANDAN:

A. Actual data, we would be able to do the analysis.

COFFEY, Q.C.:

Q. How long will that take?

DR. ALAGHEHBANDAN:

A. The data that we received from Dr.--actually the data that you received from Dr. Mullen, being linked to the database, however, we learned that there was some challenges with respect to that data. There was some

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inconsistencies between original that compiled the original scores compiled by your office and the ones that's being basically added by Mount Sinai. Also we came across some scores, some ER/PR scores that we were not matching original pathology reports that we have at the Centre. Once we addressed those issues, I don't see any huge amount of effort to be done for this request.

COFFEY, Q.C.:

Q. And the request is, in effect, to do what, what sorts of things, what sorts of information did they want?

DR. ALAGHEHBANDAN:

A. It's simply asking for, looking at internal control and also fixation status for those original slides and the other one is that I believe it crossed -

COFFEY, Q.C.:

Q. I take it they wanted, a cross by what?

DR. ALAGHEHBANDAN:

A. A cross, I believe I have to look at the reports actually, but I can recall I think the cross tab between internal control--I'm sorry, the cross tab between, the second opinion by

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Dr. Mullen and original opinion by our pathologist here in the province, looking at the original slide.

COFFEY, Q.C.:

Q. And so -

DR. ALAGHEHBANDAN:

A. I'm sorry, that's not the request at Eastern Health's request, that's not the question that you requested, the request from Eastern Health is regarding a cross tab between internal control for those who converted from negative to positive and also fixation process, again for those who changed.

THE COMMISSIONER:

Q. I'm sorry, I'm still not sure it is what you wanted, you're being asked to do. Presumably you take those who changed, the 317?

DR. ALAGHEHBANDAN:

A. I believe five hundred and some odd patients who were originally negative, being sent to--who reported as negative, being sent to Mount Sinai for Dr. Mullen to review, the original slides. That information came back to your office.

THE COMMISSIONER:

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Q. Uh-hm.

DR. ALAGHEHBANDAN:

A. That information came back to your office, so we received that information, we entered it into the database, we link it to the database. Now we have two requests, one is from your office, one is from Eastern Health.

THE COMMISSIONER:

Q. Uh-hm.

DR. ALAGHEHBANDAN:

A. From your office, I'm not going to discuss it, and from Eastern Health the question would be, give us the, actually, simply the frequency of internal control, how many did you have, how many you didn't have, also the fixation process, whether there was adequate fixation or wasn't, so give them a general view of how it was reported for six hundred and something patients or five hundred and something patients.

THE COMMISSIONER:

Q. Is that just simply a matter of in effect entering into a column Dr. Mullen's comment?

DR. ALAGHEHBANDAN:

A. That's right.

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THE COMMISSIONER:
Q. Present, not present, adequate, inadequate or whatever else -
DR. ALAGHEHBANDAN:
A. And then getting a frequency of what he reported. There is a second portion of this request which I can't recall it clearly, but if I do have the request here, I will be able to comment on it.
COFFEY, Q.C.:
Q. And this is, we'll locate that at the break, but here, just looking at--here you describe "Eastern Health wants to perform analysis on the frequency of internal control and fixation and processing by site, by facility and by years." So they wanted an analysis involving those criteria.
DR. ALAGHEHBANDAN:
A. That's what we gathered from the phone conversation and I think that was put into a letter, a letter came to the Centre from Ms. Louise Jones.
COFFEY, Q.C.:
Q. And utilizing Dr. Mullen's data?
DR. ALAGHEHBANDAN:

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A. That's right, which we did not have at that time, middle of August.
COFFEY, Q.C.:
Q. Yes. Now, and that's in the process?
DR. ALAGHEHBANDAN:
A. It is in the process actually.
THE COMMISSIONER:
Q. Wherever you can find a spot, Mr. Coffey, we'll take the break.
COFFEY, Q.C.:
Q. Thank you. Right here will be fine, Commissioner, and come back and finish -
THE COMMISSIONER:
Q. All right, we'll take the afternoon break.
(RECESS)
THE COMMISSIONER:
Q. Please be seated. Mr. Coffey.
COFFEY, Q.C.:
Q. Now, Dr. Reza, I understand there was something that you wanted to comment upon?
DR. ALAGHEHBANDAN:
A. With respect to--I just want to clarify this point, with respect to data on date samples sent to Mount Sinai and also data on the date that we entered the data into Meditech. There

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was a great effort into the first piece, which was date sent sample to Mount Sinai and that data--the data quality of that field quite improved in the database. With respect to the second piece which is the date that we entered ER/PR scores into Meditech, given the fact that a report or a consultation could have been left on a desk for one day or two days, one week or less or more, we could not rely on the date that we had in Meditech; therefore, the data quality for that piece is not that great in the database, probably at least 50 percent of the patients had that data in the database. I just want to clarify that point that which field has a better data quality as opposed to other.
COFFEY, Q.C.:
Q. Okay, and if we can look, please, at Exhibit P-2724, Mr. MacDonald, this is a letter of August 15th, 2008, from Eastern Health, Louise Jones to yourself. She says "Eastern Health would like NLCHI to add Dr. Mullen's assessment on internal control and fixation to the Centre's SPSS file. The importance of these variables have been highlighted during

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recent testimony at the Commission of Inquiry on Hormone Receptor Testing has been confirmed that you are in possession of these important data variables and it is important that this information be linked with existing SPSS's file. In addition, we would like to request the following analysis be completed, one, frequencies of the variables, internal control and fixation; two, cross tabs of internal control by site, internal control by year, internal control by Mount Sinai, ER results, internal control by pathologists, Eastern. Fixation by site, fixation by year, fixation by Mount Sinai ER results, fixation by pathologists, Eastern Health. Three, is there a discrepancy in the "fixation" measure between blocks for the same patients. Four, "Chi square analysis for the appropriate areas listed above. If you wish to follow up on the specifics of this request, please contact Mr. Miller." I take it that's the letter, Mr. MacDonald you're referring to?
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:

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Q. And Dr. Reza--perhaps I'll ask you, Mr. MacDonald, Chi square analysis, what is that?
DR. MACDONALD:
A. It's just a statistical test when you're using categorical variables, so if you have age by income, if you have income in five different levels that if you do a cross tab, you are possible to create a Chi square statistic which tells you if there is a statistical significant difference between gender. So it wasn't based on chance, there is an actual real difference in the incomes between genders, that's what she's asking there is if we do in our cross tabs, where appropriate, to see if we can actually discern a real difference.
COFFEY, Q.C.:
Q. Statistically significant difference?
DR. MACDONALD:
A. Yes.
COFFEY, Q.C.:
Q. And that's the analysis, I take it, that you referred to earlier, that well due to the misunderstanding about the Mullen database that is now in the process of being done for

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the Mullen re-examination of the original side database.
DR. MACDONALD:
A. That's right.
COFFEY, Q.C.:
Q. And this is the sort of material you're going to prepare.
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. If we can look, please, at Exhibit P-3546? Now here is an e-mail from Mr. Thompson of August 19th, 2008, it's to a number of individuals and it says, he writes--I'll come to the question because it's not sent to either of you initially, he writes, "See text below, we just received the Western results based on consult with Dr. Neil and NLCHI. We have removed one of the Western cases, the original score should have been classified as positive, so the total is down to 10. The release incorporates this result. Oscar has offered Eastern as release co-ordinator, people should contract Deborah Collins as appropriate." And there's an update on ER/PR

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database and there's an italicized text, I take it that's some kind of announcement or release. If we could go then to page 3 of this, same day, letter of the same day, Mr. Thompson, well actually what has happened is on the 19th at 1:05 in the afternoon, Dr. Howell has written to Mr. Thompson saying, "We have not reviewed any of the numbers as put forward, so I'm unsure about the four from this region. I had assumed that these data was as solid as I could be, do I need to have our own team review, considering the change from Western. Here we are at the eleventh hour making a numbers change! Signed Oscar." And then Mr. Thompson replied several minutes later saying, "I understand your concern, that case is the only one that had an ambiguous ER, all others are straightforward. NLCHI has reviewed the data as well. Please feel free to check because we do not want you to sign off on data you are unsure of. Heather P. has been the main supplier or your data to Reza at NLCHI." Dr. Reza, what was this about?
DR. ALAGHEHBANDAN:
A. So this is about, if you scroll it down

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please, go into the main message from Mr. Thompson.
THE COMMISSIONER:
Q. You actually have a mouse as well.
DR. ALAGHEHBANDAN:
A. Oh, I do, okay, thank you.
COFFEY, Q.C.:
Q. That's this update on ER/PR database.
DR. ALAGHEHBANDAN:
A. That's correct. This is referring to ten patients, new patients, who were self identified or been identified through various searches at the regions and when we received any information from any region, we always ask for source documentation. We received this information from Eastern Health and the other regions that 10 patients are going to be retested or been retested recently, but we ask, we ask for pathology reports, we ask for the reason and we reviewed those documentations and then we decided whether these patients meet the criteria or don't and enter into the database or not. So that was our involvement with respect to reviewing the information provided to us by Eastern Health

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or the regions.

