

<p>COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p>BEFORE THE HONOURABLE JUSTICE CAMERON--COMMISSIONER</p> <p>October 23, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. . . . . Commission Co-counsel Sandra Chaytor, Q.C. . . . . Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL</p> <p>Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al</p> <p>Daniel Simmons . . . . . Eastern Regional Integrated . . . . . Health Authority</p> <p>Pam Taylor.. . . . Members of the Breast Cancer . . . . . Testing Class Action</p> <p>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</p>	<p>THIS PAGE ONLY REVISED NOVEMBER 18, 2008</p> <p>LIST OF EXHIBITS</p> <p>EXHIBIT P-3472 . . . . . Pg. 5</p> <p>EXHIBITS P-3485 THROUGH P-3556, INCLUSIVE . . . . . Pg. 5</p> <p>EXHIBITS P-3560 THROUGH P-3564, INCLUSIVE . . . . . Pg. 6</p> <p>EXHIBIT P-3565 . . . . . Pg. 205</p> <p>EXHIBIT P-3559 . . . . . Pg. 205</p> <p>EXHIBIT P-3473 . . . . . Pg. 347</p>
<p>TABLE OF CONTENTS</p> <p>DR. DONALD MACDONALD - SWORN</p> <p>DR. REZA ALAGHEHBANDAN - SWORN</p> <p>Examination by Bernard Coffey, Q.C. . . . . Pgs. 5 - 347</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER: 2 Q. Please be seated. Mr. Coffey? 3 COFFEY, Q.C.: 4 Q. Thank you, Commissioner. The two witnesses 5 this morning, Commissioner, are Donald 6 MacDonald and I'll refer to him as Dr. Reza, 7 can't pronounce your last name, Doctor, in any 8 case. 9 DR. ALAGHEHBANDAN: 10 A. Sure. 11 THE COMMISSIONER: 12 Q. We have a small technical problem which we'll 13 resolve here with the chairs, okay. 14 MR. DONALD MACDONALD, SWORN 15 REGISTRAR: 16 Q. Would you please state and spell your complete 17 name for the Commission? 18 DR. MACDONALD: 19 A. Donald Morgan MacDonald, D-O-N-A-L-D M-O-R-G- 20 A-N M-A-C-D-O-N-A-L-D. 21 REGISTRAR: 22 Q. Thank you. 23 DR. REZA ALAGHEHBANDAN, SWORN 24 REGISTRAR: 25 Q. Would you please state and spell your name for</p>

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1 the Commission?  
 2 DR. ALAGHEHBANDAN:  
 3 A. Sure. Reza Alaghehbandan, R-E-Z-A A-L-A-G-H-  
 4 E-H-B-A-N-D-A-N.  
 5 REGISTRAR:  
 6 Q. Thank you.  
 7 DR. ALAGHEHBANDAN:  
 8 A. You're welcome.  
 9 EXAMINATION BY BERNARD COFFEY, Q.C.  
 10 COFFEY, Q.C.:  
 11 Q. Commissioner, there are some new exhibits, if  
 12 I could, please?  
 13 THE COMMISSIONER:  
 14 Q. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. They are Exhibits P-3472 and then 3485  
 17 through, just want to get this right, 3556  
 18 inclusive.  
 19 THE COMMISSIONER:  
 20 Q. Entered.  
 21 EXHIBIT ENTERED AND MARKED P-3472  
 22 EXHIBITS ENTERED AND MARKED P-3485 THROUGH P-3556  
 23 COFFEY, Q.C.:  
 24 Q. Then there are 3560, 3561, 3562 and 3563 and  
 25 3564

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

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1 COFFEY, Q.C.:  
 2 Q. And Mr. MacDonald, could you give the  
 3 Commissioner and overview of your background  
 4 and your current position?  
 5 DR. MACDONALD:  
 6 A. I started off back in the early '80s as a  
 7 policy analyst with the Department of Health  
 8 and Community Services, moved in 1997 to the  
 9 Centre for Health Information as an  
 10 information consultant. In 2000, I became the  
 11 director, which is my current position, of  
 12 research and evaluation. From an education  
 13 perspective, I have a diploma in electrical  
 14 technology, clinical epidemiology,  
 15 undergraduate degree in mathematics and  
 16 statistics, a Masters in science and a PhD in  
 17 science. My research expertise or area is  
 18 around the benefits of technology in health  
 19 care.  
 20 COFFEY, Q.C.:  
 21 Q. And in relation to the Masters, at that level,  
 22 the aspect of the benefits of technology in  
 23 health care was what, what particular aspect?  
 24 DR. MACDONALD:  
 25 A. Pharmacy.

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1 COFFEY, Q.C.:  
 2 Q. Pharmacy at the time, and your PhD?  
 3 DR. MACDONALD:  
 4 A. And my PhD was focused in on radiology.  
 5 COFFEY, Q.C.:  
 6 Q. And in terms of your involvement with  
 7 academia, I take it that you, in fact, have  
 8 continued your formal education, at least on a  
 9 part-time basis, up until this year when you  
 10 received your PhD?  
 11 DR. MACDONALD:  
 12 A. Yes, only recently convocated, only a couple  
 13 of weeks ago.  
 14 COFFEY, Q.C.:  
 15 Q. Now I take it, Mr. MacDonald, are you Dr.  
 16 Reza's boss?  
 17 DR. MACDONALD:  
 18 A. We're colleagues.  
 19 COFFEY, Q.C.:  
 20 Q. Colleagues, okay.  
 21 DR. MACDONALD:  
 22 A. But yes, in the hierarchy of the Department, I  
 23 suppose I would be.  
 24 COFFEY, Q.C.:  
 25 Q. Could you tell us, please, you're the

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1 Director?  
 2 DR. MACDONALD:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. Of the?  
 6 DR. MACDONALD:  
 7 A. Research and evaluation department.  
 8 COFFEY, Q.C.:  
 9 Q. And what is it that--and referred to now, I  
 10 take it, as NLCHI?  
 11 DR. MACDONALD:  
 12 A. The Centre.  
 13 COFFEY, Q.C.:  
 14 Q. The Centre, okay. Newfoundland and Labrador  
 15 Centre for -  
 16 DR. MACDONALD:  
 17 A. For Health Information.  
 18 COFFEY, Q.C.:  
 19 Q. And what was its name before that or has it  
 20 always been called that?  
 21 DR. MACDONALD:  
 22 A. It's always been the Centre for Health  
 23 Information, yes.  
 24 COFFEY, Q.C.:  
 25 Q. And is it part of any government entity? I

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1 mean, I take it it's a government agency?  
 2 DR. MACDONALD:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. Is it part of -  
 6 DR. MACDONALD:  
 7 A. It's an agency of the Crown. We had existed  
 8 actually since 1997, but we were on the  
 9 auspices of the former St. John's Health Care  
 10 Corporation and then after that, Eastern  
 11 Health, from an administrative purpose.  
 12 Recently, about a year and a half ago, we have  
 13 our own legislation. We now are an agency of  
 14 the Crown with our own Board of Directors.  
 15 Our Board of Directors are appointed by  
 16 Cabinet and we're overseen by the Ministry of  
 17 Health.  
 18 COFFEY, Q.C.:  
 19 Q. And in relation to that, when was that? That  
 20 occurred when?  
 21 DR. MACDONALD:  
 22 A. Our legislation?  
 23 COFFEY, Q.C.:  
 24 Q. Yes.  
 25 DR. MACDONALD:

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1 A. I believe it was April 1997.  
 2 COFFEY, Q.C.:  
 3 Q. And in terms of the most recent change you  
 4 referred to? You say at one time you worked  
 5 with the Health Care Corporation.  
 6 DR. MACDONALD:  
 7 A. Oh, when we got our own legislation, we  
 8 formally--like we were not a legal entity, I  
 9 would suspect.  
 10 COFFEY, Q.C.:  
 11 Q. I'm sorry, it was -  
 12 DR. MACDONALD:  
 13 A. April 2007.  
 14 COFFEY, Q.C.:  
 15 Q. April, that's what I was getting at, okay.  
 16 DR. MACDONALD:  
 17 A. Okay.  
 18 COFFEY, Q.C.:  
 19 Q. Because you had said 1997 and -  
 20 DR. MACDONALD:  
 21 A. Oh, sorry.  
 22 COFFEY, Q.C.:  
 23 Q. - and you said the original--it was originally  
 24 set up in '97.  
 25 DR. MACDONALD:

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1 A. We were actually established in 19--became  
 2 operational in 1997, but got our own  
 3 legislation in 2007.  
 4 COFFEY, Q.C.:  
 5 Q. Yes, and as of April 1, 2007, you were  
 6 legislatively a stand-alone Crown agency?  
 7 DR. MACDONALD:  
 8 A. Crown agency, yes.  
 9 COFFEY, Q.C.:  
 10 Q. With the structure you referred to.  
 11 DR. MACDONALD:  
 12 A. With our own Board of Directors.  
 13 COFFEY, Q.C.:  
 14 Q. So I just wanted to, in terms of that, so the  
 15 Commissioner understands, since that date, you  
 16 are not part of Eastern Health?  
 17 DR. MACDONALD:  
 18 A. No.  
 19 COFFEY, Q.C.:  
 20 Q. And you don't report to Eastern Health?  
 21 DR. MACDONALD:  
 22 A. And that was more from an administrative side.  
 23 Like, for example, just the logistics of  
 24 payroll, purchasing. As a new entity, we  
 25 didn't have those resources, so Eastern Health

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1 provided them for us. But other than that, we  
 2 were, you know, in a sense a stand-alone  
 3 agency still, just without legislation.  
 4 COFFEY, Q.C.:  
 5 Q. Before the -  
 6 DR. MACDONALD:  
 7 A. Before April -  
 8 COFFEY, Q.C.:  
 9 Q. Before April 1st, 2007.  
 10 DR. MACDONALD:  
 11 A. Yes.  
 12 COFFEY, Q.C.:  
 13 Q. But since that time, you've been a stand-alone  
 14 agency?  
 15 DR. MACDONALD:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. Now Mr. MacDonald, could you tell the  
 19 Commissioner, please, about--I take it that--  
 20 well, I'll refer to you as NLCHI because I  
 21 appreciate you might call yourself the Centre,  
 22 but in this context, you've been pretty well  
 23 uniformly referred to as NLCHI.  
 24 DR. MACDONALD:  
 25 A. Yes, understand.

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1 COFFEY, Q.C.:  
 2 Q. Can you tell the Commissioner, please, about,  
 3 from your perspective, how NLCHI got involved  
 4 in this?  
 5 DR. MACDONALD:  
 6 A. That would have occurred back in June 2007 and  
 7 what actually happened, I was forwarded an e-  
 8 mail from my CEO, from Robert Thompson,  
 9 requesting help from the Centre to answer some  
 10 questions around the creation of a database  
 11 that could support the Commission of Inquiry  
 12 and also the Task Force in their work with  
 13 respect to patients that had been tested for  
 14 ER/PR. Subsequent to that, we put together a  
 15 small team and started to speak to some people  
 16 at Eastern Health as to what the actual issue  
 17 was, because to be quite honest, I never knew  
 18 what an ER/PR was until some of these initial  
 19 meetings, and we formulated what we figured  
 20 would be a good approach to answering some of  
 21 these initial questions from Robert Thompson.  
 22 COFFEY, Q.C.:  
 23 Q. And do you recall, in a general way, what your  
 24 initial impression was, in terms of what the  
 25 questions were and how involved it might be

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1 initially?  
 2 DR. MACDONALD:  
 3 A. Well, initially, as I said, we were very naive  
 4 actually to what the issue was. Until we  
 5 actually--it was months later when we actually  
 6 started to get a handle on things, so no, it  
 7 was a very complex undertaking. It took us a  
 8 number of months even to understand what was  
 9 required and what we would have to do. So I  
 10 think in our initial stages, we were somewhat  
 11 overzealous, I would say, in reporting to  
 12 Government how long it might take to answer  
 13 some of their questions.  
 14 COFFEY, Q.C.:  
 15 Q. As it turns out, the estimates of the time  
 16 frame that it might take to answer the  
 17 questions posed, you were overly optimistic?  
 18 DR. MACDONALD:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Based upon a lack of knowledge about the  
 22 underlying problems, which we're going to  
 23 speak about.  
 24 DR. MACDONALD:  
 25 A. Yes, that's a fair statement.

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1 COFFEY, Q.C.:  
 2 Q. If we could, please, Registrar, Exhibit P-  
 3 3485? This is just--if we could, please, yes,  
 4 this is just an e-mail. Kind of going to pick  
 5 up the trail, as it were, the beginning of  
 6 July 2007, and there's an e-mail from Heather  
 7 Predham, Mr. MacDonald, to yourself. I  
 8 apologize, not July--well, in fact, the trail  
 9 begins here in June. Well, you had sent an e-  
 10 mail, I don't have the body, the rest of it  
 11 here, but to her back on June 16th and "been  
 12 reviewing the summary provided by Bev. Is  
 13 this summary accurate?" and Bev would be who?  
 14 DR. MACDONALD:  
 15 A. That would be Bev Griffiths of the Department  
 16 of Health and Community Services.  
 17 COFFEY, Q.C.:  
 18 Q. Department of Health. So you were getting  
 19 information from them?  
 20 DR. MACDONALD:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. Initially. And then Ms. Predham is saying,  
 24 two days later, in her response "I think it's  
 25 pretty much accurate. I do have some changes

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1 as outlined below. I don't know how important  
 2 they are to you," and she begins to talk about  
 3 then some changes. The first bullet, fifth  
 4 bullet, and "there are a few more changes that  
 5 I have to follow up with Bev, but it's only  
 6 clarification of wording. If you want to  
 7 know, I can tell you, but it's not a really  
 8 factual information." Now then you forwarded  
 9 that on, on July 4th, to Dr. Reza.  
 10 DR. MACDONALD:  
 11 A. Yes.  
 12 COFFEY, Q.C.:  
 13 Q. Now sir, I take it this would be early days,  
 14 as it were, mid June, early--certainly mid  
 15 June, early days in this?  
 16 DR. MACDONALD:  
 17 A. Yes, that would have been probably following  
 18 our first meeting.  
 19 COFFEY, Q.C.:  
 20 Q. If we could look, please, at Exhibit P-3563?  
 21 This is a document dated July 6th, 2007. It's  
 22 entitled "Estrogen and Progesterone Receptor,  
 23 ER/PR, Breast Cancer Testing Communication  
 24 Event Database, Scoping document" submitted by  
 25 the Research and Evaluation Department, NLCHI,

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1 July 6th '07. And Mr. MacDonald, what was  
 2 this document?  
 3 DR. MACDONALD:  
 4 A. Following some initial meetings with Eastern  
 5 and also with the Department of Health and  
 6 Community Services, we were asked by the  
 7 Department to put together a plan how we would  
 8 approach the creation of such database and to  
 9 outline any options which we feel may be  
 10 relevant to the task.  
 11 COFFEY, Q.C.:  
 12 Q. And here, just to give the Commissioner some  
 13 sense of the way, at least, this started out.  
 14 There's a description here at the very  
 15 beginning on page two of what ER/PR testing  
 16 involves, and a very brief summary of it, and  
 17 the second paragraph says "given the need to  
 18 identify all patients who received ER/PR  
 19 breast cancer testing at Eastern Health from  
 20 1997 to 2005 and to document relevant  
 21 communication events following testing, staff  
 22 of NLCHI met with the representatives of  
 23 Eastern Health and the Department of Health on  
 24 June 14th to discuss a framework for the  
 25 database management process. The database