COFFEY, Q.C.:

Q. And if we could look, please, at Exhibit P-3564? Now here, this is a letter of August 22nd, 2008, it's addressed to myself and Ms. Chaytor, it's from Mr. Pritchard, signed, I believe on his behalf by Ms. Brazil, saying, "Re: disclosure of Her Majesty in Right of Newfoundland and Labrador, enclosed please find attached volume 17 of the disclosure of Her Majesty. At Tabs 75 to 81, you'll find drafts of the technical briefing that was forwarded to the Commission of Inquiry on March 18th, 2008--I believe that's probably supposed to be March 14th, but anyway, "that report was the last version of many drafts compiled over a period of three months. We provided the March 18th, 2008 report to the Commission with a hope that it would be valuable to it when examining issues such as positivity change rates, geographic variations and changes over time. The tables attached to the final report were designed to enable such an analysis. In earlier drafts of the report, we attempted some of this analysis ourselves,

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but we found that the specialized nature of the science in this area did not qualify us to interpret the data. The earlier drafts showed the emerging analysis, but we dropped this material from the report by March 18th. We do not endorse the interpretations or analysis in the earlier drafts. To illustrate the dilemma, in some of the earlier drafts we based a "changed result" on a change in the ER result only. We felt this approach was consistent with the original patient identification strategy, as well as some of the scientific literature; however, we later learned that some (perhaps all) oncologists would use the PR result as a basis for treatment decisions, even if ER was negative. Therefore, it would be difficult for us without an expert perspective to decide whether to present positivity or change on the basis of ER only, or ER and PR. Another dilemma was whether our analysis should define positivity and change at the one, 10, or 30 percent level and should this percentage change over time. Our solution was to provide a larger compendium of statistical tables

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attached to the report so the Commission, with its own scientific advisors, could interpret the data as deemed necessary. I trust that this is satisfactory." Now I appreciate this is drafted for Mr. Pritchard's signature, but I very much suspect that, unless he has talents that I'm not aware of.

BRAZIL, Q.C.:

Q. That's my signature.

MS. NEWBURY:

Q. That's Jackie's signature.

COFFEY, Q.C.:

Q. It's her signature, but it's drafted for Mr. Pritchard's signature is what I said and I appreciate it's Ms. Brazil's signature.

BRAZIL, Q.C.:

Q. Yes.

COFFEY, Q.C.:

Q. That in terms of the issue about the tables, did you have any input, Mr. MacDonald into that and kind of coming to this kind of conclusion here?

DR. MACDONALD:

A. Well I mean, what it gets down to is the interpretation of what the analysis meant--not

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so much the analysis, anyone can crunch numbers, you don't need an epidemiologist to crunch numbers, but as I said, I think I've clarified the difference between database management and information management and the role of a epidemiologist in that. The Centre did not have any expertise in the epidemiology of breast cancer. We have expertise in the epidemiology of perinatal care, aboriginal research, all different types of areas, but not breast cancer and that's what we conveyed to the task force is that we can't really say what it means by the numbers that we were generating and I think in the early days we probably thought that that might be possible, but very early on we realized it's too complex of an area for us to try to interpret the analysis.

COFFEY, Q.C.:

Q. Mr. MacDonald, in relation to that, have you ever been told by an epidemiologist that without the positive--the results involving the original positives, without that data, that it's difficult for an epidemiologist to really say anything about this?

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DR. MACDONALD:
A. Certainly if you've missed a big piece of data, limit your analysis to only negatives, there's no doubt that that certainly is a limitation of the database.
COFFEY, Q.C.:
Q. Now, I'll ask Dr. Reza this, the Commissioner has heard evidence about, I'll refer to it as retro converters and you're nodding your head, you've heard the term, certainly.
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. When did you first become aware of the idea of retro converters?
DR. ALAGHEHBANDAN:
A. Early days because the first data source that we used was August 1st file. When we looked at August 1st file, we noticed that there were a number of patients who had original positive ER/PR scores and not sure how many of them basically switched to negative, so that's where we learned about retro converters.
COFFEY, Q.C.:
Q. And was there ever any analysis performed in

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terms of tables.
DR. ALAGHEHBANDAN:
A. For retro converters?
COFFEY, Q.C.:
Q. For retro converters?
DR. ALAGHEHBANDAN:
A. Well we created so many tables, I can't recall whether one of those would have been on retro converters, so that's for someone like me or someone else to go back to the draft reports and search them.
COFFEY, Q.C.:
Q. I take it it was never a focus of the analysis in particular, in terms of -
DR. ALAGHEHBANDAN:
A. Well, let me put it this way, the database was created to, again, I mentioned this earlier but I would like to re-emphasize that the database was created to answer two questions. Number one, whether everyone got retested at Mount Sinai; number two, whether everyone got communicated with. Now, along the way we -
COFFEY, Q.C.:
Q. With everyone who was negative.
DR. ALAGHEHBANDAN:

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A. Negative actually, not positive, so later on we had a database including demographic information, some limited clinical information and some communication information. The question raised that, okay, let's play with this database to see whether we can describe some extra information, you know, translating this data into knowledge and these tables are the tables that, you know, now today we say came like an evolution from day one up to this date that we reviewed earlier, some said 33 percent conversion rate or, I don't know, you call it whatever, false negative or any term used and we always--we always were confident that this is just, I guess, a descriptive report, this is not an explanatory or analytical report. It can't say why we have this number, it can't say what are the factors involved with this figure or other figure. So, I guess this letter again saying that we created, we developed this tables, we did some statistical analysis, but one has to be cognizant of other factors involved with this matter before going and making any conclusion.
COFFEY, Q.C.:

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Q. Now in this regard in terms of, perhaps outside factors, kind of cut off dates, you, for example, in terms of the communication issues, were asked to look at the number of deceased as of November 23rd, 2006 in the mortality database. Well, I'm going to ask you the following, as of May 2nd, 2003, okay, in relation to the ER and PR test results that are in that database as originally reported, are you able to differentiate in relation to 2003 whether the test occurred before May 2nd, '03 or after?
DR. ALAGHEHBANDAN:
A. For the deceased group?
COFFEY, Q.C.:
Q. No, deceased or otherwise, anyone.
DR. ALAGHEHBANDAN:
A. That means making a distinction between two groups, one pre and one post at a certain point of time, yes, it is easy to do that.
COFFEY, Q.C.:
Q. Okay, so the data -
DR. ALAGHEHBANDAN:
A. If you have the date, if you have the date the test was performed. We do have the date based

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on only year the test was performed, not based on the month or the exact date.

COFFEY, Q.C.:

Q. And that's what I was asking about, within 2003 you could say, well Mr. Coffey, I can give you all the '03s and they'll be all listed out there, okay.

DR. ALAGHEHBANDAN:

A. Yes.

COFFEY, Q.C.:

Q. But within 2003, whether it's January, February or March or April -

DR. ALAGHEHBANDAN:

A. The data exists, actually it's in the pathology report, it doesn't -

COFFEY, Q.C.:

Q. Yes, I know, I appreciate that, but within your own database as it is right now, it doesn't distinguish, just year and year alone, it doesn't distinguish about what time of year in the sense of you can't tell if a particular patient was January or -

DR. ALAGHEHBANDAN:

A. Based on month or -

COFFEY, Q.C.:

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Q. Yes.

DR. ALAGHEHBANDAN:

A. I know it's based on year, I've got to check back whether it's based on month or not, but I'm pretty sure that we do have it based on years, so we can do analysis based on year, actually whether it's happening in '02 or '03 or so on and so forth.

COFFEY, Q.C.:

Q. Even the basis for the year, let's take 2003.

DR. ALAGHEHBANDAN:

A. Right.

COFFEY, Q.C.:

Q. Was that determined based upon the date of the pathology report or the date of the surgical number?

DR. ALAGHEHBANDAN:

A. Based on the--the date that we captured, extracted from was based on specimen number, surgical number, so if an operation happened, let's say on December 31st, 2002 and the pathology testing was performed, let's say in January of next year, I guess there is a big difference between the two, even by one or two days, so the date that we captured is based on

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surgical numbers.