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1 would focus on when and how patients were  
 2 contacted to inform them of the retesting, as  
 3 well as when and how patients were informed of  
 4 the subsequent test results. It is recognized  
 5 that the database must establish the source of  
 6 supporting documentation for any core fields  
 7 included in the database. The database is to  
 8 contain, but not be limited to the following  
 9 core fields" and there is a listing of 12 of  
 10 them.  
 11 And it continues on, "following  
 12 subsequent meetings with Eastern Health  
 13 officials and a preliminary review of  
 14 available documents, it was recognized that  
 15 the development of the database would be a  
 16 complex undertaking involving a number of  
 17 patient lists and data sources created by  
 18 various agencies and individuals. While the  
 19 number of sources adds to the complexity, they  
 20 also provide a valuable tool for verification  
 21 and quality checks. There are two main phases  
 22 to the development of the database. One,  
 23 identifying all patients diagnosed with breast  
 24 cancer that had ER/PR testing carried out at  
 25 Eastern Health; and two, provide all relevant

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1 communication event dates for patients tested  
 2 at Eastern Health. The Centre proposes the  
 3 following three options for creating a  
 4 database of patient interventions and  
 5 communications specific to Eastern Health's  
 6 ER/PR breast cancer testing." And then there  
 7 are options here. Phase one, options A, B, C,  
 8 and then in particular, Option C has a number  
 9 of steps.  
 10 Now, Dr. Reza, I understand that you were  
 11 involved in kind of the nitty gritty of  
 12 dealing with Eastern Health initially?  
 13 DR. ALAGHEHBANDAN:  
 14 A. That's right.  
 15 COFFEY, Q.C.:  
 16 Q. And as time went on?  
 17 DR. ALAGHEHBANDAN:  
 18 A. That's right.  
 19 COFFEY, Q.C.:  
 20 Q. Could you tell the Commissioner, please, what  
 21 you found in June and early July when you  
 22 first got involved and kind of your sense of  
 23 the challenges, as it were, that you faced?  
 24 DR. ALAGHEHBANDAN:  
 25 A. I guess the first thing I was trying to

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

19 COFFEY, Q.C.:

20 Q. And why was it going to be complex?

21 DR. ALAGHEHBANDAN:

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

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

7 COFFEY, Q.C.:

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

12 DR. ALAGHEHBANDAN:

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

16 COFFEY, Q.C.:

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

19 DR. ALAGHEHBANDAN:

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

25 COFFEY, Q.C.:

Page 23

1 Q. And were they even all located within  
 2 Newfoundland Labrador or were some of them -  
 3 DR. ALAGHEHBANDAN:

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

10 COFFEY, Q.C.:

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

19 DR. MACDONALD:

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

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

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

17 THE COMMISSIONER:

18 Q. The first being 29.

19 COFFEY, Q.C.:

20 Q. Certainly no more.

21 DR. MACDONALD:

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

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1 side, what we're talking about is--and I'm not  
 2 an IT person, so please excuse, all my  
 3 colleagues in that area, but we're talking  
 4 about computers, technology, security, these  
 5 types of things. So it's actually a physical  
 6 creation of an entity that can store, collect  
 7 and store data. The information management  
 8 side then would take that as a tool to support  
 9 the business of the organization.  
 10 I'm a strong advocate that there is a  
 11 relationship between the two, but really--in  
 12 my department, for example, all my colleagues,  
 13 there's 27 researchers in the research and  
 14 evaluation department. None of them are IT  
 15 people.  
 16 COFFEY, Q.C.:  
 17 Q. What do you use for IT support?  
 18 DR. MACDONALD:  
 19 A. Well, I suppose, a big part of the  
 20 infrastructure you would require for database  
 21 management is a lot of the communication  
 22 pieces. So for example, in research, we don't  
 23 need to communicate between databases as such.  
 24 Reza just spoke eloquently to the dispersion  
 25 of data across the province and even in Mount

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1 Sinai that we had to bring together to create  
 2 one database, but the database that we have at  
 3 the Centre for Health Information, our ER/PR  
 4 event communication database, does not talk to  
 5 any other database. We don't need that  
 6 additional infrastructure. So we actually  
 7 have it in a package called Statistical  
 8 Package for the Social Science, SPSS. That's  
 9 a store-bought product. So we didn't need any  
 10 database management IT/expertise because we  
 11 just bought that from the store and created  
 12 the database within it. So there is--there's  
 13 more to the database management side than just  
 14 creating the infrastructure for the data.  
 15 There's a communication side to it. As I  
 16 said, security is a big thing. It's creating  
 17 information from data that is key to running  
 18 the business of any entity.  
 19 THE COMMISSIONER:  
 20 Q. Mr. MacDonald, I'm not sure--I'm sorry, I got  
 21 a chicken and egg problem here, in the sense  
 22 of it seems to me that logically one would be  
 23 interested in first determining what  
 24 information you want and need.  
 25 DR. MACDONALD:

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1 A. Yes.  
 2 THE COMMISSIONER:  
 3 Q. And then going to look at what database is  
 4 appropriate for supporting the information you  
 5 need. Have I got the order of things right or  
 6 should it go the other way?  
 7 DR. MACDONALD:  
 8 A. No, that's a good point, and you're correct.  
 9 The activity of defining your business is left  
 10 up to the organization, and at that point, IT  
 11 does not come into play, into defining your  
 12 business. Once you, as an entity, have  
 13 defined your business, then you bring in the  
 14 IT people to say "can you build the  
 15 infrastructure to support my business?"  
 16 THE COMMISSIONER:  
 17 Q. So in my other life, I had occasion to be  
 18 involved in the development of a product which  
 19 was going to assist us in keeping records,  
 20 which was very useful exercise actually  
 21 because it forced us to examine every record  
 22 we keep, why we keep it, and in effect, gave  
 23 us an opportunity to determine whether or not  
 24 it had any useful information any more,  
 25 whether we really wanted to have that kind of

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1 information, and whether there were other  
 2 kinds of information that was involved, and  
 3 all of that had to be done before the IT  
 4 people were in the position to be able to  
 5 develop the tool to enable us to get the  
 6 information out. So that's the kind of  
 7 division that I'm thinking about.  
 8 DR. MACDONALD:  
 9 A. Yes.  
 10 THE COMMISSIONER:  
 11 Q. And is that right?  
 12 DR. MACDONALD:  
 13 A. And that is correct.  
 14 THE COMMISSIONER:  
 15 Q. So that if you really wanted to get into  
 16 information management in the organization,  
 17 that's a big investment in time and energy in  
 18 terms of figuring out exactly what you do and  
 19 what you want to do, isn't it?  
 20 DR. MACDONALD:  
 21 A. That's correct. You know, it's taken us many  
 22 years, eight years to build capacity at the  
 23 Centre for Health Information to support  
 24 information management activities and we do  
 25 that in support of policy. Obviously, we're

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1 doing it in collaboration with Eastern Health  
 2 and the task force and the government in  
 3 developing this database. There is not much  
 4 expertise for capacity in this province around  
 5 information management. We have database  
 6 management capability. An example, of course,  
 7 is the development of the electronic health  
 8 record in our province. Even though those  
 9 skillsets are hard to find, we do have  
 10 somewhat capacity around that area. There was  
 11 little information management capacity in this  
 12 province until the centre was established in  
 13 1997. It's taken us almost a decade to get  
 14 where we are now because we've had to home  
 15 grow these people. It's difficult to put an  
 16 ad in the paper to look for an information  
 17 panellist. You will get a wide variety of  
 18 applicants to that because really our  
 19 university doesn't produce graduates that have  
 20 the expertise to do what we do, which is the  
 21 secondary use of administrative data,  
 22 information management, these types of  
 23 activities, but to ultimately get to the point  
 24 where you have the best of both worlds is the  
 25 marriage of the database management with the

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1 information management, but I have to be  
 2 clear, it's the information management side  
 3 which defines the business rules. The  
 4 technology just comes in to support that.  
 5 They should not be involved in defining your  
 6 business.  
 7 THE COMMISSIONER:  
 8 Q. So having the technology side walk through the  
 9 door and say you can't do that because our  
 10 program doesn't allow you to do it is not  
 11 right, you should be saying I want the program  
 12 that allows us to do whatever it is we want to  
 13 do, is that the -  
 14 DR. MACDONALD:  
 15 A. Yeah, I think the--the technology is there to  
 16 probably support any business activity.  
 17 THE COMMISSIONER:  
 18 Q. Uh-hm.  
 19 DR. MACDONALD:  
 20 A. The more dangerous thing is when IT comes in  
 21 and says this is what you need as opposed to  
 22 you saying this is what I want, and they  
 23 support that.  
 24 THE COMMISSIONER:  
 25 Q. All right, thank you.

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1 COFFEY, Q.C.:  
 2 Q. So now in terms of then--to put this in  
 3 context, this is a scoping document we're  
 4 looking at the beginning of July, 2007. Mr.  
 5 MacDonald, did you understand that NLCHI's  
 6 involvement in this was of the nature of a  
 7 research project?  
 8 DR. MACDONALD:  
 9 A. No, Mr. Coffey.  
 10 COFFEY, Q.C.:  
 11 Q. You're nodding "no", and Dr. Reza too. Go  
 12 ahead.  
 13 DR. MACDONALD:  
 14 A. We were clear on that because we are a  
 15 research entity, there's no doubt about that,  
 16 and we have relationships with several  
 17 universities across Canada in doing research,  
 18 so that certainly is our first expertise, you  
 19 might say, but we also have expertise in  
 20 database management, and when we were asked by  
 21 Robert Thompson back in June of 2007 to  
 22 undertake this, this was a database management  
 23 activity. There was never, and still is not  
 24 any intent of the Centre for Health  
 25 Information to take this activity beyond

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1 creating what was needed for the Commission of  
 2 Inquiry and the task force in support of  
 3 Eastern Health.  
 4 COFFEY, Q.C.:  
 5 Q. And never set out to carry out an  
 6 epidemiological research study here, that was  
 7 never your intention?  
 8 DR. MACDONALD:  
 9 A. No.  
 10 COFFEY, Q.C.:  
 11 Q. Never asked to do it and it was not your  
 12 intention?  
 13 DR. MACDONALD:  
 14 A. Our mandate, and still our mandate is to  
 15 gather as much information as we can on the  
 16 patients affected by the ER/PR testing and the  
 17 communication events surrounding those.  
 18 COFFEY, Q.C.:  
 19 COFFEY, Q.C.:  
 20 Q. And if we could then, just looking at this,  
 21 Phase I, development of patient list for ER/PR  
 22 testing, Option "A", and this is page three of  
 23 the document, it reads, "Option A, Eastern  
 24 Health has already identified a list of 2760  
 25 original test cases for the period '97 to



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1 2005, with 939 of these having a negative  
 2 ER/PR result. These negative results were  
 3 subsequently sent to Mount Sinai for ER/PR  
 4 retesting. A database of these 939 patients  
 5 having some of the core fields identified for  
 6 this initiative is available from Eastern  
 7 Health. This database, N=939, can be used as  
 8 the final ER/PR patient list, with additional  
 9 data fields incorporated to reflect the  
 10 requirements of Health and Community Services.  
 11 Advantages, it builds on work already  
 12 undertaken by Eastern Health, and, therefore,  
 13 would be timelier and require significantly  
 14 less resources to complete. Disadvantages,  
 15 the Centre cannot confirm all patients  
 16 impacted are included in the database as the  
 17 primary source data was not utilized in  
 18 building client listing". I'm going to ask  
 19 you about that, Dr. Reza. I take it that  
 20 you're the one who would have been on a day to  
 21 day face to face involvement with this?  
 22 DR. ALAGHEHBANDAN:  
 23 A. That's right.  
 24 COFFEY, Q.C.:  
 25 Q. And the disadvantage here that's articulated

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1 here, why is it that you could not confirm all  
 2 patients impacted, which I presume is all  
 3 patients impacted by way of having--should  
 4 have been retested, based upon the retest  
 5 criteria, whatever they might have been. Did  
 6 you have reason to doubt at that point that  
 7 all patients had been identified to be  
 8 retested?  
 9 DR. ALAGHEHBANDAN:  
 10 A. Well, I guess here we're referring to one  
 11 source as the core source to build a database,  
 12 and that was Eastern Health's database at a  
 13 time they reported as 939, so we knew at the  
 14 time that there were other sources available  
 15 to us. One option was to just simply  
 16 disregard the rest of the options, the  
 17 sources, the just go with this one and build a  
 18 database based on this. We also learned that  
 19 from Eastern Health that 939, that it was  
 20 reported, I believe, back in 2006 or 2007, was  
 21 not really the case based on the database they  
 22 had at the time. So the disadvantage was the  
 23 fact that we were not going to be quite sure  
 24 that this option would give us 100 percent  
 25 accuracy in respect to patient listings.

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1 COFFEY, Q.C.:  
 2 Q. Because here it says, "As the primary source  
 3 data was not utilized in building the client  
 4 listing", I take it that's the client listing  
 5 of the 939 that's -  
 6 DR. ALAGHEHBANDAN:  
 7 A. That was the client listing, yes.  
 8 COFFEY, Q.C.:  
 9 Q. And -  
 10 DR. MACDONALD:  
 11 A. If I might just interject for one second  
 12 there.  
 13 COFFEY, Q.C.:  
 14 Q. Sure.  
 15 DR. MACDONALD:  
 16 A. I just want to get back to when you asked us  
 17 whether it was intent to be a research  
 18 project, but this is really a research  
 19 activity and inherent in us researchers is we  
 20 were--an option was to take what someone  
 21 already created and we would not then be able  
 22 to say that's--we did not create it, so we  
 23 couldn't confirm that all the cases were  
 24 there. So even--this report was written  
 25 probably three weeks into our first foray into

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1 this activity. So even then we knew that  
 2 without using a primary source, we couldn't  
 3 say we had all the cases.  
 4 COFFEY, Q.C.:  
 5 Q. To go on then to Option B, which was, "The  
 6 database be developed completely independent.  
 7 The work carried out by Eastern Health to  
 8 create the database containing N=939 patients,  
 9 this new database would use as its main source  
 10 a download from Meditech of all ER/PR testing  
 11 carried out from '97 to 2005 from each of the  
 12 four health authorities. Identification of  
 13 those tests specific to breast cancer and  
 14 confirmation of test results,  
 15 positive/negative, this list would then be  
 16 cross-referenced with Mount Sinai's list of  
 17 all ER/PR testing and retesting for the  
 18 province over the period '97 to 2005". Go  
 19 back here just to show here, "The advantages  
 20 are the Centre can confirm all patients  
 21 impacted are included in the database as  
 22 primary source data was utilized in building  
 23 the client listing. The disadvantages, it  
 24 would require significant resources and time  
 25 to complete. It should be noted that ER/PR

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1 testing can be either interpreted based on  
 2 laboratory guidelines or clinical criteria by  
 3 an oncologist/pathologist. Thus, re-  
 4 evaluating each ER/PR test as either positive  
 5 or negative using Option "B" needs to be  
 6 considered in the decision, given the  
 7 subjectivity of the testing and the resources  
 8 required to review all ER/PR test results".  
 9 Could you elaborate a bit, Dr. Reza, on what  
 10 the disadvantage here was identified with  
 11 Option "B".  
 12 DR. ALAGHEHBANDAN:  
 13 A. So this is the second potential option that we  
 14 proposed. So basically, go into Meditech and  
 15 downloading the data that we wanted to use as  
 16 the core of the database, and then going to  
 17 Mount Sinai and bringing that data and merge  
 18 with this. The first challenge was basically  
 19 the timing and resources. We were under some  
 20 certain timeline with respect to deliver the  
 21 work, and going through this activity would  
 22 require extensive time and also resources. We  
 23 also said here that the interpretation of  
 24 ER/PR scores and also the clinical criteria  
 25 which were used by clinicians is something

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1 that we should be cognizant of, and--but again  
 2 the main disadvantage as I mentioned was  
 3 significant resources that we're going to  
 4 basically consider for this option and that's  
 5 why we came up with Option "C" as an  
 6 alternative option to this one.  
 7 COFFEY, Q.C.:  
 8 Q. So Option "C" indicates, "The database could  
 9 develop using a hard copy/electronic data of  
 10 all positive/negative ER/PR testing results,  
 11 N=2760, developed by Eastern Health laboratory  
 12 ER/PR testing from Central, Western, and  
 13 Labrador, Grenfell, and Mount Sinai's list of  
 14 all ER/PR testing and retesting for the period  
 15 '97 to '05. A step by step approach is  
 16 provided below for Option "C", although many  
 17 of these steps are also relevant to Option  
 18 "B", and then there are a listing of steps;  
 19 Step 1, Step 2, Step 3, and Step 4, and Step  
 20 5. "Following completion of Step 5, the  
 21 database will contain: (a) all patients that  
 22 had ER/PR breast cancer testing carried out at  
 23 Eastern Health from May, 1997, to August,  
 24 2005; (b) all patients that had ER/PR breast  
 25 cancer testing carried out by Mount Sinai from

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1 1997 to 2005 would include samples sent  
 2 directly to Mount Sinai by-passing Eastern  
 3 Health; (c) all patients that had ER/PR breast  
 4 cancer retesting carried out at Mount Sinai  
 5 from May, '97 to August, 2005; (d) patients  
 6 that are deceased since 1997, and (e) data for  
 7 some core fields, in particular", and they're  
 8 spelled out here. The report then says--the  
 9 scoping document says, "Of note, regardless of  
 10 what option is chosen to develop the patient  
 11 list for ER/PR testing, it will be necessary  
 12 to identify how best to obtain a complete list  
 13 of ER/PR testing/retesting conducted at Mount  
 14 Sinai. It's understood that several lists of  
 15 ER/PR testing and retesting already exists at  
 16 Eastern Health, however, one of these lists  
 17 has no dates included in the database, while a  
 18 second is yet to be reviewed. It's possible a  
 19 new list will need to be obtained from Mount  
 20 Sinai", and then--now in relation to this,  
 21 this would be under Option "C" after it says  
 22 here at paragraph (a), all patients that had  
 23 ER/PR breast cancer testing carried out at  
 24 Eastern Health from May, 1997, to August,  
 25 2005. Now to this date, has that been done,

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1 that all patients who had ER/PR testing done,  
 2 is it in the database?  
 3 DR. ALAGHEHBANDAN:  
 4 A. At the moment, no, it is not.  
 5 COFFEY, Q.C.:  
 6 Q. Yes.  
 7 DR. ALAGHEHBANDAN:  
 8 A. All original tests?  
 9 COFFEY, Q.C.:  
 10 Q. Yes.  
 11 DR. ALAGHEHBANDAN:  
 12 A. No.  
 13 COFFEY, Q.C.:  
 14 Q. Okay, and Mr. MacDonald, can you tell us why  
 15 that is?  
 16 DR. MACDONALD:  
 17 A. Back when the scoping document was prepared,  
 18 obviously we had some assumptions that the  
 19 patients had been identified. As we've gone  
 20 through the last sixteen months, even until  
 21 today, we recognized that it's been a  
 22 challenge to identify the patients for various  
 23 reasons. So we were a bit naive back then to  
 24 say that by doing this activity, we would  
 25 gather all the patients.

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1 COFFEY, Q.C.:

2 Q. I take it you had started from the assumption

3 that perhaps they were in electronic database

4 at Eastern Health, all ER/PR tests or slides

5 that had ever been produced, there would be a

6 record of them there -

7 DR. MACDONALD:

8 A. We thought it would be -

9 COFFEY, Q.C.:

10 Q. In the database or elsewhere within Eastern

11 Health?

12 DR. MACDONALD:

13 A. Yeah, we certainly thought it would be a lot

14 more uncomplicated to gather the information

15 we required.

16 COFFEY, Q.C.:

17 Q. To this day, have the patients who were

18 originally reported as ER/PR positive, the

19 group, and I understand there would be upwards

20 of 1800 or so, give or take a bit, have they

21 been entered in any database that you're aware

22 of?

23 DR. MACDONALD:

24 A. Not that I'm aware of, no.

25 COFFEY, Q.C.:

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1 Q. And why was that?

2 DR. MACDONALD:

3 A. I'll pass that to Reza.

4 COFFEY, Q.C.:

5 Q. Sure.

6 DR. ALAGHEHBANDAN:

7 A. Let me just go back a few steps. Option "C"

8 simply proposes that we go and take all

9 multiple sources across the province, bring

10 them together and merge them and reconcile

11 them starting from all pathology reports being

12 printed back in '05 at Eastern Health, and

13 Mount Sinai, pathology reports from the

14 regions, other sources available to us, such

15 as mortality system, probably Meditech, and

16 creating the database including all those

17 patients who had an ER/PR test regarding their

18 scores, whether negative or positive, or

19 whatever the case may be. So initially we

20 thought that would be the best option to go

21 with with respect to creating a database. We

22 started that activity back in June and started

23 reviewing pathology reports, and after a few

24 weeks we came to learn that the timeline that

25 we proposed was a little underestimated with

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1 respect to the amount of sources that we had

2 to go through, and the work that we had to do,

3 and then we met with Mr. Thompson, the

4 department rep at the time, and his group, and

5 it was decided to redirect approach and mainly

6 focusing on those patients who had ER/PR

7 negative, and that was the main question that

8 the Centre was asked to be basically creating

9 a database based on that. So really the

10 approach changed from collecting all positive

11 and negatives to just focusing on negatives,

12 and the reason was basically the timeline and

13 the time required for that activity.

14 COFFEY, Q.C.:

15 Q. I take it, it was a combination of, well, the

16 time within which it was desired that a

17 database come into existence?

18 DR. ALAGHEHBANDAN:

19 A. That's right.

20 COFFEY, Q.C.:

21 Q. A useful database come into existence.

22 DR. ALAGHEHBANDAN:

23 A. That's right, a functional database.

24 COFFEY, Q.C.:

25 Q. Functional--bearing in mind the amount of

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1 time. Do you recall what kind of time frame--

2 well, actually, we'll see it here, I believe,

3 actually. I'll come back to Phase 2 in a

4 moment. Look here at page eight, the heading,

5 "Timelines are estimated based on available

6 information", would be available at that time.

7 "A major contributor to length of time to

8 complete the database will be the time

9 required by the data holders in providing data

10 to NLCHI", and Phase 1, which is Option "A",

11 in effect, timeline for each Option, for

12 Option "A" was then thought four to six weeks.

13 Option "B", 12 to 16 weeks, and Option "C" was

14 8 to 12 weeks.

15 DR. ALAGHEHBANDAN:

16 A. That's right.

17 COFFEY, Q.C.:

18 Q. And initially the choice was to go with which

19 option initially?

20 DR. ALAGHEHBANDAN:

21 A. Initially with Option "C".

22 COFFEY, Q.C.:

23 Q. And then as you got into it and embarked on

24 creating Option "C" or pursuing Option "C"

25 with a view to having it completed within

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1 eight to twelve weeks, which would be two to  
 2 three months -  
 3 DR. ALAGHEHBANDAN:  
 4 A. Just the patient listing, between four to six  
 5 weeks.  
 6 COFFEY, Q.C.:  
 7 Q. And the--I'm sorry, the patient listing, and  
 8 then the event fields which would be--I'll  
 9 come back to that, but there's some indication  
 10 which is the whole communications issue is  
 11 described here at page six, as Phase 2, "Data  
 12 specific to communication event fields. In  
 13 Phase 2, additional data fields will be  
 14 incorporated into the database to reflect the  
 15 requirements of Health and Community Services.  
 16 The purpose of this scoping document  
 17 concerning communication event field is used  
 18 and is considered a field in the database  
 19 which contains data for a specific event that  
 20 occurred along the patient's ER/PR testing  
 21 time continuum. These would include", and  
 22 there's a number of things. It begins with  
 23 the date that the sample was obtained by  
 24 Eastern Health, all the way down to  
 25 verification that the doctor reviewed the

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1 results with a patient. It says, "In  
 2 obtaining data for these event fields, several  
 3 steps utilizing various data sources will be  
 4 investigated", and there's Steps 1, 2, 3, and  
 5 4. Then you go on to refer to the core field,  
 6 number 12, "Verification the doctor reviewed  
 7 results with patient" as being identified as  
 8 one that may be difficult to obtain supporting  
 9 documentation. In order to verify that the  
 10 physician reviewed results with patient, it  
 11 may be necessary to contact each physician  
 12 and/or perform a chart audit, and the  
 13 timelines are set out here. So I take it,  
 14 Option "C", the patient list was thought to be  
 15 four to six weeks, and Phase 2 of the event  
 16 fields was another four to six, adding up to  
 17 eight to twelve weeks for Option "C"?  
 18 DR. ALAGHEHBANDAN:  
 19 A. That's right.  
 20 COFFEY, Q.C.:  
 21 Q. That's the one that was initially chosen, and  
 22 when you got into it, pursuing Option "C", the  
 23 difficulty in relation to getting a patient  
 24 list within four to six weeks was what?  
 25 DR. ALAGHEHBANDAN:

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

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1 reconcile them. For instance, one of the core  
 2 data--one of the data sources that we were  
 3 going to consider was Eastern Health's August  
 4 1st one, did not have MCP as identifiable  
 5 information for us.  
 6 COFFEY, Q.C.:  
 7 Q. Sorry, the -  
 8 DR. ALAGHEHBANDAN:  
 9 A. I'm sorry, one of the data sources that we  
 10 were going to use for creating the database  
 11 was August 1st file at management risk  
 12 department at Eastern Health, the data that we  
 13 referred to as 939.  
 14 COFFEY, Q.C.:  
 15 Q. Okay.  
 16 DR. ALAGHEHBANDAN:  
 17 A. And that database did not have MCP. So we had  
 18 to find patients names, match with MCP, be  
 19 able to use that MCP for further linking,  
 20 merges, and cross-referencing down the road.  
 21 So as we move forward over next couple of  
 22 weeks after we started the work, we learned  
 23 these things, and that's why we had to  
 24 redirect the approach from Option "C" to  
 25 something much more, I guess, reasonable with

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1 respect to the task that we had been given.  
 2 COFFEY, Q.C.:  
 3 Q. And which was then to focus on those who -  
 4 DR. ALAGHEHBANDAN:  
 5 A. Were negative.  
 6 COFFEY, Q.C.:  
 7 Q. Negative.  
 8 DR. ALAGHEHBANDAN:  
 9 A. That's right.  
 10 COFFEY, Q.C.:  
 11 Q. Or reported originally as negatives?  
 12 DR. ALAGHEHBANDAN:  
 13 A. Go into other sources and again try to  
 14 reconcile them.  
 15 DR. MACDONALD:  
 16 A. And, Mr. Coffey, it's important to realize too  
 17 back during the early days as we were all  
 18 learning about what was needed with respect to  
 19 this activity, and we didn't realize at the  
 20 Centre--I don't think anyone really realized  
 21 how much of this data is actually in hard copy  
 22 form.  
 23 COFFEY, Q.C.:  
 24 Q. Yes.  
 25 DR. MACDONALD:

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

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

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1 DR. ALAGHEHBANDAN:  
 2 A. I believe that was in July '07.  
 3 COFFEY, Q.C.:  
 4 Q. Sometime later on in July?  
 5 DR. ALAGHEHBANDAN:  
 6 A. That's right, after we reported to him the  
 7 challenges we faced.  
 8 COFFEY, Q.C.:  
 9 Q. Dr. Reza, then I take it you--take up the  
 10 account then, then what happened in terms of  
 11 what did you do? Okay, you're told by Mr.  
 12 Thompson, well, let's narrow it down. Was it  
 13 still to be Option "C" focused on the  
 14 negatives?  
 15 DR. ALAGHEHBANDAN:  
 16 A. It was just Option "C", excluding positives,  
 17 and again I just want to mention that the  
 18 question was to focus on those who were  
 19 negative and were tested in Mount Sinai. So  
 20 really we redirected the approach, but really  
 21 we still were going to answer the same  
 22 question, although we changed the approach. So  
 23 it was Option "C", excluding the positives,  
 24 meaning that we had to go to different  
 25 sources, different data, inside the province,

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1 outside the province, and following the same  
 2 process actually.  
 3 COFFEY, Q.C.:  
 4 Q. So identifying those who had been originally  
 5 reported as negative and had been retested at  
 6 Mount Sinai?  
 7 DR. ALAGHEHBANDAN:  
 8 A. That's right.  
 9 COFFEY, Q.C.:  
 10 Q. Okay, so that's the initial approach?  
 11 DR. ALAGHEHBANDAN:  
 12 A. That's the initial.  
 13 COFFEY, Q.C.:  
 14 Q. So what then happened? Okay, that's your  
 15 task. What did you do?  
 16 DR. ALAGHEHBANDAN:  
 17 A. So basically we started with what we called  
 18 August 1st file from Eastern Health, and -  
 19 COFFEY, Q.C.:  
 20 Q. That's the day, August 1st, 2007?  
 21 DR. ALAGHEHBANDAN:  
 22 A. August 1st, 2007, was the day that we received  
 23 that file from Eastern Health. We also had to  
 24 review spreadsheet manual--spreadsheet  
 25 written, and prepared by Mr. Gulliver,

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1 including all positives and negatives actually  
 2 from '97 to 2007. We had to convert them into  
 3 electronic format. They were in hard copies.  
 4 We requested the regions to send us their  
 5 pathology reports. At the same time, we asked  
 6 the department to request copy of Mount Sinai  
 7 spreadsheets from Mount Sinai. That also  
 8 happened.  
 9 COFFEY, Q.C.:  
 10 Q. The regions were asked to send in pathology  
 11 reports for all ER/PRs or just negative  
 12 ER/PRs?  
 13 DR. ALAGHEHBANDAN:  
 14 A. Just negatives.  
 15 COFFEY, Q.C.:  
 16 Q. Negatives.  
 17 DR. ALAGHEHBANDAN:  
 18 A. And then--so we had to review all pathology  
 19 reports from the region. We had to review  
 20 spreadsheets created by Mr. Gulliver. We had  
 21 to enter them into the database. We came to  
 22 know that there were some sporadic, I guess,  
 23 requests on some ER/PR testing in Central  
 24 Mount Sinai, we called them--it was called  
 25 consult at the time. We came to learn that

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1 some of them existed at risk management  
 2 department with Ms. Predham and we also  
 3 included them. At a later date, we learned  
 4 that there were probably more than those at  
 5 Dr. Cook's office at St. Clare's. We also had  
 6 a copy of those reports, again there were  
 7 reports and we had to enter them into SPSS  
 8 program. And we received Mount Sinai files,  
 9 so basically we were reconciling all those--  
 10 within the province data and then cross-  
 11 referencing it with Mount Sinai data and gave  
 12 us a fairly concrete idea of what is the  
 13 patient listings which respect to this issue.  
 14 And we took it from there and we added the  
 15 communication piece to the database. So the  
 16 first phase was really getting a list of  
 17 patients and once we had that, we could go on  
 18 and look for communication piece and add it to  
 19 each patient.  
 20 COFFEY, Q.C.:  
 21 Q. Now I'm going to come back to the patient  
 22 identification issue, okay, but could you tell  
 23 the Commissioner then, in a general way then,  
 24 how the communications piece was approached?  
 25 What did you do to -