COFFEY, Q.C.:

Q. That little two digit code for year.

DR. ALAGHEHBANDAN:

A. That's right, indicates the year that operation -

COFFEY, Q.C.:

Q. And in relation to, for example, the date of April 1st, 2004, which again, I don't know how certain the Commissioner might find that that date was, but we understand that around April 1st, 2004, the Ventana machine came into utilization. Are you able to distinguish within 2004 between old tests that occurred before April 1 and after April 1? I take it you can't right now.

DR. ALAGHEHBANDAN:

A. Right, Eastern Health provided us with some information on the system, either DAKO or Ventana, whether it was performed on the old one or the new one, so we do have that information in the database and basically for each specimen, we know whether this happened based on DAKO or that happened based on Ventana.

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COFFEY, Q.C.:

Q. Okay, so you can do that?

DR. ALAGHEHBANDAN:

A. You can do that, analysis is possible.

COFFEY, Q.C.:

Q. So if the database does capture whether or not -

DR. ALAGHEHBANDAN:

A. What system was used for performing the test.

COFFEY, Q.C.:

Q. Okay. So one would be able to distinguish, presumably, the pre Ventana from the post or the current Ventana days.

DR. ALAGHEHBANDAN:

A. It's possible to do that.

COFFEY, Q.C.:

Q. But back in 2003 in particular, Dr. Ejeckam's intervention as it is referred to here -

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. There's no distinguishing there, you would have to actually go into the pathology reports and get the dates?

DR. ALAGHEHBANDAN:

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A. With respect to year, I'm pretty sure that we have it by year. With respect to month, I think we do have it in the database. I've got to check that, but I'm kind of confident that we do have it by month and year, definitely not by day.

COFFEY, Q.C.:

Q. And if it isn't there, in fact by searching the pathology reports, you could -

DR. ALAGHEHBANDAN:

A. Yes, now I can recall right now that we do have that by month as well. And if we don't, that's simply go back and capture it from the pathology reports, but I believe we do have it.

COFFEY, Q.C.:

Q. And then in terms of, for example, if one wanted to ascertain whether there was any significant difference between the period before Dr. Ejeckam's intervention and afterward, you'd have to ensure that that was able to be broken down that way?

DR. ALAGHEHBANDAN:

A. Now I can recall that we received a request from Eastern Health asking us for a similar

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analysis, pre and post Dr. Ejeckam's letter and at the time we indicated that we don't have such information in the database. So the request was sent to us and we replied to that. Based on that request, that information was captured by month for each year and was sent to us and we entered it into the database. So the date based on year and month exists for each specimen within the database.

COFFEY, Q.C.:

Q. And when was that done?

DR. ALAGHEHBANDAN:

A. I can't recall exactly, but a few months ago.

COFFEY, Q.C.:

Q. Has there been any analysis done of that?

DR. ALAGHEHBANDAN:

A. Based on that, I don't recall, I don't think so.

COFFEY, Q.C.:

Q. And when I say has any been done, I take it I'm asking you in relation has NLCHI done any?

DR. ALAGHEHBANDAN:

A. Well whatever analysis we've done was at the request of either Mr. Thompson's office or Eastern Health.

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COFFEY, Q.C.:

Q. So there hasn't been any analysis -

DR. ALAGHEHBANDAN:

A. I don't recall any analysis being done on that.

COFFEY, Q.C.:

Q. How about in terms of the Ventana versus the DAKO?

DR. ALAGHEHBANDAN:

A. It has been done. I think we have seen a table or two within one of these exhibits this morning.

COFFEY, Q.C.:

Q. If we could, please, I'm going to ask you, Registrar, to bring up Exhibit P-3555. Now this is an e-mail from - well, it's two e-mails; one from Ms. Chislett to Mr. Thompson, October 2nd, 2008, and then from Mr. Thompson to Lorraine Barrett of October 17th, and the attachment is "A summary of interviews.doc", and Ms. Chislett has attached a summary table of interviews that Dr. Reza and Ms. Chislett have conducted with the regions regarding their search strategies. "If you have any questions, please, call. Please let me know".

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So this is this series of interviews you referred to earlier, Dr. Reza?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. I take it then your purpose in conducting these interviews in September of 2008 was to ascertain, as it were, from the source as to what had or hadn't happened in relation to the searches from time to time that they had conducted to identify patients?

DR. ALAGHEHBANDAN:

A. That's correct, to document it basically.

COFFEY, Q.C.:

Q. Document it.

DR. ALAGHEHBANDAN:

A. Describe it.

COFFEY, Q.C.:

Q. And I'm going to ask you, in terms of the material in this, I take it that - would it be appropriate for me to assume that as best - to your knowledge, as best you and Ms. Chislett could do it, that this accurately reflects what you were told?

DR. ALAGHEHBANDAN:

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A. That's right.
COFFEY, Q.C.:
Q. And were able to see?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Okay. Here is a question, and you have a column of questions, and the questions are indicated to be, "How many LIS", which is laboratory information systems, "are they interconnected". Question, "How are pathology reports stored? When did search begin, did you limit male/female, age, years, etc, who performed the search, the details about the search, were other searches done to look for others, was a manual review of pathology reports done after electronic search, was cross-referencing done to ensure completeness, and then anything to add".
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. So that's kind of what you canvassed with each of the authorities or hospitals outside St. John's. I want to take you then through them.

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You've got here written "Carbonear", first hospital - I apologize, Commissioner, I'll just come up - right there. September 9th, 2008, and you would have interviewed Dr. Baker. I take it that's - here. How many LIS, are they interconnected; one LIS system, Meditech, first specimens only in Carbonear, skin biopsies, others may come from other hospitals, Old Perlican, Placentia, and Whitbourne". I take it that's the areas that they -
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Collect samples from.
DR. ALAGHEHBANDAN:
A. Cover by Carbonear.
COFFEY, Q.C.:
Q. And the question, "How were pathology reports stored; pathology module only installed up and running since 2004. Before that, hard copies were kept in binders by year. 1997 to 2003, hard copies for all. 2004 onward, hard copies kept electronically". Then in relation to when did the search begin, "Received memo from

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Dr. Cook in 2005 about sending all ER negatives". Was it limited by any criteria, "No, all reports were searched". Who performed the search, "Secretary for 25 years, comfortable with pathology reports as she was the only one that entered them. Any questions she would have had would have been brought to Dr. Baker's attention". Then details about the search, "Dealing with hard copies, approximately 2600 per year, with 125 per year for breast. All those found by secretary were sorted in benign and malignant. Those malignant were sorted into ER and PR performed. Those with ER/PR sorted into negative and positive. Technologist took list of negatives, grouped slides and blocks, and sent them to St. John's. Reported zero as negative, and any staining as positive. Percent would be reported as well, so that oncologist could make decision based on the percentage". Then it refers to, "When sent the requested all ER/PR reports, found additional "non-zero negatives", and this is in answer to the question "were other searches done to look for others". So it's when the

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Centre, that would be yourselves -
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. "Requested all ER/PR reports, found additional non-zero negatives. This search was done by a casual secretary", and then a question in relation to the manual search, "Only manual search was done as they were having technical difficulties. Hard copies from '97 to 2005, so no need to do an electronic search", and then in terms of cross-referencing, "No way to cross-reference. Would have been nice to have a master list from a testing facility, Health Sciences Centre, St. John's, showing all tests done for Carbonear as a way to double check". Anything to add, "Wondered if tumour registry was used by any region as a way to cross-reference". So that was your dealings with Dr. Baker?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And then if we could then - I'm going to take you then to Clarenville which is the next one.

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I have some questions about Clarenville. Now you had understood what about Clarenville?
DR. ALAGHEHBANDAN:
A. In terms of?
COFFEY, Q.C.:
Q. Your involvement, yes.
DR. ALAGHEHBANDAN:
A. I'm just going to go through that report. That would be -
COFFEY, Q.C.:
Q. Okay, what I'll do is I'll take you through it then because this may refresh your memory as we're going, okay. The question - you spoke to Kathy Escott, the lab tech, Meditech support specialist, and Jim Humbie, Director for Peninsulas Labs, and that was September 10th, 2008, and September 16th, 2008. How many LIS, "Meditech in region since 2000. Prior to that, had another electronic Health Vision System. When old system was converted to Meditech, some data was lost". Now had you been aware before that?
DR. ALAGHEHBANDAN:
A. No, that was the first time I came to learn that.