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

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1 the communications and with respect to, for  
 2 example, panel letters, we had the date that  
 3 patient was discussed at the panel, that  
 4 letter was issued and there were a number of  
 5 ways of communication, as I have said, some  
 6 patients were contacted via panel letters,  
 7 some patients were contacted by the regions,  
 8 some by physicians and we gathered all this  
 9 information for every patient after we  
 10 completed the patient listings.  
 11 COFFEY, Q.C.:  
 12 Q. I take it then that you would look at, for  
 13 example, if Eastern Health provided a sheet of  
 14 paper with a number of names in a particular  
 15 person's handwriting, I'll just say, for  
 16 example, Nancy Parsons' handwriting, number of  
 17 person's names and dates and you would be  
 18 given to understand that on a particular day,  
 19 that day, she contacted that patient and told  
 20 that patient about the patient's retest  
 21 results, that would be the sort of thing -  
 22 DR. ALAGHEHBANDAN:  
 23 A. That would be the documentation source.  
 24 COFFEY, Q.C.:  
 25 Q. And you would record Ms. Parsons' name as the

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1 contact person from Eastern Health.  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's right.  
 4 COFFEY, Q.C.:  
 5 Q. Ms. Parsons and the date.  
 6 DR. ALAGHEHBANDAN:  
 7 A. And the date and the communication contents.  
 8 COFFEY, Q.C.:  
 9 Q. And, then, of course, in relation to that  
 10 particular patient.  
 11 DR. ALAGHEHBANDAN:  
 12 A. That's correct.  
 13 COFFEY, Q.C.:  
 14 Q. Now did you always take what was written at  
 15 face value in the sense of assume that it was  
 16 correct?  
 17 DR. ALAGHEHBANDAN:  
 18 A. Always because that was the source of  
 19 communication for us and a health care  
 20 professional recorded it, one would assume  
 21 that that's accurate and valuable.  
 22 COFFEY, Q.C.:  
 23 Q. So there was no, I'm going to suggest to you  
 24 there was no audit in the sense of having done  
 25 all that, you didn't call and pick out every

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1 tenth patient and contact every tenth or  
 2 twentieth patient yourself and say, well, we  
 3 have this information -  
 4 DR. ALAGHEHBANDAN:  
 5 A. No.  
 6 COFFEY, Q.C.:  
 7 Q. - Ms. or Mr. So and So, is this -  
 8 DR. ALAGHEHBANDAN:  
 9 A. No, that type of audit form never happened at  
 10 the time, it wasn't part of our mandate;  
 11 however, Eastern Health performed that audit  
 12 at a later time and they ensured that the  
 13 patient was communicated that way.  
 14 COFFEY, Q.C.:  
 15 Q. And that later check by Eastern Health, audit  
 16 in effect by Eastern Health, was the fact that  
 17 that was done, was that recorded in the  
 18 database?  
 19 DR. ALAGHEHBANDAN:  
 20 A. It is recorded in the database, it is in the  
 21 database right now.  
 22 COFFEY, Q.C.:  
 23 Q. It was a subsequent -  
 24 DR. ALAGHEHBANDAN:  
 25 A. Absolutely, we added that field to the

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1 database.  
 2 COFFEY, Q.C.:  
 3 Q. Now in relation to the reliability of what was  
 4 written down, what you were reading, did you  
 5 ever have reason to come to question like the  
 6 reliability of a date or a month?  
 7 DR. ALAGHEHBANDAN:  
 8 A. If I had that doubt in my mind, I would not  
 9 have entered such information in the database  
 10 and we were quite transparent in that manner.  
 11 If and neither of our parties, that means the  
 12 centre in Eastern Health or the regions were  
 13 not sure about certain things, we would not  
 14 have been entering the database.  
 15 COFFEY, Q.C.:  
 16 Q. Were there ever any instances where after data  
 17 had been entered in the database it came to  
 18 your attention that perhaps that's not  
 19 accurate?  
 20 DR. ALAGHEHBANDAN:  
 21 A. I can't recall such an event off the top of my  
 22 head.  
 23 COFFEY, Q.C.:  
 24 Q. There will be one, I'll just refer to it  
 25 because it was referred to it yesterday.

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1 DR. ALAGHEHBANDAN:  
 2 A. Right.  
 3 COFFEY, Q.C.:  
 4 Q. Janet Henley-Andrews.  
 5 DR. ALAGHEHBANDAN:  
 6 A. Right.  
 7 COFFEY, Q.C.:  
 8 Q. There's been evidence, the Commission has  
 9 heard that well, in fact, Ms. Predham told us  
 10 yesterday that in fact what she had written  
 11 down was just, you know, she said she was just  
 12 mistaken and what she had written down -  
 13 DR. ALAGHEHBANDAN:  
 14 A. The earliest, the early time that we were  
 15 involved with gathering the communication  
 16 events and information, I did not encounter  
 17 such experience. Later that we were more  
 18 involved with communications and Eastern  
 19 Health also throughout the regions, we were  
 20 given updates on communications and as you  
 21 mention, yes, at a later time we encountered  
 22 such a -  
 23 COFFEY, Q.C.:  
 24 Q. And what would you do then if something was  
 25 brought to your attention, would you change

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

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1 overwritten, so it was not, a copy of--a  
 2 previous version of the database wasn't kept  
 3 and so it was impossible for us to go back and  
 4 to retain that information based under that  
 5 version of the database. So when on August  
 6 1st, 2007 we received a copy of the database,  
 7 when we went through it and got the MCP  
 8 numbers for all those patients and counted  
 9 them, as a matter of fact, we came up with a  
 10 different number as opposed to 939, so yes,  
 11 again, the file was overwritten each time  
 12 information was entered into the database and  
 13 the database was updated.  
 14 COFFEY, Q.C.:  
 15 Q. So I take it that at least from the time you  
 16 got involved, you were in a position where you  
 17 weren't able to reconstruct the 939?  
 18 DR. ALAGHEHBANDAN:  
 19 A. No, it was not possible.  
 20 COFFEY, Q.C.:  
 21 Q. Because of this overwriting -  
 22 DR. ALAGHEHBANDAN:  
 23 A. Overwriting.  
 24 COFFEY, Q.C.:  
 25 Q. Well, the overwriting and a failure to keep an

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1 earlier copy of what had been overwritten.  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's right.  
 4 COFFEY, Q.C.:  
 5 Q. It's the combination of the two.  
 6 DR. ALAGHEHBANDAN:  
 7 A. That's right.  
 8 COFFEY, Q.C.:  
 9 Q. There's nothing wrong with overwriting  
 10 something as long as you keep a copy -  
 11 DR. ALAGHEHBANDAN:  
 12 A. No, you overwrite something, but you always  
 13 keep a copy of your old file.  
 14 COFFEY, Q.C.:  
 15 Q. And again, perhaps an illustration for the  
 16 Commissioner of what you encountered in the  
 17 early stages, P-1064 please? Now, Mr.  
 18 MacDonald, this is an e-mail from yourself to  
 19 Mr. Thompson on August 17th, 2007 and you  
 20 write, "We continue to work with staff at  
 21 Eastern Health's lab to resolve discrepancies  
 22 in patient listings, demographics and clinical  
 23 entries for breast cancer patients, (1997--  
 24 2005) who were sent to sent to Mount Sinai for  
 25 retesting. Having first completed the



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1 straightforward cases, we were left with 50+  
 2 patient records that required further  
 3 investigation. As of today, we resolved all  
 4 but 19 of these 50+ records. It is expected  
 5 that the majority of this work will become  
 6 completed this weekend. But we received the  
 7 file on ER/PR retesting from Newfoundland and  
 8 Labrador breast cancer patients (1997--2005)  
 9 from Mount Sinai on Thursday night." That  
 10 would be, just presumably the Thursday before.  
 11 "We have only just learned that individual  
 12 samples sent for retesting were considered  
 13 consults and as such, generated a full  
 14 pathology report that was sent back to  
 15 Eastern. They were not included in the Excel  
 16 spreadsheet we have just received." Which is,  
 17 I take it, Mr. MacDonald, the spreadsheet from  
 18 Mount Sinai.  
 19 DR. MACDONALD:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. And, "We are following up with Mount Sinai to  
 23 address this oversight; nevertheless, we have  
 24 preliminary evidence to suggest that the  
 25 number of patients sent for retesting at Mount

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1 Sinai may be less than 939. We have received  
 2 information from Central, Western and Labrador  
 3 Grenfell regarding communication events. Upon  
 4 preliminary review, it appears that everything  
 5 they have has been provided, however, some  
 6 follow up will be required. Further  
 7 communication with Rolf Pritchard will take  
 8 place regarding documents previously sent to  
 9 the department. Work begins with Heather  
 10 Predham on Monday, August 20th to document  
 11 communication events in Eastern Health." And  
 12 just while we're at it, it says copied to a  
 13 number of individuals, Dr. Reza as well as  
 14 Michael Barron, who I take it is your CEO?  
 15 DR. MACDONALD:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. Dr. Reza, could you tell us then about your  
 19 interaction with Ms. Predham in the later  
 20 summer or early fall?  
 21 DR. ALAGHEHBANDAN:  
 22 A. So before August 20th, we had a list of  
 23 patients that we thought that they were  
 24 basically ER/PR negative and they were tested  
 25 at Mount Sinai. So that was the time for us

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1 to start gathering communication information  
 2 on those patients. On August 20th, Ms.  
 3 Predham and myself started working on that,  
 4 she provided me with source documents, we  
 5 reviewed each patient one by one and entered  
 6 the information into the database, and that  
 7 actually started August 20th and continued on  
 8 up to the end of the year, actually, with  
 9 regard to whatever we already had in regard to  
 10 some of the patients that she had to contact  
 11 or she had to gather the information for us to  
 12 be entered into the database.  
 13 COFFEY, Q.C.:  
 14 Q. If we could look, please, at Exhibit P-3495?  
 15 This, Mr. MacDonald is a series of e-mail  
 16 exchanges, August 27th, 2007 with Maria  
 17 Mendes, who I take it works with Mount Sinai  
 18 and there's a note--there's one here from her  
 19 on a date to you, saying, "Hi Don, we received  
 20 samples in June and July, but these were for  
 21 QA 2007 cases. All cases for retrospective  
 22 testing were received starting in August '07  
 23 and these results should start coming out in  
 24 September '07. I think since the beginning of  
 25 August '07, we have received about 79 blocks

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1 for testing." And just to put this in context  
 2 here, what I'm going to do, actually, if I  
 3 could Commissioner, I'm just going to go and  
 4 follow this through because it will give you  
 5 some sense of--the first e-mail here, page 3,  
 6 at the bottom of page 2 of the exhibit, on  
 7 August 16th, it's from Maria Mendes to  
 8 yourself, Mr. MacDonald. You say "All  
 9 information has been sent to you, the Excel  
 10 chart was e-mailed and I have called and given  
 11 you the password. The letter from Dr.  
 12 Pritzker has been faxed. Please let me know  
 13 if you require any other information." So I  
 14 take it that by the middle of August, Mount  
 15 Sinai had supplied in electronic format their  
 16 database?  
 17 DR. MACDONALD:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. Such as that Excel spreadsheet with the retest  
 21 results.  
 22 DR. MACDONALD:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. But it did not include, as you found out

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1 afterward, it did not include the consults.  
 2 DR. MACDONALD:  
 3 A. That's correct.  
 4 COFFEY, Q.C.:  
 5 Q. Individual consults.  
 6 DR. ALAGHEHBANDAN:  
 7 A. That's correct, yes.  
 8 COFFEY, Q.C.:  
 9 Q. And then, here then you wrote, getting back to  
 10 her the same day, August 27th, saying, "Hi  
 11 Maria, again, thanks for providing ER  
 12 retesting database. I am now hoping you might  
 13 answer a question for me. In our original  
 14 request to Dr. Pritzker we asked for two  
 15 specific date fields, namely two, the date the  
 16 sample received at Mount Sinai and three, the  
 17 date result sent back to the hospital/health  
 18 authority. In the file you sent back, the  
 19 only date included was ordered. Is this the  
 20 date the test was ordered from Newfoundland or  
 21 from your LIS system? Is it not possible to  
 22 obtain the dates as per your request." And  
 23 she came back to you, Mr. MacDonald, the same  
 24 day saying "In regards to the two line items,  
 25 date sample received, you can use the order

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

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1 A. I don't know.  
 2 COFFEY, Q.C.:  
 3 Q. You don't--Reza, do you -  
 4 DR. ALAGHEHBANDAN:  
 5 A. I believe it's a group of deceased people that  
 6 were sent in July '07 to Mount Sinai for  
 7 retesting.  
 8 COFFEY, Q.C.:  
 9 Q. And I take it then, well you realized, Dr.  
 10 Reza, that these were being sent for  
 11 retesting, there would eventually be results.  
 12 DR. ALAGHEHBANDAN:  
 13 A. That's right.  
 14 COFFEY, Q.C.:  
 15 Q. And the plan was to incorporate them into -  
 16 DR. ALAGHEHBANDAN:  
 17 A. Absolutely, we were in touch with Eastern  
 18 Health and we were just about to receive the  
 19 results later.  
 20 COFFEY, Q.C.:  
 21 Q. Now here, Mr. MacDonald, this reference to you  
 22 following up with Dr. Cook in the date sent  
 23 back, okay, that is the date that Mount Sinai  
 24 sent, I suppose the spreadsheets from time to  
 25 time back to St. John's. How did that unfold

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1 afterwards, can you tell the Commissioner  
 2 about -  
 3 DR. MACDONALD:  
 4 A. Well, one of the questions that we wanted  
 5 answered certainly that Robert Thompson asked  
 6 us to investigate was actually when the  
 7 samples were sent to Mount Sinai and actually  
 8 when they were returned, so what was the  
 9 turnaround time and what was the action taken  
 10 between the results being there and any action  
 11 taken after results come in, so obviously it  
 12 was important for those two dates. So we  
 13 worked with Mount Sinai for a little while  
 14 trying to figure that out and it's clear in  
 15 the e-mail from Maria that they didn't collect  
 16 that information, so basically the order of  
 17 date, which she refers to in her e-mail, is  
 18 the date that they actually ordered it in  
 19 their own LIS, so she's assuming that as soon  
 20 as it showed up in their lab, they will place  
 21 an order and Dr. Mullen would do the testing.  
 22 So there's an assumption right there. We went  
 23 back to Eastern Health and asked them, okay,  
 24 we can't get the date that it was returned  
 25 because Mount Sinai doesn't capture that, but

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1 can you tell us when the files came in? And  
 2 as I recall, we never were able to get those,  
 3 the dates that the Excel spreadsheets were  
 4 sent back. I don't know if they existed  
 5 anymore, the e-mails might have been deleted  
 6 but the files kept, there was some challenge I  
 7 believe on that end and I'll ask Reza to  
 8 correct me on that end, but the other  
 9 challenge we had were the consults. So it's  
 10 very simple actually. If two or three samples  
 11 were sent up, blocks were sent up, it was  
 12 considered a batch and it was included in an  
 13 Excel spreadsheet, that's just the way they  
 14 did it at Mount Sinai.  
 15 COFFEY, Q.C.:  
 16 Q. Yes. Sometimes the Excel spreadsheet might be  
 17 too -  
 18 DR. MACDONALD:  
 19 A. Well, they'd add it all up. When we got ours,  
 20 we asked them to create a new Excel  
 21 spreadsheet right from their LIS. We didn't  
 22 want anything that was done, we wanted to go  
 23 primary into their database. But we also then  
 24 had to add in the consults because they  
 25 weren't a part of the spreadsheets, so when we

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1 asked--okay, well we need to find out then  
 2 when the consults was sent back, which was  
 3 basically your path report, they were faxed  
 4 and the only way that we could have, and we  
 5 couldn't--eventually couldn't even get that,  
 6 was the date on the fax cover sheet and they  
 7 were not kept. So we were never able to -  
 8 COFFEY, Q.C.:  
 9 Q. They weren't kept by Eastern Health or by the  
 10 other authorities, I take it?  
 11 DR. MACDONALD:  
 12 A. No, not to my understanding.  
 13 DR. ALAGHEHBANDAN:  
 14 A. The majority of them were Eastern Health's,  
 15 Dr. Cook's office at a time, probably  
 16 sporadically what regions, but as Don said,  
 17 they were just, you know, they were not a part  
 18 of that batch, so they were not a part of the  
 19 Excel sheet to come back to Eastern Health  
 20 again.  
 21 COFFEY, Q.C.:  
 22 Q. Now in terms of this, the idea of trying to  
 23 locate the electronic version of the  
 24 spreadsheets that came from Mount Sinai from  
 25 time to time, I take it as you got into this,

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1 you realized Mount Sinai has sent them in, in  
 2 waves, as it were, they would send a  
 3 spreadsheet with -  
 4 DR. MACDONALD:  
 5 A. That's right.  
 6 COFFEY, Q.C.:  
 7 Q. - five results or 150 results, depending upon  
 8 which spreadsheet, you understood that.  
 9 DR. MACDONALD:  
 10 A. That's right.  
 11 COFFEY, Q.C.:  
 12 Q. Did you ever ask Eastern Health for their copy  
 13 of those electronic--an electronic copy of  
 14 those spreadsheets?  
 15 DR. ALAGHEHBANDAN:  
 16 A. Yes, we did and they had a copy of it in their  
 17 e-mail accounts and I received a copy of that,  
 18 but as Dr. MacDonald mentioned, we went to the  
 19 primary source for Mount Sinai data. We also  
 20 kept a copy of those Mount Sinai copies were  
 21 sent to Eastern Health; however, we directly  
 22 requested Mount Sinai for the original copies.  
 23 COFFEY, Q.C.:  
 24 Q. Yes, so in terms of have you been able to  
 25 locate Eastern Health's received electronic

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1 version of, for example, the first reports?  
 2 Do you have those?  
 3 DR. MACDONALD:  
 4 A. Yes, we do.  
 5 COFFEY, Q.C.:  
 6 Q. And when did you receive those?  
 7 DR. ALAGHEHBANDAN:  
 8 A. Early days actually, that was, I believe, in  
 9 July/August, '07.  
 10 COFFEY, Q.C.:  
 11 Q. In terms of this, Mr. MacDonald, in terms of  
 12 your dealing with Mount Sinai, as time went on  
 13 in terms of that, Mount Sinai in the end  
 14 referred you to Eastern Health to tell you  
 15 look, they'll have it, presumably because we  
 16 sent it to them?  
 17 DR. MACDONALD:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. And that's what -  
 21 DR. MACDONALD:  
 22 A. That's--we pursued it from that end.  
 23 COFFEY, Q.C.:  
 24 Q. Have those dates been recorded in the  
 25 database?

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

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1 DR. ALAGHEHBANDAN:  
 2 A. Or Dr. Carter or whoever the attending  
 3 pathologist would be.  
 4 COFFEY, Q.C.:  
 5 Q. What about the date that the results were sent  
 6 from Mount Sinai electronically to Eastern  
 7 Health, do you have that recorded?  
 8 DR. ALAGHEHBANDAN:  
 9 A. Yes, we do have that.  
 10 COFFEY, Q.C.:  
 11 Q. Okay, so for example the first wave--and we  
 12 know this because of documents we have,  
 13 September 26th, 2005, there's an e-mail with  
 14 an attachment.  
 15 DR. ALAGHEHBANDAN:  
 16 A. Yeah, that data exists but that data is not a  
 17 part of the database.  
 18 COFFEY, Q.C.:  
 19 Q. Okay, and that's what I wanted to ask you  
 20 about. Why is that?  
 21 DR. ALAGHEHBANDAN:  
 22 A. The question was when the data entered into a  
 23 database and that was the most accurate data  
 24 that we could gather from the Meditech source  
 25 because we did not have a date received for

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

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

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1 Q. I'm sorry, I just want to make sure I  
 2 understand, you're saying that in respect of  
 3 the issue of when the information was received  
 4 back from Mount Sinai, there were a number of  
 5 different potential sources, some of which  
 6 were clearer than others, for example, you  
 7 could discover--you could find the electronic  
 8 spreadsheets that came with each sending of a  
 9 "batch" from Mount Sinai to Dr. Cook, but  
 10 there were not electronic spreadsheets for  
 11 every single case because of the complication  
 12 of the consults?  
 13 DR. ALAGHEHBANDAN:  
 14 A. Well consult was an separate issue, even with  
 15 respect to the batches they came, as I came to  
 16 learn, some electronically, some were sent in  
 17 hard copies from Mount Sinai to Eastern  
 18 Health.  
 19 THE COMMISSIONER:  
 20 Q. So even that wasn't consistent.  
 21 DR. ALAGHEHBANDAN:  
 22 A. Even that wasn't consistent because they were  
 23 sending some electronically and some as hard  
 24 copies. Sometimes they sent electronically  
 25 and hard copies.

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1 THE COMMISSIONER:  
 2 Q. Okay, so are you then saying for the purpose  
 3 of consistency wanting to have one source of  
 4 information for the data of when it came back,  
 5 you chose to use Meditech?  
 6 DR. ALAGHEHBANDAN:  
 7 A. In consultation with the Eastern Health  
 8 officials and the other matter was with  
 9 respect to the hard copies spreadsheets they  
 10 would receive from Mount Sinai. There was no  
 11 date on those spreadsheets, so we could not  
 12 really be consistently capturing the data with  
 13 respect to that matter. We decided to go with  
 14 the date the data is entered into Meditech.  
 15 THE COMMISSIONER:  
 16 Q. So for the purposes of material coming back,  
 17 what we know is not necessarily when it  
 18 actually came back, but when it got processed  
 19 to the point that it was entered into  
 20 Meditech?  
 21 DR. ALAGHEHBANDAN:  
 22 A. That's correct and that's what the database  
 23 can speak to.  
 24 THE COMMISSIONER:  
 25 Q. All right, thank you.

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1 DR. MACDONALD:  
 2 A. And that is important, if you look at even  
 3 coming from Mount Sinai, they told us we can't  
 4 tell you when we got it, we can only tell you  
 5 when it was ordered in our LIS. So it's the  
 6 same situation when it came back. We can't  
 7 tell you exactly when it came back, we can  
 8 only tell you when it was entered in the  
 9 Meditech. So at both ends, we didn't get the  
 10 dates we wanted.  
 11 COFFEY, Q.C.:  
 12 Q. How about being sent off, were you able to  
 13 tell when things left St. John's?  
 14 DR. ALAGHEHBANDAN:  
 15 A. The main source was Meditech, so if we sent a  
 16 Reza sample to Mount Sinai within Meditech, we  
 17 say sample on this block and the specimen  
 18 number was sent on this date. Interestingly  
 19 enough to know that that date was not captured  
 20 consistently across the board for all  
 21 patients. Sometimes they mentioned just the  
 22 year, sometimes it was the year and the month  
 23 and sometimes it was year and the month and  
 24 the date.  
 25 COFFEY, Q.C.:

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1 Q. That they were sending it in '05 and '06?  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's correct, so that was another challenge.  
 4 We went back to Mr. Gulliver's office for  
 5 clarification and we tried to improve the  
 6 data, I guess the data quality of this field  
 7 in the database, it had been improved since  
 8 then. But that was a challenge at the time  
 9 because in all, it said for some patients in  
 10 Meditech was that the sample was sent in 2005  
 11 or this sample was sent in October '05, or  
 12 this sample was sent in October 1st, 2005, so  
 13 with respect to analysing it, standardizing  
 14 it, that was a challenge because they were not  
 15 consistently captured.  
 16 DR. MACDONALD:  
 17 A. And that's a database management issue, not a  
 18 data technology issue.  
 19 COFFEY, Q.C.:  
 20 Q. So in terms of that, Dr. Reza, how far has  
 21 that been able to be clarified, to what  
 22 extent?  
 23 DR. ALAGHEHBANDAN:  
 24 A. Off top of my head, I can't give you a  
 25 proportion, but I believe that has been

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

11 COFFEY, Q.C.:

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

14 DR. ALAGHEHBANDAN:

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

18 COFFEY, Q.C.:

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

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

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

12 DR. MACDONALD:

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

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

10 COFFEY, Q.C.:

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

13 DR. ALAGHEHBANDAN:

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

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1 patient got married and the last name got  
 2 changed--the first name sometimes, for  
 3 example, Cathy with "C" and with "K", we had,  
 4 you know, this difference between one patient  
 5 and--reading one patient or between one and  
 6 two patients, the MCP was the key for us to  
 7 identify unique patients, not name or anything  
 8 like -  
 9 COFFEY, Q.C.:  
 10 Q. Now, in terms of MCP numbers, I take it that,  
 11 of course, that relies upon the number  
 12 actually being accurately recorded. If it's  
 13 not recorded accurately, then--maybe  
 14 transposed, for example two digits.  
 15 DR. MACDONALD:  
 16 A. It is 12 digits long.  
 17 DR. ALAGHEHBANDAN:  
 18 A. It is.  
 19 COFFEY, Q.C.:  
 20 Q. Did you ever run into a situation where the  
 21 same patient apparently had two MCP numbers?  
 22 DR. ALAGHEHBANDAN:  
 23 A. No, I didn't, but I can recall sometimes we  
 24 had an NL resident, Newfoundland and Labrador  
 25 resident who must have had a valid MCP, yet

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1 the patient had what we call pseudo MCP, let  
 2 me give you a scenario here, a patient was  
 3 sent from Western Memorial to St. John's for  
 4 ER/PR retesting. For some reason, they forgot  
 5 to mention the MCP for that patient, so once  
 6 we received that patient in here, in St.  
 7 John's, the Meditech system automatically  
 8 generates a pseudo MCP number for that  
 9 patient, so that's one of the challenges that  
 10 we had, so we captured that pseudo MCP from  
 11 Meditech, yet we had to go back to MCP  
 12 registry to find the proper MCP number for  
 13 that patient so we'd be able to do the rest of  
 14 the cross-referencing and linkages down the  
 15 road. That was one of the challenges that we  
 16 had.  
 17 COFFEY, Q.C.:  
 18 Q. Just on this August 1st database, I'll refer  
 19 to it as, to use your terminology. You say  
 20 that did not have any MCP numbers in it?  
 21 DR. ALAGHEHBANDAN:  
 22 A. No.  
 23 COFFEY, Q.C.:  
 24 Q. Did Eastern Health provide you with anything  
 25 that actually had the MCP numbers in it?

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1 DR. ALAGHEHBANDAN:  
 2 A. Yes, Mr. Gulliver's spreadsheets contained all  
 3 MCP numbers for those patients and those are  
 4 basically coming from original pathology  
 5 reports that he reviewed, I believe 26 or 2700  
 6 including all positives and negatives. So he  
 7 reviewed all of them, he created the  
 8 spreadsheets, he logged them on into the  
 9 spreadsheets, including their MCP numbers.  
 10 COFFEY, Q.C.:  
 11 Q. And these were handwritten -  
 12 DR. ALAGHEHBANDAN:  
 13 A. Handwritten, so the challenge was to convert  
 14 them into electronic format.  
 15 COFFEY, Q.C.:  
 16 Q. Did Eastern Health provide NLCHI with an  
 17 electronic database identifying patients by  
 18 MCP numbers, that you recall?  
 19 DR. ALAGHEHBANDAN:  
 20 A. Two main sources that we received from Eastern  
 21 Health was August 1st file, which was in  
 22 electronic format, but did not have MCP.  
 23 COFFEY, Q.C.:  
 24 Q. No MCP numbers.  
 25 DR. ALAGHEHBANDAN:

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1 A. And then spreadsheets handwritten by the lab  
 2 which included MCPs but it was not in  
 3 electronic format, so I'm sure you can  
 4 appreciate the challenge that we face in terms  
 5 of marrying this to, and bring them under one  
 6 roof and basically reconciling them.  
 7 COFFEY, Q.C.:  
 8 Q. So they did not have--at least, you were not  
 9 made aware of Eastern Health having an  
 10 electronic database for the patients that  
 11 contained--identified the patients by MCP  
 12 number, an electronic one?  
 13 DR. ALAGHEHBANDAN:  
 14 A. Not that I'm aware of to state.  
 15 COFFEY, Q.C.:  
 16 Q. Now with respect to--you referred to this  
 17 before. Mr. Gulliver, you understood--you saw  
 18 he had spreadsheets, handwritten, that  
 19 recorded the patient's name, I take it,  
 20 amongst other things, the patient's name and  
 21 the patient's MCP number?  
 22 DR. ALAGHEHBANDAN:  
 23 A. That's correct.  
 24 COFFEY, Q.C.:  
 25 Q. And that was for all patients who were

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1 negative?  
 2 DR. ALAGHEHBANDAN:  
 3 A. And positives. I'm sorry, just the negatives  
 4 and he called them "weak positive", the second  
 5 group.  
 6 COFFEY, Q.C.:  
 7 Q. Weak positives, okay, but not the  
 8 positive/positives?  
 9 DR. ALAGHEHBANDAN:  
 10 A. No.  
 11 COFFEY, Q.C.:  
 12 Q. He didn't record those.  
 13 DR. ALAGHEHBANDAN:  
 14 A. He reviewed them, but he did not record them.  
 15 COFFEY, Q.C.:  
 16 Q. Yes, we've seen some of the--we've seen some  
 17 of his spreadsheets there, perhaps all of  
 18 them, but the negatives and the weak  
 19 positives?  
 20 DR. ALAGHEHBANDAN:  
 21 A. That's right.  
 22 COFFEY, Q.C.:  
 23 Q. We've looked at those, but the idea--a listing  
 24 of all the patients, including all the  
 25 positives, handwritten, that didn't exist?

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

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

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



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1 involved. Once we hear back from Eastern  
 2 Health on our request, there will be further  
 3 updates to this database". You copied it to  
 4 Dr. Reza and others. So here on the second  
 5 page of this exhibit, Mr. MacDonald, is what's  
 6 referred to as an interim report, dated  
 7 September 19th, 2007. Now what was this  
 8 report related to?  
 9 DR. MACDONALD:  
 10 A. Going back to our scoping document, which  
 11 we've already spoken to, we did tell the task  
 12 force that we would have a functional database  
 13 ready within eight to twelve weeks, which  
 14 brought us into sometime in September, given  
 15 the June or July creation of that. So we were  
 16 really putting a lot of resources towards the  
 17 database during these three months to provide  
 18 the task force with at least some foundational  
 19 activity around the database and particular  
 20 analysis. So on this particular date, on this  
 21 report we were providing a report to the task  
 22 force which outlined our activities to date  
 23 with the creation of the database and  
 24 informing them perhaps--I'm not really  
 25 intimate with what's in the report at this

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1 particular moment, but I would say informing  
 2 them of some of the challenges and limitations  
 3 we would have in doing an analysis, but  
 4 basically saying we are now ready to begin  
 5 trying to answer some questions.  
 6 COFFEY, Q.C.:  
 7 Q. And here then there's a table of contents, and  
 8 the project background is there, and here  
 9 toward the bottom of that section, you say,  
 10 "For the purpose of this report, the resulting  
 11 database is called the "ER/PR patient listing  
 12 and communication events database".  
 13 DR. MACDONALD:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. And, Dr. Reza, you're nodding. I take it  
 17 that's the title?  
 18 DR. ALAGHEHBANDAN:  
 19 A. Yes, but just let me go back with regard to  
 20 this report. As Dr. MacDonald mentioned, the  
 21 purpose of this report was to document how we  
 22 created the database. So down the road, if  
 23 someone take the database and wants to use  
 24 that, that person would know what steps we  
 25 took to create the database and what are the

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1 components and elements and variables within  
 2 this database, and what is the definition of  
 3 each variable and what are the values of each  
 4 variable within this database. Within this  
 5 report, we also indicated what criteria was  
 6 considered before creating the database,  
 7 original criteria, revised criteria, and this  
 8 is all going back to database management, and  
 9 this is a database management piece. Whatever  
 10 you create, whatever you do, you have to  
 11 basically document it, and this report is  
 12 about it. So the name of the database,  
 13 "Patient listing and communication events"  
 14 simply describes the fact that this database  
 15 has two components into it, patient listing,  
 16 demographic and clinical information to a  
 17 certain extent, plus the communication events.  
 18 COFFEY, Q.C.:  
 19 Q. The sentence following that says, "The aim of  
 20 this report is to describe the methodology  
 21 used to develop the database and present a  
 22 description of the variables within the  
 23 database".  
 24 DR. ALAGHEHBANDAN:  
 25 A. That's right.