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COFFEY, Q.C.:
Q. That was brought to your attention in September of this year?
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. And then the question, How are pathology reports stored, "No hard copy, back up to old system, or Meditech that they knew of". So there was literally no back up copy?
DR. ALAGHEHBANDAN:
A. So that was a major challenge. The challenge was that when they switched from old system to new technology, obviously some information, some data got lost".
COFFEY, Q.C.:
Q. And they didn't create a hard copy of the report?
DR. ALAGHEHBANDAN:
A. No, so they did not have hard copy backup at the time. I asked them whether it would be a way to go back and somehow capture that information. Of course, there is a way, and that would be going back to original medical charts because once you have a pathology

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report, you generate it, you send a copy to most responsible physician. That was a challenge with respect to Clarenville search.
COFFEY, Q.C.:
Q. And then when did the search begin in Clarenville, "Only search performed was when the pathologist asked for list of patients who had specimens sent to St. John's for ER/PR. List was sent to Clarenville from St. John's and they pulled reports based on that list. This was a list of specimens that St. John's received from Clarenville". See that, and then did you limit it by gender, age, etc, "Limited years for April, 2000, to December, 2005. Prior to 2000, searched data during conversion and pulled out a couple, but probably not complete as some data was lost". What was that about, do you recall?
DR. ALAGHEHBANDAN:
A. Again the same issue of converting from old system to new system. So they had that concern and they said that we may not have had basically captured everyone.
COFFEY, Q.C.:
Q. In relation to this then, they were limited to

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the years from April, 2000, to December, 2005. I take it that's what this is saying. That's your understanding?
DR. ALAGHEHBANDAN:
A. Limited years for April, 2000, to December, 2005.
COFFEY, Q.C.:
Q. So prior to 2000, they just couldn't search without going through every chart?
DR. ALAGHEHBANDAN:
A. This is how things happened, actually. So they switched from old system to new system. Their concern was pre 2000 because pre 2000 was the old system. So now here they are saying that we're not quite confident about pre 2000, whether we lost any data, and if we did, whether that would have been an ER/PR negative breast cancer patient. That's what they're saying.
COFFEY, Q.C.:
Q. And who performed the search?
DR. ALAGHEHBANDAN:
A. Ms. Kathy -
COFFEY, Q.C.:
Q. Kathy Escott?

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DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. The pathologist, and the secretary did the search, and then details about the search are described as, "Searched Meditech for word "ER/PR, estrogen/progesterone". Was able to designate data section to do search. Searched in "send out" date section, "referred out". Also searched in addendum for "ER" and "PR". Printed reports out and gave to pathologist for review. Not sure when started sending to Mount Sinai, but since Meditech was implemented in 2000, very few were sent to St. John's".
DR. ALAGHEHBANDAN:
A. So prior to that implementation of new system, they usually send it to St. John's lab for staining. After 2000, that was my understanding from the interview, that most of the cases were sent to Mount Sinai for testing, and, of course, it wasn't a part of ER/PR, it was just routine exercise to send those samples directly from Clarenville to Mount Sinai.

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COFFEY, Q.C.:
Q. In terms of were searches done to look for others, you've noted, "A few months ago did another search to see if they missed anybody the first time. Used the same strategy, and picked up one extra". Was a manual review of pathology reports done after electronic and you've noted, "No hard copies that Kathy knew of". In other words, they didn't have any paper?
DR. ALAGHEHBANDAN:
A. No, they didn't.
COFFEY, Q.C.:
Q. And then was cross-referencing done to ensure completeness, "No cross-referencing with first search and second search because didn't have the results of the first search. It wasn't an organized search".
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. That's what she told you?
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:

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Q. And anything to add, you've written here, "Not good quality before Meditech. That is what caused the problems when the conversion to Meditech took place. When the system switched, data lost during transition because some MCPs didn't match. A major issue, and they tried to do what they could. Only way to get pre 2000 specimens would be to go to the patients charts. Jim Humbie thought all blocks were being sent to Mount Sinai, and then found out that some were sporadically sent to St. John's. No manager of pathology, cutbacks caused one director to have to look over all five sites".
DR. ALAGHEHBANDAN:
A. Human resource was a factor there. One individual was in charge of a number of sites back then.
COFFEY, Q.C.:
Q. Years ago.
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Okay, back in 2000 and 2001.
DR. ALAGHEHBANDAN:

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A. That's correct.
COFFEY, Q.C.:
Q. That's what you were told. Here is an entry for St. John's. The people you spoke to were Mr. Gulliver and Mr. Dyer, September 10th, 2008. How many LIS, "There were three systems, the Health Sciences Centre, St. Clare's, and the Grace, connected in 1999. Now one system as old Health Sciences Centre became St. John's system. Any patient record from Health Sciences Centre not affected, but for Grace and St. Clare's, records were transferred over to new system, demographic info transfer, but maybe not all of record, i.e. info before 1999 at those hospitals, but can still access old systems to get that info". So I take it you understood that they were able to get all this electronically?
DR. ALAGHEHBANDAN:
A. So after 2000, they could do one search within Meditech for the entire St. John's region. Prior to 2000, they had to identify those patients who had ER/PR testing at Health Sciences Centre, and then going back to the old systems and looking at their ER/PR scores.

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COFFEY, Q.C.:
Q. And here, how are pathology reports stored, and the answer, "Meditech at St. Clare's from 1986, at the Health Sciences Centre from 1987, and from Grace, 1994/1995, but Grace didn't use MCP number".
DR. ALAGHEHBANDAN:
A. And that was a great challenge because if you don't have MCP number, then you have to go by name, and that caused some issues.
COFFEY, Q.C.:
Q. "And Grace and St. Clare's did keep hard copies. St. Clare's still printed hard copies with slides up until four to five years ago". So did you actually - but you didn't actually go to look at the hard copies yourselves?
DR. ALAGHEHBANDAN:
A. No.
COFFEY, Q.C.:
Q. You described that to us.
DR. ALAGHEHBANDAN:
A. There was no need of that because in Health Sciences Centre you can simply access the old system, whether that would be old Grace or St. Clare's.

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COFFEY, Q.C.:
Q. And when did the search begin, you noted, "Told to do search by Dr. Williams and saw memo from Dr. Cook. Searched in early/mid July, 2005. Done because Dr. Carter needed a list of all patients because she was going to do the review. Interested in the positivity rate". In terms of limited, "Search males and females, all ages for 1997 to 2005". Who performed the search, "Terry performed one search, Barry performed another". Then details about the search, "Search done by procedure, ER/PR ordered, because they were asked to find patients that had ER/PR. This search gave info and results for patients from Health Sciences Centre system in 1997. For Grace and St. Clare's, only got number assigned to do, that ER/PR was done and that it was sent back for interpretation. Then would have to go into the old system and get the results. Got names from "big" system, and then went in old system to get reports. After systems merged, it didn't make a difference where the specimen was from as all info was in the one system. Printed all reports and made

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spreadsheets of neg and weak positives. Told by oncologist to assume all positives were treated, but also gave list of weak positives, "greater than zero, but less than the clinical guidelines". So this is what Mr. Gulliver -
DR. ALAGHEHBANDAN:
A. That's right again.
COFFEY, Q.C.:
Q. And Mr. Dyer told you. Then in terms of were other searches done to look for others, you've noted here, "For out of town's or the other hospitals, couldn't search by word "breast", but could search by procedure ordered. There was no text, no codes, in those referred to Health Sciences Centre, just that Health Sciences Centre was asked to do procedure. Grace didn't even use MCP. So then went into Grace system to pull report, had to cross-reference by the Health Sciences Centre surgical number. Did have other options in mind initially, but chose to do order entry because of their experience with documentation. Wanted oncologist to provide list of patients, but Dr. Laing said their system wasn't able to do it. Health Sciences

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Centre was only site in Newfoundland and Labrador that performed ER/PR no matter where specimen was from. Wouldn't change the way the review was done. Still the way of getting the highest confidence of capturing the patients, starting with a broader search at the beginning, for example, all specimens with word "breast" and narrowed down from there would still not be comprehensive. The only way would be to print all breast specimens and have someone review all". So this is what they -
DR. ALAGHEHBANDAN:
A. And that's what we're in the process of doing.
COFFEY, Q.C.:
Q. And then here, was it a manual review, and you've noted, "Electronic search provided a list of reports to print out. Then reports would have been reviewed manually, but no manual search was done without first narrowing it down electronically". This would be in St. John's. You've noted here, was cross-referencing done to ensure completeness, and the response is, "No cross-referencing done with St. John's patients. Cross-referencing

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could/should be done with the out of town specimens by cross-referencing the out of town lists with the outside St. John's patients in the database".

DR. ALAGHEHBANDAN:

A. And that's another initiative that we're taking right now.

COFFEY, Q.C.:

Q. Could you tell the Commissioner about that, what's that about?

DR. ALAGHEHBANDAN:

A. Sure. So out of town facilities, when the breast sample comes in, basically they create their blocks. The blocks get sent down to, say, Health Sciences for creating ER/PR slides, and those slides go back again to the requesting authority, for example, Western, Central, or whoever that would be. At each region, we have a list of those patients who were sent for retesting at St. Clare - at Eastern Health, actually St. John's - specifically Health Sciences. We have a list of those requests that came in from the regions for staining. So we can cross-reference this to a list. So we can create a

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list of those procedure requested by each region, and then sending it back to the regions and asking them to cross-reference with their own list, whether there is any missing patients or not.

COFFEY, Q.C.:

Q. I take it that's in the process of being done?

DR. ALAGHEHBANDAN:

A. We are in the process of developing a protocol. Dr. MacDonald and officials at Eastern Health met this week and last week, and we are in the process of doing that.

COFFEY, Q.C.:

Q. For the out of St. John's -

DR. ALAGHEHBANDAN:

A. Creating a list for out of town, actually.

THE COMMISSIONER:

Q. I just want to make sure I'm clear again. So you're taking the list created by the region of what they sent?

DR. ALAGHEHBANDAN:

A. That's correct.

THE COMMISSIONER:

Q. And comparing that to a list created within Eastern Health of what it received?

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DR. ALAGHEHBANDAN:

A. That's correct. So they received -

THE COMMISSIONER:

Q. Originally.

DR. ALAGHEHBANDAN:

A. They received for testing staining. We create that list. We send it back to the regions, asking them to cross-reference with the list that they basically they came up with with respect to their search and see whether there is any discrepancy.

COFFEY, Q.C.:

Q. Would that be to make sure that everyone on this list St. John's sent them -

DR. ALAGHEHBANDAN:

A. Exactly.

COFFEY, Q.C.:

Q. Grand Falls is told what St. John's -

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. We have a record that all these patients we did a test for?

DR. ALAGHEHBANDAN:

A. For example -

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COFFEY, Q.C.:

Q. And would you check -

DR. ALAGHEHBANDAN:

A. Central sent ten patients to St. John's. Now in St. John's Meditech, we do have a list of these ten patients who had an ER/PR testing performed on them. So we have a list from St. John's because Central send ten patients. In Central, we have, for example, list of nine patients who are sent to Mount Sinai. Now we have to cross-reference this list and the other one. So we come across this patient who is on St. John's list for testing, but it is not on Central list for being sent to Mount Sinai. Based on the search they performed back in 2005, each region has a list, and I'm referring to that list.

THE COMMISSIONER:

Q. I didn't -

COFFEY, Q.C.:

Q. Perhaps you can -

THE COMMISSIONER:

Q. Well, it's just - I just thought that I had this vague memory, and I can't remember which of the pathologists it was when they were here

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giving evidence was talking about just that, about how valuable it would have been -

COFFEY, Q.C.:

Q. Yes.

THE COMMISSIONER:

Q. - had they--and I thought one of them had actually raised it at the time, but perhaps I've got the wrong tense. I thought it had been done for one reason, but I know that--think more than one said it would have been valuable to know what Eastern Health thought they should have in their records.

BROWNE, Q.C.:

Q. Yes, and I believe it was Dr. Neil.

COFFEY, Q.C.:

Q. Yes, he did.

THE COMMISSIONER:

Q. I frankly don't remember which of the pathologists it was, but it was one of the pathologists.

BROWNE, Q.C.:

Q. Yes, I think Dr. Neil spoke to that, but I could be wrong.

THE COMMISSIONER:

Q. I believe one of the ones from Central did as

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well.

COFFEY, Q.C.:

Q. And in fact, Commissioner, and if I recall correctly, I think Mr. Dyer and certainly Mr. Gulliver did say that, in fact, it would have been a good idea to have done it, you know, in terms of that.

THE COMMISSIONER:

Q. Yes, okay.

COFFEY, Q.C.:

Q. Back then, but -

DR. ALAGHEHBANDAN:

A. So now we are in the process.

COFFEY, Q.C.:

Q. In the process of -

DR. ALAGHEHBANDAN:

A. Performing that.

COFFEY, Q.C.:

Q. And here, the last note, in terms of commentary from St. John's, "after all systems were merged, the search was more straightforward. Almost all that were missed were from 1997 to 1999 because of the complexities of the systems before they became one. One thing they didn't do was send out a

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list to other regions of the specimens done for that region for them to cross reference."

DR. ALAGHEHBANDAN:

A. And again, he's referring to the point that we just discussed.

COFFEY, Q.C.:

Q. And dealing with, if we could, because Central, of course, is actually two different, Central East and Central West. Central East would be Gander. You dealt with, I take it, on September 16th of this year, Ms. Freake and Dr. Gallagher, Sherry Freake?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And "they had two LIS systems in Central, separate with minimal connections." I take it that's one in Gander and one in Grand Falls?

DR. ALAGHEHBANDAN:

A. Um-hm.

COFFEY, Q.C.:

Q. "The reports were electronic since 1995, still have paper based printed for patients charts." I apologize, yes, that's it. Page three, in terms of how did--"when did the search begin,

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a letter from Dr. Cook sent to the lab director, June 14th, 2005. Dr. Gallagher received the September '05 letter requesting all ERs/PRs." And then "did you limit it? January 1997 to August 2005, ages zero to 100. Initially limited to females, but redid the search to include males as well." Commissioner, you'll recall Dr. Gallagher made a comment about that.

Then it says "Dr. Gallagher performed the search and spoke to IT to get advice on how to do it." That's in terms of who performed the search. Then in terms of the details about the search, you've noted "did the search in 'miscellaneous' and searched for various words: 1. breast, 2. breast plus carcinoma, 3. breast plus carcinoma plus hormone receptor. Pathology prefix S and retrieved surgical report in its entirety. A miscellaneous search is a way to do a search that is not set up already. Printed all reports that the search provided. A minimum of nine searches done, maybe more, but searches aren't stored in the system, so unable to go back to get them, but know there were at least nine

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searches because in October ’05 sent an e-mail saying he," that is Dr. Gallagher, "had done nine searches and wanted to make sure that he had them all. Carcinoma of breast was a search routine set up already, so he wanted to ask IT about that search."

And then here in terms of "were other searches done to look for others?" and you’ve noted here he told you "redid the search to look for any males that may have been missed. ER and PR also searched based on text, but Dr. Gallagher can’t remember what the search turned up." And then there was a manual review of pathology reports performed. "Reports were reviewed manually," you were told.

And then finally, "was cross referencing done to ensure completeness?" You’ve written "established a master list and compared master with more inclusive multiple searches so would see if there were more they had to include. Master list was done of ER negative cases as defined by Dr. Cook. Most of the manual work and cross referencing was done by Dr. Somers. Dr. Gallagher did some as well."

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So in relation to Central West, I take it again Ms. Freake is being interviewed, as well as Glenn Mouland and Evelyn Saunders from Grand Falls, that would be, October 1st?

DR. ALAGHEHBANDAN:

A. That’s right.

COFFEY, Q.C.:

Q. And "how many LIS? One Meditech system with pathology module implemented in November 2001. Before that, used a locally developed program called Medicus, somewhat similar to Meditech, and when went to Meditech merged the two systems. We’re told all reports were now stored in Meditech, as Medicus data converted to Meditech data. Hard copy is kept up to November 2001. Some challenges with merge. Initially contracted company to do it, but some difficulties with that, so was done by IT people in Central West. Confident the data was transmitted, but there were occasional files with problems. Most are okay. Having hard copies increases the confidence because come across any issues, able to go back through hard copies."

And then in terms of when the search

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began, "in 2005, when Dr. Cook memo came out. Did you limit it? Search for ages zero to 120, males and females, 1997 to 2005. Initially didn’t look for breast related but new review in spring ’08 did include those. Who performed the search? Told Evelyn, manual log book search, and Glenn, the Meditech search." That’s all for Grand Falls.