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1 COFFEY, Q.C.:  
 2 Q. The selection criteria noted here, "The  
 3 following criteria were initially used to  
 4 develop the ER/PR patient listing and  
 5 communication events database", and they are  
 6 listed here as a number of bullets, okay, and  
 7 the--on September 11th--it continues on  
 8 saying, "On September 11th, 2007, a meeting  
 9 between the Department of Health and the  
 10 Centre resulted in the original criteria being  
 11 revised", and then there are revised criteria,  
 12 and there's one through four, or one through  
 13 three.  
 14 DR. ALAGHEHBANDAN:  
 15 A. That's right.  
 16 COFFEY, Q.C.:  
 17 Q. And here when we look back at this, at the top  
 18 of the page five of the exhibit, there's a  
 19 reference to original ER testing, either  
 20 negative or positive done in Newfoundland and  
 21 Labrador and retested at Mount Sinai, okay,  
 22 and that was originally what you set out to  
 23 do, include all the ER positives as well, but  
 24 as well positive or negative and they ended up  
 25 being retested in Mount Sinai, include tissue

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1 other than breast at the time, and include  
 2 DCIS, insufficient tumour for ER testing at  
 3 Mount Sinai, include deceased patients who had  
 4 been recently sent for retesting, include all  
 5 originally negative ER done in Newfoundland  
 6 and Labrador, but not retested in Mount Sinai,  
 7 include all ER tested in Mount Sinai, but no  
 8 original ER testing in Newfoundland and  
 9 Labrador and called in and asked to be tested  
 10 at Mount Sinai, but did not meet the  
 11 eligibility criteria, and then under the  
 12 revised criteria, you've written, "Had  
 13 original ER test done in Newfoundland; two,  
 14 had original ER test for sample related to  
 15 breast cancer, example, breast, lymph node,  
 16 chest, etc; three, had original ER test  
 17 between January '97 and August '05; four, had  
 18 original ER test done prior to January of '97  
 19 and sent to Mount Sinai for retesting; had  
 20 original--negative original ER test result or  
 21 had positive original ER test result and sent  
 22 to Mount Sinai for testing, and then there's a  
 23 larger "or", which is had sample taken in  
 24 Newfoundland related to breast cancer; two,  
 25 had sample taken between January '97 and

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1 August '05, or had a sample taken prior to '97  
 2 and sent to Mount Sinai for testing, and,  
 3 three, had no original ER testing in  
 4 Newfoundland, but sample sent to Mount Sinai  
 5 for testing". It goes on with another  
 6 proviso, "In addition, if an individual met  
 7 the above criteria, he or she would not be  
 8 excluded based on any of the following  
 9 criteria. Sample not retested at Mount Sinai  
 10 due to DCIS, sample not retested at Mount  
 11 Sinai due to insufficient tumour for ER  
 12 testing, and patient is deceased", and then  
 13 there's a description of the data sources  
 14 spelled out here. This goes on and it's quite  
 15 detailed. I'm not going to take you all the  
 16 way though it. I'm going to ask you, Mr.  
 17 MacDonald, was this the approach adopted?  
 18 Perhaps Dr. Reza actually -  
 19 DR. ALAGHEHBANDAN:  
 20 A. I'm sorry, I missed your question.  
 21 COFFEY, Q.C.:  
 22 Q. Was this the approach adopted then?  
 23 DR. MACDONALD:  
 24 A. Well, I might just start by we're still  
 25 basically still in our infancy and still

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

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1 found as we went forward that really didn't  
 2 fit the criteria as we had originally thought  
 3 it would, so we had to fit it in somewhere.  
 4 So I would suggest that through evolution,  
 5 that probably changed also.  
 6 COFFEY, Q.C.:  
 7 Q. Here when we look at page 15, under action  
 8 items, it says, "Database maintenance and  
 9 analysis implications. The Centre is  
 10 currently maintaining the ER/PR patient  
 11 listing and communication events database on  
 12 behalf of the Department of Health. It is  
 13 recognized that it will require ongoing  
 14 maintenance and updating for several months as  
 15 more data becomes available". So this is in  
 16 mid September you realize, look, at least  
 17 until the end of 2007 perhaps, several months  
 18 at least?  
 19 DR. MACDONALD:  
 20 A. This particular context was really--originally  
 21 we were to create the database and give it to  
 22 the task force and they would do their  
 23 analysis, and a few months in, I think we all  
 24 recognized that it was a very complex  
 25 undertaking and that it would be best

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1 undertaken by the Centre, so--actually that's  
 2 the way it still exists today, the task force  
 3 has never received a copy of the database, we  
 4 do the analysis on their behalf.  
 5 COFFEY, Q.C.:  
 6 Q. Now there's a reference on the last page of  
 7 this exhibit to having Eastern prepare the  
 8 interface, "It has the advantage of having  
 9 significant resources with expertise in the  
 10 area of database interface development. The  
 11 disadvantages are that; one, Eastern may not  
 12 be able to access some data in the database,  
 13 negate them accessing the full database for  
 14 developing the interface; two, having Eastern  
 15 develop the interface would require that they  
 16 maintain it. Having one agency responsible  
 17 for the data, another responsible for the  
 18 interface, is not good database management  
 19 practice. Having the Centre develop the  
 20 interface has the disadvantage that we do not  
 21 have extensive development resources or  
 22 expertise compared with that of Eastern  
 23 Health. The Centre has the advantage of  
 24 keeping all interface maintenance and updating  
 25 activities located at one source. It is

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1 recommended the Centre develop the interface.  
 2 Protocol database access--protocol will need  
 3 to be put in place to transfer the database to  
 4 the Commission of Inquiry, and if possible, to  
 5 the Eastern Health Authority". So what was  
 6 decided then in terms of the interface?  
 7 DR. MACDONALD:  
 8 A. And just to explain what we meant by the  
 9 interface because we've spoken to the various  
 10 diverse and dispersed databases that actually  
 11 came together to create this, at the Centre  
 12 for Health Information we did that in the  
 13 Research and Evaluation Department, so we  
 14 would get the Excel file from Mount Sinai, we  
 15 would get the hard copy spreadsheet from the  
 16 lab, we would have the August 1st file from  
 17 Eastern Health, and we would--our  
 18 epidemiologist would actually basically by  
 19 hand bring all that together. So that was the  
 20 interface. We had the human interface between  
 21 the dispersed databases and the creation of  
 22 the ER/PR database. What Eastern Health was  
 23 proposing, and I was not comfortable with from  
 24 the start, was to do that electronically, to  
 25 create a layer on a software platform called

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1 "COGNOS" that would interface with MCP, with  
 2 mortality, with all the different databases to  
 3 funnel down in or filter down into the  
 4 database. I did not recommend that because I  
 5 didn't have a level of comfort that--this is  
 6 again the bringing together of database  
 7 management and information management. Given  
 8 the complexity and sensitivity of this data, I  
 9 didn't feel a level of comfort, so I  
 10 recommended to the task force that we do not  
 11 go with Eastern Health's proposal coming from  
 12 their IT Department. It was welcomed, but it  
 13 was just something that I decided against.  
 14 COFFEY, Q.C.:  
 15 Q. And what was the result? Did they go with  
 16 your advice?  
 17 DR. MACDONALD:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. They accepted your approach. If we could,  
 21 please, Exhibit P-3498. Now there are a  
 22 number of these letters. I'm not going to  
 23 take you through--for the other health  
 24 authorities, but this is a letter of September  
 25 20th, 2007, to Pat Pilgrim at Eastern Health,

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

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1 and his colleagues had identified people who  
 2 fell into that category?  
 3 DR. MACDONALD:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. In fact, the regions in question, Western,  
 7 Central, St. John's, Carbonear. So they were  
 8 from various hospitals throughout the  
 9 province, and the original ER and the original  
 10 PRs are noted there. So I take it, this was  
 11 ensuring that a patient who had been  
 12 identified as originally a negative, or  
 13 falling into the negative category--well, it's  
 14 hard to tell with that '02 one, 25 to 30,  
 15 would have been the positive--would have  
 16 fallen into the positive category, we'll talk  
 17 about that, but the point being that there are  
 18 a number of these, eight of them here, that  
 19 you wanted confirmation--the Centre wanted  
 20 confirmation from Eastern Health, or  
 21 confirmation that they couldn't give it to  
 22 you, documentation that would prove that  
 23 samples for them were sent for retesting?  
 24 DR. MACDONALD:  
 25 A. Yes, I mean, one of the sources that we did

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1 have was obviously we've asked all the  
 2 authorities to send in the original--copies of  
 3 the path reports for their ER breast cancer  
 4 patients for testing. So we actually had what  
 5 the authorities had sent in, we had what Mount  
 6 Sinai sent back, and so when we started  
 7 consolidating all this information, we had to  
 8 reconcile some of the things, so in this  
 9 particular case we probably, if I'm not  
 10 mistaken, would have a path report that Mount  
 11 Sinai said insufficient tumour.  
 12 COFFEY, Q.C.:  
 13 Q. Yes.  
 14 DR. MACDONALD:  
 15 A. And there was no amendment to it. So we would  
 16 go back to Eastern Health and ask for further  
 17 information.  
 18 COFFEY, Q.C.:  
 19 Q. What happened with that patient?  
 20 DR. MACDONALD:  
 21 A. Yes, exactly.  
 22 COFFEY, Q.C.:  
 23 Q. Here on the second page, it says "for the 60,  
 24 6-0, breast cancer patients listed in--  
 25 provided in list number two, the Centre has

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1 been provided documentation by the three  
 2 health authorities other than Eastern  
 3 indicating an ER/PR of less than or equal to  
 4 30. However, the Centre has no documentation  
 5 that these patients had specimens retested at  
 6 Mount Sinai." You "request confirmation that  
 7 a specimen was sent for retesting or if not,  
 8 the reason why the specimen was not sent.  
 9 Note: If a specimen was not sent to Eastern  
 10 for retesting by the health authority  
 11 identified in the list, please report same."  
 12 And there's a listing of these. A number of  
 13 them are Western. There's a Central, another  
 14 Western, Grenfell has some and then Carbonear  
 15 has a whole list.  
 16 Dr. Reza, I'm going to ask you here, in  
 17 terms of list number two, in the main, what  
 18 were they comprised of?  
 19 DR. ALAGHEHBANDAN:  
 20 A. I'm sorry?  
 21 COFFEY, Q.C.:  
 22 Q. In the main, what was list two comprised of?  
 23 DR. ALAGHEHBANDAN:  
 24 A. We reviewed pathology reports from the regions  
 25 and we came across some patients who were--who

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1 had ER/PR scores less than 30, regardless of  
 2 the year, and at the same time, cross  
 3 referenced this list against Mount Sinai and  
 4 other sources that we had and we couldn't find  
 5 them there. So the question was have these  
 6 patients been sent to Mount Sinai in a  
 7 different method, such as consult that we  
 8 don't have, because we received from Mount  
 9 Sinai just Excel spreadsheets, so they were  
 10 not in that file. The question was whether  
 11 they had been sent or not, because in our  
 12 understanding, they were somehow negative and  
 13 they might have been considered for the ER/PR  
 14 recall, and you could see a number of them  
 15 from different regions.  
 16 COFFEY, Q.C.:  
 17 Q. In particular, there are quite a number from  
 18 Western.  
 19 DR. ALAGHEHBANDAN:  
 20 A. That's right.  
 21 COFFEY, Q.C.:  
 22 Q. And then there are quite a number from  
 23 Carbonear. Do you recall anything about the  
 24 Carbonear ones?  
 25 DR. ALAGHEHBANDAN:

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1 A. We received, as I said, reports from the  
 2 regions, including Carbonear. Carbonear is a  
 3 part of Eastern Health, but at the time, we  
 4 received reports from Carbonear and also  
 5 Clarenville as a part of Eastern Health.  
 6 Reviewed the pathology reports and came across  
 7 these patients, as you can see the list here,  
 8 and noted that we can't find them in Mount  
 9 Sinai's file. So that was the point for us to  
 10 notify the regions.  
 11 COFFEY, Q.C.:  
 12 Q. The next page says "for the 22 breast cancer  
 13 patients provided in list number three, the  
 14 Centre has been provided documentation by  
 15 Eastern Health indicating an ER/PR of less  
 16 than or equal to 30. However, the Centre has  
 17 no documentation that these patients had  
 18 specimens retested at Mount Sinai." And the  
 19 request is "documentation that the specimen  
 20 was sent for retesting or if not, the reason  
 21 why." So again, Dr. Reza, what was this  
 22 about?  
 23 DR. ALAGHEHBANDAN:  
 24 A. The same thing again. We came across these  
 25 patients, same story, less than--ER/PR less

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1 than 30 actually and again, the question was  
 2 posed to Eastern Health is whether they had  
 3 been tested, retested or not at Mount Sinai  
 4 because we were not able to track them down in  
 5 Mount Sinai file.  
 6 COFFEY, Q.C.:  
 7 Q. I take it here, these were--this was based  
 8 upon information you'd received from Eastern  
 9 Health itself?  
 10 DR. ALAGHEHBANDAN:  
 11 A. That's correct.  
 12 COFFEY, Q.C.:  
 13 Q. And do you recall what, in the main, what the  
 14 explanation was?  
 15 DR. ALAGHEHBANDAN:  
 16 A. Well, some of them basically, the patient had  
 17 one sample being tested and the other sample  
 18 wasn't, so that could have been one of the  
 19 main reasons for this table actually.  
 20 COFFEY, Q.C.:  
 21 Q. And then it says "for the four breast cancer  
 22 patients provided in list number four, the  
 23 Centre has been provided documentation by  
 24 Eastern Health indicating the patient had more  
 25 than one sample originally tested. The

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1 specimens provided in the list below were not  
 2 sent for retesting. Request documentation as  
 3 to why these specimens were not sent for  
 4 retesting." And then final page, "for the 17  
 5 breast cancer patients provided in list number  
 6 five, the Centre has been provided  
 7 documentation by Eastern Health indicating  
 8 that the patient is deceased and have been  
 9 sent for retesting in the summer of 2007. The  
 10 specimens provided in the list below were not  
 11 sent for retesting. Request documentation as  
 12 to why these specimens were not sent for  
 13 retesting."  
 14 DR. ALAGHEHBANDAN:  
 15 A. Again, the same thing, but for the deceased  
 16 group.  
 17 COFFEY, Q.C.:  
 18 Q. I take it, Mr. MacDonald, as well there were  
 19 other similar letters sent to the other  
 20 regions or certain of the other regions?  
 21 DR. MACDONALD:  
 22 A. There was always initially certainly a bit of  
 23 confusion as to who was responsible for some  
 24 of the tests.  
 25 THE COMMISSIONER:

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1 Q. In what way?  
 2 DR. MACDONALD:  
 3 A. We would basically ask--for example, ask  
 4 Western for this particular type of  
 5 information, and obviously not these  
 6 specifically. This is obviously to Eastern.  
 7 But they would say "well, we've given that to  
 8 Eastern. They would know." So we would go to  
 9 Eastern as the primary source for retesting.  
 10 That was the position taken by the  
 11 authorities.  
 12 THE COMMISSIONER:  
 13 Q. So if you went to question an authority  
 14 outside of Eastern regarding a particular  
 15 file, if they had sent it in, they would say  
 16 "go ask Eastern Health"? Is that it?  
 17 DR. MACDONALD:  
 18 A. In most cases, yes. They would say "we've  
 19 already given that to Eastern Health. We  
 20 don't know if they sent it or not, perhaps, so  
 21 go to the source."  
 22 THE COMMISSIONER:  
 23 Q. Okay.  
 24 DR. MACDONALD:  
 25 A. So most of our work was with Eastern Health

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1 around the clinical side of things. More work  
 2 with the other authorities on the  
 3 communication side.  
 4 THE COMMISSIONER:  
 5 Q. Okay. Was there ever any point along the way  
 6 where Eastern Health indicated that for some  
 7 reason certain specimens were not sent on,  
 8 other than the one that's been referred to by  
 9 Dr. Reza, i.e. we sent another specimen, not  
 10 the one that you're looking for?  
 11 DR. ALAGHEHBANDAN:  
 12 A. I'm trying to understand your question.  
 13 THE COMMISSIONER:  
 14 Q. Well, I'm wondering whether or not there was  
 15 any culling of specimens that came from  
 16 outside of St. John's at Eastern Health itself  
 17 to say, for example, "this doesn't meet our  
 18 criteria. We're not sending it," or were they  
 19 just sending on -  
 20 DR. ALAGHEHBANDAN:  
 21 A. Right, this is my understanding from this  
 22 exercise. The samples came in from the  
 23 regions to Eastern Health. Clinical chief,  
 24 pathology, at the time, reviewed the blocks  
 25 and the slides and decided which ones should

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1 go, with respect to appropriateness of that  
 2 sample and which one probably may not be  
 3 appropriate for that purpose. That was all on  
 4 my understanding. However, I don't have a  
 5 list of those that were not sent based on that  
 6 exercise back in August '05.  
 7 THE COMMISSIONER:  
 8 Q. Okay. So your--we've had some various  
 9 evidence on this, not all entirely consistent,  
 10 but your view was that what the pathologists  
 11 locally did vis-a-vis those samples that came  
 12 in from outside was to try to choose the best  
 13 block to send on to Mount Sinai, effectively  
 14 so you wouldn't have to resend because you had  
 15 sent perhaps a less than best example of -  
 16 DR. ALAGHEHBANDAN:  
 17 A. At least a sample, and I believe that at each  
 18 region, a responsible pathologist also looked  
 19 at those blocks and the slides before shipping  
 20 them to Eastern Health.  
 21 THE COMMISSIONER:  
 22 Q. All right, thank you.  
 23 COFFEY, Q.C.:  
 24 Q. Just before we break, Commissioner, just  
 25 looking at this, I wanted to ask you about

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1 this because it's going to come up on an  
 2 exhibit I'll refer you to after the break.  
 3 Look at this letter. See at the top of page  
 4 two here, it says "for the 60 breast cancer  
 5 patients provided in list number two, the  
 6 Centre has been provided documentation by the  
 7 three health authorities indicating an ER/PR  
 8 of less than or equal to 30." See that?  
 9 DR. ALAGHEHBANDAN:  
 10 A. That's right.  
 11 COFFEY, Q.C.:  
 12 Q. And then there's, at the top of page four, a  
 13 listing provided of 22 patients provided by  
 14 Eastern Health indicating an ER/PR of less  
 15 than or equal to 30, and why 30 at that point,  
 16 at this point in time?  
 17 DR. ALAGHEHBANDAN:  
 18 A. Our understanding always has been that there  
 19 was clinical criteria set out by clinicians  
 20 with respect to offering treatment. The cut  
 21 off point was, again this is my understanding,  
 22 less than 30 for '97 up to 2000 and from 2001  
 23 onward, was less than ten. So the cut off  
 24 point changed with respect to that clinical  
 25 ER/PR scoring. In this letter, we chose to go

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1 with 30, just to be on the safe side, although  
 2 we understood that there are some specimens  
 3 who were coming from years after 2000, yet  
 4 ER/PR score was greater than ten. But again,  
 5 for the sake of clarity, we put that there and  
 6 for some of those, of course, we received same  
 7 answer, that because they were greater than  
 8 ten, they were not sent to Mount Sinai.  
 9 COFFEY, Q.C.:  
 10 Q. As an example here, just looking at page three  
 11 of this exhibit, 3498, under the Carbonear  
 12 Listings. For example, yes, I got the cursor  
 13 on S564-2002, Carbonear. ER/PR is 15 to 20  
 14 and, sorry, ER is 15 to 20, the PR is 60 to  
 15 70.  
 16 DR. ALAGHEHBANDAN:  
 17 A. That's right.  
 18 COFFEY, Q.C.:  
 19 Q. So that would not have met the retest  
 20 criteria?  
 21 DR. ALAGHEHBANDAN:  
 22 A. Obviously not.  
 23 COFFEY, Q.C.:  
 24 Q. Okay. But at the time -  
 25 DR. ALAGHEHBANDAN:

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1 A. We considered it as a part of the letter for  
 2 the sake of clarity.  
 3 DR. MACDONALD:  
 4 A. You know, and on that one too, Mr. Coffey, I  
 5 mean, that was just basically from a database  
 6 management perspective to be more  
 7 encompassing. When we're going to the  
 8 regions, we didn't want to have to go back.  
 9 Another example with that, originally the  
 10 retesting time frame was somewhere April 1997  
 11 to July 2005 and we recommended to the task  
 12 force that we include all of 1997 and all of  
 13 2005, just again to be more encompassing as we  
 14 go out. We don't want to have to go back  
 15 again. So it's just being a bit more cautious  
 16 in what we ask for.  
 17 COFFEY, Q.C.:  
 18 Q. In that regard, if I could, Commissioner,  
 19 Exhibit P-1022? These are two e-mails. One  
 20 is October 25 from Dr. Reza to a number of  
 21 individuals within Eastern--within NLCHI, I'm  
 22 sorry. You write, "in follow up to our  
 23 meeting with Robert on Tuesday, please see  
 24 below a summary of the process used to select  
 25 breast cancer patients for retests at Mount

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1 Sinai by Eastern Health. Later today, I will  
 2 be sending a further note re: Meditech search  
 3 for ER/PR pathology reports." But the  
 4 original e-mail that you were forwarding was  
 5 from Terry Gulliver to yourself, Dr. Reza,  
 6 July 24th '07. The subject is ER/PR clinical  
 7 cut off points, and he says "Reza, as per your  
 8 request, here is a summary of the  
 9 guidelines/process used from July 2005 onwards  
 10 to select patients for possible retest at  
 11 Mount Sinai." And then there's a fairly  
 12 detailed description here, ten numbered  
 13 paragraphs and other things, okay.  
 14 So you had known about this, this 30 and  
 15 10 issue and cut offs, clinical cut off  
 16 points, dating back to late July, and the  
 17 document we just looked at is, I believe,  
 18 September. The letter to Ms. Pilgrim is  
 19 toward the end of September. You refer to  
 20 this 30 at the time, you're using the 30 to be  
 21 careful. Did you, at that time, by the end of  
 22 September, did you have any reason to believe  
 23 that some authorities might have been using  
 24 less than 30 all along?  
 25 DR. ALAGHEHBANDAN:

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1 A. Yeah.  
 2 COFFEY, Q.C.:  
 3 Q. And St. John's was using 10 and 30?  
 4 DR. ALAGHEHBANDAN:  
 5 A. I appreciate your question. ER/PR is a  
 6 subjective test.  
 7 COFFEY, Q.C.:  
 8 Q. Yes.  
 9 DR. ALAGHEHBANDAN:  
 10 A. And we all know that, and the clinical  
 11 guideline is not a concrete guideline. It's a  
 12 controversial guideline. Some centres go by  
 13 ten, 30, zero, one. This is the information  
 14 that I received from Mr. Gulliver, who is not  
 15 a clinician, and I appreciate that he received  
 16 this information from either oncologists or  
 17 pathologists. Relying on this information, we  
 18 decided to be on the safe side, just to  
 19 basically going by less than 30, regardless of  
 20 the year. So as Dr. MacDonald mentioned, that  
 21 was mostly for, I guess, not underestimating  
 22 as opposed to overestimating here in this  
 23 matter. That's why we chose 30, as opposed to  
 24 being much more precise, saying that for this  
 25 time period, less than ten, for the other time

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1 period, less than 30.  
 2 COFFEY, Q.C.:  
 3 Q. Okay.  
 4 THE COMMISSIONER:  
 5 Q. I'm missing a step here. I'm not sure how  
 6 they got on your list in the first place if a  
 7 source of your list was either Mr. Gulliver or  
 8 Ms. Predham. So how did they get there?  
 9 Presumably, Mr. -  
 10 DR. MACDONALD:  
 11 A. We had all the pathology reports sent in from  
 12 the authorities as another source.  
 13 DR. ALAGHEHBANDAN:  
 14 A. From the regions.  
 15 THE COMMISSIONER:  
 16 Q. So you would have, in making up--in  
 17 establishing your list, you would have done an  
 18 independent look at all of the pathology  
 19 reports?  
 20 DR. ALAGHEHBANDAN:  
 21 A. That's right, from the regions.  
 22 THE COMMISSIONER:  
 23 Q. From the regions, okay, but not within St.  
 24 John's?  
 25 DR. ALAGHEHBANDAN:

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

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1 if a patient needed to be retested. He asked  
 2 that the pathologists/technologists in each  
 3 lab review all of their ER/PR results and send  
 4 to Barry Dyer and myself. We received batches  
 5 of patients and their original block slides  
 6 and control slides every week for a couple of  
 7 months."  
 8 Paragraph eight, "each batch received by  
 9 Barry and I, we then made a retesting  
 10 spreadsheet for the referring site, example,  
 11 Western Memorial, by year. This was exactly  
 12 the same as we did for St. John's patients.  
 13 This process of logging and documenting the  
 14 out-of-town patients took until about the end  
 15 of October 2005. Remember that Mount Sinai by  
 16 then had already received hundreds of blocks  
 17 for retest and were starting to get results  
 18 back from the St. John's patients and still  
 19 packing up out of town blocks and sending."  
 20 Number nine, "the out-of-town patients  
 21 were reviewed by the pathologist from the  
 22 referring site to determine the clinical cut  
 23 off results as provided by the oncologists.  
 24 The block slides were reviewed by our  
 25 pathologists to ensure that we had a good

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1 block for retesting. We discovered, after the  
 2 out-of-town results started to come back, that  
 3 they did not review their patient list and  
 4 remove patients that were deceased. Hence the  
 5 reason why we have about 175 deceased patients  
 6 retested."  
 7 Number nine, "once results started to  
 8 come back, they were reviewed by our  
 9 pathologists and then the new results from  
 10 Mount Sinai were added to the patients  
 11 original report in our LIS Meditech system and  
 12 a new report generated with both the original  
 13 and new results."  
 14 So did you understand that there was any  
 15 filtering going on in St. John's from the out-  
 16 of-town -  
 17 DR. ALAGHEHBANDAN:  
 18 A. Before the sample is being sent to Mount  
 19 Sinai.  
 20 COFFEY, Q.C.:  
 21 Q. You understood there was?  
 22 DR. ALAGHEHBANDAN:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. That they were, they were pulling out the

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1 deceased, if they knew about it, if they knew  
 2 -  
 3 DR. ALAGHEHBANDAN:  
 4 A. If they knew about it, yes.  
 5 COFFEY, Q.C.:  
 6 Q. And other than that, they were -  
 7 DR. ALAGHEHBANDAN:  
 8 A. Checking the appropriateness of the blocks.  
 9 COFFEY, Q.C.:  
 10 Q. Appropriateness of the blocks.  
 11 DR. ALAGHEHBANDAN:  
 12 A. If the sample was enough there for retesting.  
 13 COFFEY, Q.C.:  
 14 Q. How about the 30, 10 issue? If, for example,  
 15 Carbonear sent--not Carbonear. Say Western  
 16 sent one--better still, I'll use Central.  
 17 Central sent one that was 20 in 2002, for  
 18 retesting. Did you have any understanding -  
 19 DR. ALAGHEHBANDAN:  
 20 A. We learned from Carbonear that Carbonear  
 21 initially sent only the zeros, technical  
 22 negatives, and not clinical negatives, and  
 23 obviously at the time probably they were  
 24 looking at it, but not from that point of view  
 25 that looking at it from clinical, you know,



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1 cut off point.  
 2 COFFEY, Q.C.:  
 3 Q. Did you have any understanding, ever get any  
 4 understanding that in St. John's, the lab,  
 5 someone in the lab, connected with the lab,  
 6 was screening out patients for retesting, out-  
 7 of-town patients, out of St. John's patients,  
 8 screening them out for retesting based upon  
 9 the fact that they didn't meet the ten or 30  
 10 criteria?  
 11 DR. ALAGHEHBANDAN:  
 12 A. I'm not sure about that.  
 13 COFFEY, Q.C.:  
 14 Q. Okay. The suitability of the block is  
 15 referred to here, yes.  
 16 DR. ALAGHEHBANDAN:  
 17 A. Definitely.  
 18 COFFEY, Q.C.:  
 19 Q. But you'll notice here that Mr. Gulliver says  
 20 that he told you that the out-of-town patients  
 21 were reviewed by the pathologists from the  
 22 referring site, the out-of-town site, to  
 23 determine the clinical cut off results as  
 24 provided by the oncologists. So the  
 25 assumption was -

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1 DR. ALAGHEHBANDAN:  
 2 A. It was a screen at the primary site and then  
 3 being sent to St. John's.  
 4 THE COMMISSIONER:  
 5 Q. You would have had, I assume, the  
 6 communication from Central to Mr. Gulliver or  
 7 Dr. Cook, or whoever it was that they sent it  
 8 to, saying "here is my list of patients for  
 9 retesting"?  
 10 DR. ALAGHEHBANDAN:  
 11 A. Plus the original scores.  
 12 THE COMMISSIONER:  
 13 Q. Yes.  
 14 DR. ALAGHEHBANDAN:  
 15 A. I came across -  
 16 THE COMMISSIONER:  
 17 Q. So would you have--are you confident that, in  
 18 terms of the list that came from Western or  
 19 Central or wherever it came from, somewhere  
 20 along the way, by the end, you had a retest  
 21 result for all of those patients?  
 22 DR. ALAGHEHBANDAN:  
 23 A. If it happened back in '05, yes. If it  
 24 happened, for example, in '07, we would have  
 25 basically waited to hear back from Mount--from

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1 Eastern Health and then from Mount Sinai. For  
 2 instance, the deceased group, where it was  
 3 sent in August, in July '07.  
 4 THE COMMISSIONER:  
 5 Q. Um-hm.  
 6 DR. ALAGHEHBANDAN:  
 7 A. And we indicated to Eastern Health that we  
 8 understand that this batch has been sent in  
 9 '07, July, and please inform us as soon as you  
 10 receive the information back, so we can update  
 11 the database. So it depends on the timing.  
 12 THE COMMISSIONER:  
 13 Q. All right. So if it was sent in 2005 from  
 14 Central and you had that list, you know that  
 15 on your database, each of those names is  
 16 reflected and there is a retest result from  
 17 Mount Sinai?  
 18 DR. ALAGHEHBANDAN:  
 19 A. We could cross reference them.  
 20 THE COMMISSIONER:  
 21 Q. Yes.  
 22 DR. ALAGHEHBANDAN:  
 23 A. Because we had the pathology reports from the  
 24 regions and that was one of our ways to go and  
 25 cross reference making sure that those who

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

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1 and others, and this is a presentation, at  
 2 least a draft of a presentation entitled  
 3 "Database Development, Patient Listing and  
 4 Communications Events, ER/PR Retesting,  
 5 Preliminary Results. Presentation to the  
 6 Department of Health and Community Services,  
 7 October 19th, 2007."  
 8 There are here, just a couple of things I  
 9 wanted to ask you about, just to comment upon.  
 10 Here under the heading, it says,  
 11 "preliminary"--it's page five of the exhibit,  
 12 "preliminary analysis as of October 19th,  
 13 2007," and there's certain numbers given for  
 14 the total number of records and the total  
 15 number of unique patients and broken down by  
 16 gender. Total number of deceased are--I  
 17 apologize. I apologize, there it is.  
 18 Apologize, it's page six. I apologize,  
 19 Commissioner. Total number of deceased is 296  
 20 based on the mortality system as of June 2007.  
 21 I wanted to ask you about this.  
 22 I take it that NLCHI, when you got  
 23 involved in this, did hook--as you got your  
 24 database up and fronting, did connect it or  
 25 did access the Provincial Mortality Database?