Then there’s, in terms of the details about the search, "Had log booked the recorded blocks, slides, ER/PR, etcetera of those that were sent out. Included 1999 to 2005 onwards. Identified patients that way. After manual log book search, Glenn search in Meditech for breast and carcinoma and checked that against the log book. Each specimen was assigned the nature of the specimen--has a sign," I’m sorry, "nature of specimen has it’s own data field and he looked for carcinoma in diagnosis, coded as carcinoma in final diagnosis, so anything coded as carcinoma would have been picked up because after sign out computer automatically codes."

And then in terms of this, "were other searches done to look for others?" in terms of

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Grand Falls. You’ve noted "after Sherry contacted about a new patient identified in the spring of ’08, repeated search and printed every nature of specimen for 1997 to 2001. Greater than 20,000 surgical specimens. Four people to review. Anything related to breast was counted and looked up. Finished this on April 30th, 2008. Electronic search was done again for 2001-2005 and manual search for 1997 to 2001. Found three new cases, including the one that called in. Couldn’t find them in 2005 because one wasn’t in log book and one must have been overlooked."

And then "was a manual review done? Manual log book search done." And then there’s, in terms of "was cross referencing done?" It’s noted "cross referencing between log book and Meditech and found a couple that the log book didn’t find." Finally "anything to add? Had to make note of those cases that were written as ER positive but number given as less than ten for example. Some things were confusing and made things complex. The way of reporting ER/PR was not standardized and this may have caused a lot of problems.

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If other regions limited search to ER negative, they may have missed cases that were clinically negative but written in report as positive. Always had to check reports for the year to see if they were negative or positive according to clinical guidelines."

So in terms of to complete this request here, you interviewed Dr. Neil and Dr. Jenkins and Hedy Dalton Kenny and Donna Hicks on September 30th, 2008. "Have two LIS systems, 1989 to 1990/1990 to '99. Was a primitive computer system, was not searchable. 1999 onward is Meditech, is searchable. Contains all Western for lab and pathology. How are they stored? Electronically in old system until 1999, then Meditech." Then you've written "when did the search begin? Search was done when received Dr. Cook memo." It's indicated "looked at everything, primary breast and all breast related specimens. Everything with an ER/PR ordered, male and females, all ages. Included deceased when asked to do so."

Now in relation to this, I want to ask you about this. Do you have any reason to

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believe that any of the regions outside St. John's were sending in non-breast--ER/PRs but non-breast?

DR. ALAGHEHBANDAN:

A. To Eastern Health for being sent to Mount Sinai?

COFFEY, Q.C.:

Q. Yes.

DR. ALAGHEHBANDAN:

A. I can't really comment on that. What I can say is that there were two, I guess, screening, a screening process here. One at each site and one at Eastern Health. So even if they sent a non-breast sample to St. John's, one would have picked up on that, and if they sent a non-breast sample to Mount Sinai, Mount Sinai would have reported it.

COFFEY, Q.C.:

Q. And here then, in terms of "who performed the search? Evelyn, manual long book search and"--I'm sorry, I apologize. "Search was done by a technologist who looks after pathology module here, in Corner Brook."

THE COMMISSIONER:

Q. Sorry.

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COFFEY, Q.C.:

Q. Yes, go ahead, Commissioner.

THE COMMISSIONER:

Q. But that just reminded me of something. There's a reference to primary breast and all breast related -

COFFEY, Q.C.:

Q. Yes, turn back.

THE COMMISSIONER:

Q. - I think searched primary breast. Yeah, I think so.

COFFEY, Q.C.:

Q. There it is, Commissioner. "Looked at everything, primary breast and all breast related specimens."

THE COMMISSIONER:

Q. Right, and all breast related specimens. Do you know whether or not that is consistent with what was done elsewhere or were there -

DR. ALAGHEHBANDAN:

A. Originally, that wasn't a part of our interview. During the course of the interviews, we received a suggestion from Mr. Thompson's office regarding including this basically question with our interviews, and

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that's why we asked the questions from officials at Western.

THE COMMISSIONER:

Q. Okay.

DR. ALAGHEHBANDAN:

A. And I believe that -

THE COMMISSIONER:

Q. So it wasn't part of what you asked the others?

DR. ALAGHEHBANDAN:

A. No, but I believe that at some point we will be asking the other regions the same question, just to be consistent across the board.

THE COMMISSIONER:

Q. Thank you.

DR. ALAGHEHBANDAN:

A. You're welcome.

COFFEY, Q.C.:

Q. Here then, page four, here in terms of "details about the search" you've told them "Western used ER"--apologize, just come across here. "Used ER/PR immunohistochemical order sheet. When pathologists wanted ER/PR stains done on a specimen, secretary sends it to St. John's and keeps requisition form, so able to

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search all hard copy requisition forms for 1997 to 2005. Asked the Newfoundland Cancer Treatment Research Foundation for all cases over the years, '97 to '05, by place of residence for Western. Found this helpful. Searched Meditech from 1999 onwards. Tumor markers placed in system individually marked and technologists provided list of cases for 1999 to 2005. Tumor markers specifically for ER/PR were used to search Meditech. Automatically assigns an ER/PR marker to every malignant breast tumor. After diagnosis made, it automatically attaches the tumor markers and then searched for those markers."

And then continuing on, in terms of "were other searches done?" Western told you "double checked first method with requisition forms. Have a record book, manual lists to say that something was sent out to St. John's." And then in terms of "was a manual review of pathology reports done?" It's noted "printed reports that electronic search provided and Dr. Jenkins reviewed them all. Spreadsheets detailed this and Commission of Inquiry has those spreadsheets." And "was

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cross referencing done to ensure completeness?" Noted "cross referenced lists, double check using record book saying that something was sent out to St. John's."

"Anything to add?" You've noted, "Stephenville and Corner Brook are two areas that do breast specimens for Stephenville. They are put in formalin and in fridge and transported to Corner Brook same day or next day." So that's what you were told there?

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

Q. And finally then, in terms of -

THE COMMISSIONER:

Q. I'm sorry, Mr. Coffey, but before you move on.

COFFEY, Q.C.:

Q. Yes.

THE COMMISSIONER:

Q. Dr. Reza or Dr. MacDonald, I don't know who would best answer this, but are all Meditech systems created equal that are used in this province?

DR. MACDONALD:

A. They're all bought from the same company.

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THE COMMISSIONER:

Q. Um-hm.

DR. MACDONALD:

A. So they all use the same technology and the same modules, but it's up to the regions to standardize their own programs. So where the difference occurs is around how they enter in their data into the Meditech.

THE COMMISSIONER:

Q. Because when you're looking at something like this where it's all sort of lined up together, it would appear that while I understand that some regions got Meditech at different times than others did, but it would also appear that the use of it, for this purpose, varied a great deal across the regions and the perceived capability of Meditech was different. At least I'm gleaning that from witnesses.

DR. MACDONALD:

A. That is true. We have--I don't know how many Meditechs we have. I'm going to guess here it's six, eight maybe. They don't talk to each other.

THE COMMISSIONER:

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Q. Um-hm.

DR. MACDONALD:

A. So they're silos, and they use different standards, different--you know, everything is--it's up to the regions when they generated their own modules for service providing care, it was up to them how they wanted to design it. So for example, a region may say, you know, order entry, put in ER/PR. Another one might set it up, you have to spell it out. Some use drop down windows, so you don't have to worry about spelling or inconsistencies. So it is really very much a silo type of information system across our regions.

THE COMMISSIONER:

Q. Okay. So I could not, for example, assume because Meditech exists in a particular region that there is a capability just because it happens to be--Meditech happens to be capable of making a search on a certain basis in another region?

DR. MACDONALD:

A. Yeah, you know, for example, if you had a test done in St. John's and you're living out in Gander and went to your hospital and did a

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search on that test, they won't get it.
COFFEY, Q.C.:
Q. Or even if the same search was--a particular search was done, Meditech existed in Gander and existed in St. John's, and you adopted a particular approach, for example, the tumor markers one we just referred to there. Some Meditech systems, I take it, might code by that and some might not?
DR. MACDONALD:
A. Well, yes, it's how you design your own lab system, and let's not forget, there's a lot different modules in Meditech than lab.
COFFEY, Q.C.:
Q. Yes.
DR. MACDONALD:
A. So this is not just an issue for our labs.
THE COMMISSIONER:
Q. Yes, the search fields could be different in different places, etcetera, etcetera. So just because it's all called Meditech, we can't make assumptions about what it -
DR. MACDONALD:
A. Yeah, I mean -
THE COMMISSIONER:

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Q. - is set up to do, as opposed to what it might be capable of doing?
DR. MACDONALD:
A. - an authority, when they were first purchasing Meditech years ago, would decide how much they want to expend on it and what modules, what they want, what functionality they want. So they would cherry pick from the list available, functionality, and build it. So it's--the fact that you have Meditech here and Meditech there does not imply -
THE COMMISSIONER:
Q. Doesn't tell you anything.
DR. MACDONALD:
A. No.
THE COMMISSIONER:
Q. Okay, thank you.
DR. MACDONALD:
A. And just to follow up on that, it presented much challenges for us in developing the database because we had to deal with individual Meditechs and the inconsistencies around standards.
COFFEY, Q.C.:
Q. Here, in terms of Labrador Grenfell, Dr. Reza,

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I take it, on September 3rd, 2008, you interviewed Dr. Dankwa?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And it says he told you "one LIS system Meditech introduced in July '03. From '97 to 2005, patient info typed into computer and hard copies kept. '03 onward, Meditech was used with electronic info available. July ' 03 onward, had both hard copies and electronic Meditech info available." And in terms of "when the search began? They did initial search in 2005 when the letter came from Dr. Cook regarding all ER negative patients." And reference, "did you limit the search? First letter came saying only 2002 patients. No Meditech system then, so went through all reports manually to find ER negative for 2002. Then 2005 letter required all cases from ' 97 to '05." And then there's reference to "who performed the search? Dr. Dankwa and clerical staff. Whatever clerical staff weren't sure about, they would bring to Dr. Dankwa's attention."

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Just go over here then, in terms of the details about the search, you indicated that Dr. Dankwa told you "he searched for breast and looked at reports to find ER negative. Even though electronic reports were there, still looked manually to find ER negative for the 2002 search. Knew the manual search would take forever, so requested electronic list. Asked St. John's to help by asking for a list of all breast specimens that went to St. John's from 1997 to 2005. Received a list with patient names. All malignant specimens were sent to St. John's. Took that list and went through each patient on that list to find ER negatives." And then there's -
THE COMMISSIONER:
Q. So is that what you're now suggesting should happen or is it something more complicated than that?
DR. ALAGHEHBANDAN:
A. Currently, we're suggesting to create a cross check list from St. John's lab and sending it to the regions, so they can basically cross reference them with their own list.
THE COMMISSIONER:

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Q. So what Dr. Dankwa says happened here was he asked St. John's to send him out a list -
DR. ALAGHEHBANDAN:
A. To cross reference with his own list that he created. That's right, I believe so.
THE COMMISSIONER:
Q. Well, yes, to help -
COFFEY, Q.C.:
Q. "Asked St. John's to help by asking for a list of all breast specimens that went to St. John's from '97 to '05."
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:
Q. All that went from his shop to St. John's.
DR. ALAGHEHBANDAN:
A. His region to St. John's.
THE COMMISSIONER:
Q. So that's the kind of nature of the kind of thing that you're now anticipated in respect of all other centres?
DR. ALAGHEHBANDAN:
A. That's correct.
THE COMMISSIONER:
Q. All right, thank you.

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DR. ALAGHEHBANDAN:
A. You're welcome.
COFFEY, Q.C.:
Q. And the next page, Commissioner, here in terms of "were other searches done to look for others?" You were told "when the Centre requested ER/PR cases, they went through everything again. This time, went through everything manually, approximately 2,000 reports a year, went through" and this is underlined and italicized, "every report." So in terms of that, what was Dr. Dankwa telling you then about that?
DR. ALAGHEHBANDAN:
A. Extensive effort.
COFFEY, Q.C.:
Q. When they were asked to -
DR. ALAGHEHBANDAN:
A. Went through all those pathology reports himself.
COFFEY, Q.C.:
Q. When they were asked, in 2008, by yourselves to look at this again, he went through everything?
DR. ALAGHEHBANDAN:

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A. Everything.
COFFEY, Q.C.:
Q. Every -
DR. ALAGHEHBANDAN:
A. Every pathology report.
COFFEY, Q.C.:
Q. - pathology report.
DR. ALAGHEHBANDAN:
A. Within his region.
COFFEY, Q.C.:
Q. In that time frame?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And has any other region done that, to your knowledge?
DR. ALAGHEHBANDAN:
A. Dr. Baker.
COFFEY, Q.C.:
Q. In Carbonear?
DR. ALAGHEHBANDAN:
A. Carbonear. Central done manual work using word press (phonetic) and Western as well, some manual work too.
COFFEY, Q.C.:

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Q. But in terms of actually sitting down and getting all your pathology reports and looking through them all, Dr. Dankwa is the only one who has actually done that?
DR. ALAGHEHBANDAN:
A. Dr. Dankwa, yes, that's right.
COFFEY, Q.C.:
Q. And here, "was cross referencing done to ensure completeness?" You've noted "yes, when the Centre requested the reports," he told you. And then "anything to add?" You note he's told you "wrote to CEO about the time it would take to go through the reports again in 2007, but did it manually because they wanted to be able to stand behind their search."
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. Indicated to you. Now, having conducted all those interviews, created your chart here, did you have then any concerns?
DR. ALAGHEHBANDAN:
A. My first concern would be with the potential data got missed during the transfer from old system to new system in Clarenville. So, that

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would be major concern, if I would look at this report. Within St. John's region, we did the search based on ER/PR procedure code. So, that would be another area of concern because now we learn that there are some patients out there who got missed through the initial search because the ER/PR entry code was not added into the system. The rest of the regions basically, I must say, that they would be, felt sufficient to create a cross-check list from St. John's area, Health Sciences Lab, sending it to the regions and they can cross-reference with their own list. So, that would be hopefully sufficient enough to give better level of confidence.

COFFEY, Q.C.:

Q. And if I could, could I see Exhibit P-2152, please? And I appreciate you've probably-- I'll ask you, I don't know if you've seen this, page 8 please. Dr. Reza, this is just the one copy of all the--just go back a page, this is on the back of this page.

DR. ALAGHEHBANDAN:

A. That's right.

COFFEY, Q.C.:

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Q. Original sheet of paper. Have you seen a form like this, this sort of print out before, in the context of the special procedure request forms.

DR. ALAGHEHBANDAN:

A. I have never seen this form, this page.

COFFEY, Q.C.:

Q. Have you seen anything like it?

DR. ALAGHEHBANDAN:

A. No, not that I can recall.

COFFEY, Q.C.:

Q. Okay. So, we're told, advised by a witness that--because you can read here, it's an immunohistochemical report. This is of probably May 6, 1998, the patient's name is not filled in, but there's a case number, surgical number there, the doctor is indicated to be Khalifa. The technician is Peggy. The institution is the Health Sciences Centre. There's a slide number spelled out here. This happens to be number 19 and 20, the antibody is estrogen receptor, 1--50, 30 minutes. Progesterone receptor, 1--10, 30 minutes. Protocol is all spelled out here. And staining--there's a space for staining, see

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note, noise, and commentary. We're advised that this was produced by a DAKO computer, related to the DAKO machine.

DR. ALAGHEHBANDAN:

A. Right.

COFFEY, Q.C.:

Q. That's what we understand. If this sort of data had been, as it was being generated over the years, days and years as tests were going on, was being generated and stored in the DAKO, if it had been and that was available to you, would that have been of assistance perhaps in identifying exactly when a particular test was done?

DR. ALAGHEHBANDAN:

A. I guess I would question one point here, whether DAKO system read the slide.

COFFEY, Q.C.:

Q. Oh, no, no, it didn't read the slide.

DR. ALAGHEHBANDAN:

A. No, -

COFFEY, Q.C.:

Q. This is just -

DR. ALAGHEHBANDAN:

A. This is just the DAKO system stored it.

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COFFEY, Q.C.:

Q. Yes, it just simply--the DAKO system, we understand, in slot number 19, there was an ER slide processed with that -

DR. ALAGHEHBANDAN:

A. Yes, well that's one thing. The second this is let's look at the specimen. I don't know whether this is a lung specimen, this is an ovary specimen, this is a breast specimen. I don't know what specimen is this. And normally when you look at a pathology report, it contains two major sections, gross and microscopy. So, you simply explain what you have right now. For example, I have a breast specimen with this size and these are the characteristics of this and then I go into microscopy and I describe what kind of cells I see. Here I just see two numbers, it sounds like an addendum to me, that someone performed the ER/PR testing and reported it as what -

COFFEY, Q.C.:

Q. No, no, this is not a report.

DR. ALAGHEHBANDAN:

A. This is just -

COFFEY, Q.C.:

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Q. You don't recall--I want to get some sense from yourself in terms of how much actual familiarity you would have with this.
DR. ALAGHEHBANDAN:
A. I'm not familiar with this.
COFFEY, Q.C.:
Q. Okay. So, do you have, and I'll ask you this because it might be of some interest, in relation to the whole idea of analysing information management, are you able to or have you ever been made aware of what protocols were being utilized from time to time?
DR. ALAGHEHBANDAN:
A. With respect to?
COFFEY, Q.C.:
Q. ER and PR, like what particular protocol happened to be used, what dilution rates were used.
DR. ALAGHEHBANDAN:
A. I had a brief discussion at the beginning of my work with respect to developing the database with Mr. Gulliver, but that was just a technical/scientific for my own benefit. That did not have any benefit to the creation

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of the database at the time. So, again, with respect to the database, I don't see any value of that at this moment.
DR. MACDONALD:
A. So, Bernard, would you be asking if we actually had in our database, protocols -
COFFEY, Q.C.:
Q. Oh yes, in terms of--well, no, I'm just asking about whether or not Dr. Reza was ever actually, you know, introduced to the idea and if so, if he understood the potential significance of the change in protocols over time.
DR. MACDONALD:
A. We certainly had identified the issue of different protocols used at Mount Sinai and a lab here and that that might interject a difference in and of itself into the change in results, but we didn't take it any further than that and it certainly wasn't part of the database.
COFFEY, Q.C.:
Q. Okay.
DR. MACDONALD:
A. So, our results, as we've said, you have your

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original ER/PR, there is no protocol around that. You have to retest ER/PR and there is no protocol around that. So, it's basically a flat file saying here's what you had and here's what you got.
THE COMMISSIONER:
Q. I'm not sure your original question was answered, Mr. Coffey and I'm not sure the witness understood you original question.
COFFEY, Q.C.:
Q. So, in terms of--if you were to be told, okay, that this would indicate, that for that surgical number, see that surgical number right here?
DR. ALAGHEHBANDAN:
A. I can see that, yes.
COFFEY, Q.C.:
Q. And that's the pathologist?
DR. ALAGHEHBANDAN:
A. That's right.
COFFEY, Q.C.:
Q. And that's the technician.
DR. ALAGHEHBANDAN:
A. That's correct.
COFFEY, Q.C.:

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Q. That on that particular day -
DR. ALAGHEHBANDAN:
A. That test was -
COFFEY, Q.C.:
Q. - that surgical number, those two, an ER and a PR slide were produced.
DR. ALAGHEHBANDAN:
A. Um-hm.
COFFEY, Q.C.:
Q. Would that have been of any use--if that was available just unmasked to you, you were able to tell from the computerized database that using that surgical number, you can search the database, search it using that surgical number and identify what particular day it was done, by what technologist -
DR. ALAGHEHBANDAN:
A. So, let's look at the surgical number here. The surgical number is from 1998. It's says Central. If I am at Centre and I'm looking at Meditech in Central, if I have access to Meditech in Central, I can put that number into Meditech and I can pull out the pathology report. However, if I'm in St. John's and St. John's Meditech is not connected to Central

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Meditech, I won't be able to basically pull out that patient. All I can is to pull out that patient based on the procedure ordered from Central, for Health Sciences to perform the testing, but with respect to reporting, I have to have access to Central Meditech. The bottom line is that we got 9 LOI (sic.) Lab Information Systems across the province, they're not connected.

COFFEY, Q.C.:

Q. Um-hm.

DR. ALAGHEHBANDAN:

A. So, when I'm looking at this, this is a surgical number from Central. If I'm here or somewhere else, except Central, I won't be able to pull it out.

DR. MACDONALD:

A. If we had those fields, we could further analysis, obviously, on associations. For example, doctors, technicians, to look to see if something, if there's a trend, in results.

COFFEY, Q.C.:

Q. Um-hm.

DR. MACDONALD:

A. So, I mean, if that's what the question was,

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if those fields could add additional analysis to the database, certainly yes, they could.

THE COMMISSIONER:

Q. Well, what about something as simple as identifying whether or not you have all the patients identified? If you have a DAKO system or two DAKO systems and you have a DAKO machine, whatever they're called, which provides, within it, a record of every test done by that machine and that record includes a number through which I assume you can identify the patient, why could that machine not make you aware of whether or not you actually got every patient, up to the point that they stopped using the DAKO?

DR. MACDONALD:

A. Well, it gets back to your earlier comment around the non-standard ways our Meditechs and our Lab Information Systems have been implemented across the province. So, when we looked at how we can actually identify every test, or for that matter, every patient, is what we were really interested in, that was our core.

THE COMMISSIONER:

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Q. Um-hm.

DR. MACDONALD:

A. Identify the patient and then identify the test associated with the patient. Some of the different search parameters we're looking at, specimen numbers, but there's so many different specimen numbers, as you've heard, we finally decided in consultation with people in the system, that to search for "breast".

COFFEY, Q.C.:

Q. I appreciate that. There's no suggestion at all, I'm just asking you, in terms of this that if this existed, if somebody was to come in here today with a computer, plank it down there and you could access it and all of these were recorded, every ER/PR done in Newfoundland on that DAKO machine and that DAKO machine did all the ER/PRs in Newfoundland -

DR. ALAGHEHBANDAN:

A. That's useful -

DR. MACDONALD:

A. That would be very -

DR. ALAGHEHBANDAN:

A. That's valuable.

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COFFEY, Q.C.:

Q. In terms of that -

DR. ALAGHEHBANDAN:

A. It is.

COFFEY, Q.C.:

Q. Because you wouldn't be running around, amongst other things, looking at handwritten lists.

DR. ALAGHEHBANDAN:

A. It is valuable in a sense that you can break it down by regions and basically send a cross-check reference to regions. What I was saying that if you have only that surgical number and you have limited access to Central Meditech, you would not be able to pull out the full pathology report for that individual.

THE COMMISSIONER:

Q. Yes, I understand that. What I was trying to figure out was why that wouldn't--with your concern about whether or not you got everybody, why lists produced from the surgical numbers could not give you some sense of assurance that you, in fact, had gotten everybody who--now some of them, obviously, would be eliminated because they're not going

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to be breast or whatever, but -
DR. ALAGHEHBANDAN:
A. If the surgical number indicates where that specimen is coming from, then that would be quite valuable.
THE COMMISSIONER:
Q. Um-hm.
DR. ALAGHEHBANDAN:
A. In this case it indicates that it's coming from Central (CNH).
THE COMMISSIONER:
Q. Yes.
DR. ALAGHEHBANDAN:
A. If that doesn't indicate where it is coming from, then you have a surgical number, could come from Anywhere.
THE COMMISSIONER:
Q. Okay, all right, I understand. Wherever you find a convenient spot, Mr. Coffey, we'll break.
COFFEY, Q.C.:
Q. Exhibit P-3550. This, Mr. MacDonald, is an e-mail from yourself to Mr. Thompson of October 15, 2008 indicated that "a 'manual' search is a robust approach given it applies all hard

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copy of pathology reports were reviewed and those noted as be related to breast cancer would be further investigated. A limitation of this approach would be if the hard copy report, for whatever reason, was not included in the review. While I know there is human error in missing the term 'breast' when it actually was in a report. Electronic search on the term 'breast' might be considered a gold standard as it searches all pathology reports. But this approach would not capture cases where the test results were not entered or no longer available on Meditech. Below is a summary of the search strategies. Carbonear, manual review of pathology reports; Labrador/Grenfell, manual review of pathology reports; Central East, electronic search of term 'breast'; Central West, electronic search of term 'breast', 2001--2005 and a manual review of pathology reports '97--2000; Western, electronic search using other criteria felt to be appropriate to that Meditech system; Clarenville, did electronic search but not on term 'breast', also lost some data, both hard and electronic--any lost

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cases only available through patient chart; and St. John's, electronic search using criteria other than 'breast'".
So, Mr. MacDonald, as of last Wednesday, I take it that that was your advice to Mr. Thompson.
DR. MACDONALD:
A. That was basically a summary of that table.
COFFEY, Q.C.:
Q. Yes. And thank you, Commissioner. I'm asked to enter Exhibit P-3473.
THE COMMISSIONER:
Q. 3473, all right, entered.
EXHIBIT P-3473 MARKED AND ENTERED.
COFFEY, Q.C.:
Q. And I'll come back then and, if I could, clue up very quickly in the morning.
THE COMMISSIONER:
Q. Okay, thank you. 9:30.

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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 23rd day of October, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.
Dated at St. John's, Newfoundland and Labrador this 23rd day of October, A.D., 2008
Judy Moss

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