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1 DR. ALAGHEHBANDAN:  
 2 A. That's right.  
 3 COFFEY, Q.C.:  
 4 Q. Electronically, you could do that?  
 5 DR. ALAGHEHBANDAN:  
 6 A. That's right.  
 7 COFFEY, Q.C.:  
 8 Q. And in the course of your involvement in this  
 9 matter, did you come to learn anything about  
 10 whether or not Eastern Health had ever used  
 11 it?  
 12 DR. ALAGHEHBANDAN:  
 13 A. No, I believe they don't.  
 14 COFFEY, Q.C.:  
 15 Q. Here, just looking at this, this is October  
 16 19th, 2007 that you're presenting a draft of  
 17 your presentation. It says "based on the  
 18 mortality system as of June 2007." So how up  
 19 to date, in your experience, is the Mortality  
 20 Database?  
 21 DR. ALAGHEHBANDAN:  
 22 A. I'm just going to pass it on to Dr. MacDonald  
 23 because that's his expertise.  
 24 COFFEY, Q.C.:  
 25 Q. Yes.

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1 DR. MACDONALD:  
 2 A. Currently, we're usually only a couple of  
 3 months behind now before they get entered in  
 4 and quality assurance put on it.  
 5 COFFEY, Q.C.:  
 6 Q. So it's about a two-month lag?  
 7 DR. MACDONALD:  
 8 A. Two or three month lag.  
 9 COFFEY, Q.C.:  
 10 Q. Two or three month lag time, and here, Dr.  
 11 Reza, you've written, "for the purpose of  
 12 analysis, looking at unique patients, an  
 13 assumption was made that if a patient was  
 14 tested, retested at Mount Sinai more than once  
 15 and had a status change, example, from  
 16 negative to positive, only the worst case  
 17 scenario was retained." What does that refer  
 18 to?  
 19 DR. ALAGHEHBANDAN:  
 20 A. Let me just give you an example. We had--we  
 21 have a patient here who had two specimens  
 22 being sent to Mount Sinai for retesting, for  
 23 example. Mount Sinai reported it back, on the  
 24 first one, a changed result; on the second  
 25 one, no changed result. For the purpose of

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1 this analysis, we used the one that had a  
 2 changed result.  
 3 COFFEY, Q.C.:  
 4 Q. Okay, for dealing with that particular  
 5 patient?  
 6 DR. ALAGHEHBANDAN:  
 7 A. For that particular patient. So we were  
 8 dealing with a unique patient as opposed to  
 9 number of records, because a patient may have  
 10 had more than two records.  
 11 COFFEY, Q.C.:  
 12 Q. Yes, so in terms of the unique patients, if  
 13 the patient had more than one retest, then the  
 14 worst case one, which is the conversion, as it  
 15 were -  
 16 DR. ALAGHEHBANDAN:  
 17 A. That's right.  
 18 COFFEY, Q.C.:  
 19 Q. - and I'll use that phrase advisedly, the  
 20 changed result would be the one that you would  
 21 record for that unique patient?  
 22 DR. ALAGHEHBANDAN:  
 23 A. For the purpose of the analysis, that's right.  
 24 COFFEY, Q.C.:  
 25 Q. But your database kept track of, for unique

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1 records -  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's right.  
 4 COFFEY, Q.C.:  
 5 Q. - of any particular block that did or didn't  
 6 have a change in results?  
 7 DR. ALAGHEHBANDAN:  
 8 A. Correct.  
 9 DR. MACDONALD:  
 10 A. And that was another database management  
 11 property of the database, whether we're  
 12 talking about tests or unique patients.  
 13 COFFEY, Q.C.:  
 14 Q. Yes.  
 15 DR. MACDONALD:  
 16 A. So we always had to be--we would qualify this,  
 17 because we're talking about, in this  
 18 particular context, the deceased, we have to  
 19 talk about the individual and therefore we had  
 20 to separate those individuals who had more  
 21 than one test.  
 22 COFFEY, Q.C.:  
 23 Q. And here, one thing I wanted to ask you, Dr.  
 24 Reza about is this, is in the course of your  
 25 involvement in this matter, did you ever

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1 become aware of situations where a patient had  
 2 been ER/PR tested years ago, back, I'll just,  
 3 I'll pick say in 2002, and had a negative  
 4 result and then in 2003, you know, pick a  
 5 year, was retested, same sample retested, and  
 6 the result was positive?  
 7 DR. ALAGHEHBANDAN:  
 8 A. On the same sample?  
 9 COFFEY, Q.C.:  
 10 Q. On the same sample.  
 11 DR. ALAGHEHBANDAN:  
 12 A. I can't recall that, but probably on a  
 13 separate tissue sample, yes.  
 14 COFFEY, Q.C.:  
 15 Q. Okay, no, on the same sample was retested, and  
 16 the issue of whether or not that patient or  
 17 that patient's samples were ever retested at  
 18 Mount Sinai. You recall I said 2002 and 2003  
 19 and of course, Mount Sinai is '05 and '06.  
 20 DR. ALAGHEHBANDAN:  
 21 A. Right.  
 22 COFFEY, Q.C.:  
 23 Q. So was it ever brought to your attention that,  
 24 in the course of originally identifying  
 25 patients, that those patients were weeded out,

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1 as it were?  
 2 DR. ALAGHEHBANDAN:  
 3 A. No, but I just want to clarify here. First of  
 4 all, I never came across such a patient, but  
 5 if we came and if we knew that the patient was  
 6 tested and again retested in house, yet our  
 7 assumption would have been that this patient  
 8 must have been sent to Mount Sinai, no matter  
 9 had the patient got retested once or twice in  
 10 house. But matter of fact, I never come  
 11 across any of those patients.  
 12 COFFEY, Q.C.:  
 13 Q. In terms of actually retested in house before  
 14 2005?  
 15 DR. ALAGHEHBANDAN:  
 16 A. Before 2005.  
 17 COFFEY, Q.C.:  
 18 Q. Because there were a number of them retested  
 19 in house in '05.  
 20 DR. ALAGHEHBANDAN:  
 21 A. Right.  
 22 COFFEY, Q.C.:  
 23 Q. And ended up at Mount Sinai as well.  
 24 DR. ALAGHEHBANDAN:  
 25 A. That's correct.

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1 COFFEY, Q.C.:  
 2 Q. But retested before '05 in house, you didn't  
 3 come across?  
 4 DR. ALAGHEHBANDAN:  
 5 A. No.  
 6 COFFEY, Q.C.:  
 7 Q. Okay.  
 8 THE COMMISSIONER:  
 9 Q. Dr. MacDonald, on the point of the use of the  
 10 Provincial Mortality Database, is there any  
 11 impediment to Eastern Health having easy  
 12 access to that?  
 13 DR. MACDONALD:  
 14 A. No, they wouldn't have access to the  
 15 provincial database. They would certainly  
 16 have, in their own Meditech system, those  
 17 patients that they were interested in who had  
 18 died in hospital. 99 percent of the people do  
 19 die in hospital. So for their own region,  
 20 yes, they would have access to the deceased  
 21 record. But this is a provincial database and  
 22 only the Centre has access to the provincial  
 23 database.  
 24 THE COMMISSIONER:  
 25 Q. So it would not have been--I'm just thinking

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1 in terms of--one of the problems we've been  
 2 told in this whole process was the matter of  
 3 the ability to identify exactly who was  
 4 deceased, and I'm not talking about  
 5 necessarily what they did in respect, as I  
 6 understand it, to the concern about recent  
 7 deceased was check obituaries and that kind of  
 8 thing, but it wasn't just confined to the last  
 9 month or two. So I was wondering if, outside  
 10 of what was contained within the institution,  
 11 there was another way of checking with the  
 12 provincial database as to whether or not  
 13 specific patients might be alive or not. But  
 14 that wouldn't have been easily done?  
 15 DR. MACDONALD:  
 16 A. Not--oh, it certainly would have been easily  
 17 done if they had asked.  
 18 THE COMMISSIONER:  
 19 Q. Okay.  
 20 DR. MACDONALD:  
 21 A. The database has been around for many years.  
 22 We were not asked.  
 23 THE COMMISSIONER:  
 24 Q. So, okay, if the hospital had that kind of  
 25 problem, then do I take it had they made the

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1 contact with the appropriate officials, there  
 2 might have been a way of determining whether  
 3 or not the people on the list, in fact, had  
 4 died?  
 5 DR. MACDONALD:  
 6 A. Yes.  
 7 THE COMMISSIONER:  
 8 Q. All right, thank you.  
 9 COFFEY, Q.C.:  
 10 Q. Look at, just to go a bit further through  
 11 this, in relation to this, page 11 of the  
 12 exhibit, and within the database, how many of  
 13 the negatives were deceased. In other words,  
 14 you've written here, "as of February 2006,  
 15 using the updated criteria, 237 negative  
 16 patients were deceased. 248 patients were  
 17 deceased in total. As of November 23rd, 2006,  
 18 using the updated criteria, 264 negative  
 19 patients were deceased. 281 patients were  
 20 deceased in total." The choice of November  
 21 23rd, 2006, why that date? Is that the date  
 22 that the -  
 23 DR. ALAGHEHBANDAN:  
 24 A. I believe -  
 25 COFFEY, Q.C.:

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1 Q. That's a briefing note?  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's correct, yes.  
 4 COFFEY, Q.C.:  
 5 Q. Provided to -  
 6 DR. ALAGHEHBANDAN:  
 7 A. The Minister.  
 8 COFFEY, Q.C.:  
 9 Q. - Minister Tom Osborne.  
 10 DR. ALAGHEHBANDAN:  
 11 A. I can't recall who was the Minister at the  
 12 time, yes.  
 13 COFFEY, Q.C.:  
 14 Q. And as of May 18th, that would be the date  
 15 that Mr. Tilley held a press conference?  
 16 DR. ALAGHEHBANDAN:  
 17 A. I believe so.  
 18 COFFEY, Q.C.:  
 19 Q. Okay. These dates, were they ones that you  
 20 came up with or were you asked to -  
 21 DR. ALAGHEHBANDAN:  
 22 A. We were asked.  
 23 COFFEY, Q.C.:  
 24 Q. Mr. Thompson asked that -  
 25 DR. ALAGHEHBANDAN:

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1 A. By Mr. Thompson.  
 2 COFFEY, Q.C.:  
 3 Q. - as of those dates?  
 4 DR. ALAGHEHBANDAN:  
 5 A. That's right.  
 6 COFFEY, Q.C.:  
 7 Q. Here in this, question 4A poses "how many of  
 8 the patients sent for retesting had ER status  
 9 changes and how many did not have ER status  
 10 changes?" and I should actually, perhaps  
 11 before I get to that, Commissioner, I wanted  
 12 to have Dr. Reza clarify something here, in  
 13 terms of the context here, because by the time  
 14 you're involved here now. You've noted on  
 15 page five of this slide presentation that  
 16 "Eastern Health had reported way back there  
 17 were 939 negative ER patients retested at  
 18 Mount Sinai, November/December '06. 176  
 19 reported as deceased. The existing database,  
 20 NLCHI, does not match with the 939," and then  
 21 you've noted on the next page here, page six,  
 22 "preliminary analysis as of October 19th,  
 23 2007, the total number of records is 1,195.  
 24 The total number of unique patients is 1,032."  
 25 DR. ALAGHEHBANDAN:

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1 A. That's right.  
 2 COFFEY, Q.C.:  
 3 Q. So 939, you've identified a not insignificant  
 4 number more than 939 by that point?  
 5 DR. ALAGHEHBANDAN:  
 6 A. That's right.  
 7 COFFEY, Q.C.:  
 8 Q. And then here then, apologize, here in page 12  
 9 of this, question 4A, and I appreciate again  
 10 this is as of that date, "how many of the  
 11 patients sent for retesting had ER status  
 12 changes and how many did not have ER status  
 13 changes? 392 patients sent for retesting had  
 14 ER status change. 504 patients sent for  
 15 retesting had no ER status change." This is,  
 16 it was just ER?  
 17 DR. ALAGHEHBANDAN:  
 18 A. That's right.  
 19 COFFEY, Q.C.:  
 20 Q. This doesn't include someone who, for example,  
 21 went from an ER negative PR positive to an ER  
 22 negative PR negative?  
 23 DR. ALAGHEHBANDAN:  
 24 A. We did not consider PR here.  
 25 COFFEY, Q.C.:

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1 Q. Yes.  
 2 DR. ALAGHEHBANDAN:  
 3 A. We just considered ER.  
 4 COFFEY, Q.C.:  
 5 Q. And this would be then, these numbers here  
 6 were based upon, as they existed at the time,  
 7 I take it, the results from Mount Sinai?  
 8 DR. ALAGHEHBANDAN:  
 9 A. That's right.  
 10 COFFEY, Q.C.:  
 11 Q. Mount Sinai results. And now status change,  
 12 at that point, you were defining status change  
 13 as what?  
 14 DR. ALAGHEHBANDAN:  
 15 A. If you go back to previous slides, it's been  
 16 noted as less than 30 up to 2000, less than  
 17 ten after 2000.  
 18 COFFEY, Q.C.:  
 19 Q. So that's the critical--the clinical criteria?  
 20 DR. ALAGHEHBANDAN:  
 21 A. Clinical time line.  
 22 COFFEY, Q.C.:  
 23 Q. That Mr. -  
 24 DR. ALAGHEHBANDAN:  
 25 A. Was defined.

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1 COFFEY, Q.C.:  
 2 Q. - Gulliver had sent to you back in July, in  
 3 terms of their criteria for retesting?  
 4 DR. ALAGHEHBANDAN:  
 5 A. And we confirmed it with other parties as  
 6 well.  
 7 COFFEY, Q.C.:  
 8 Q. So sir, I'm going to ask, please, Registrar,  
 9 you bring up Exhibit P-1025. Now this is--the  
 10 first page of this is an e-mail from Mr.  
 11 Thompson to Mr. MacDonald here, October 27,  
 12 2007, draft notes, and he says "Reza, these  
 13 are my draft notes on this morning's meeting.  
 14 If you have time, could you give them a scan  
 15 to see if they reflect your understandings as  
 16 well. If so, I'll base my communications with  
 17 Louise to tell her the outcomes and with the  
 18 other CEOs accordingly." Look at the very  
 19 next page. It's a draft of some notes of a  
 20 meeting of October 27th 2007, meeting  
 21 regarding outstanding ER/PR data retest and  
 22 communications issues at Department of Health  
 23 and Community Services boardroom. Attendance  
 24 are Ms. Jones, Mr. Gulliver, Ms. Pilgrim, Ms.  
 25 Predham, Dr. Reza and Mr. Thompson in his

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

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

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

20 DR. MACDONALD:

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

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

17 COFFEY, Q.C.:

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

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1 the direct contact with living patients is  
 2 necessary. Their communications director is  
 3 currently planning an approach and will be in  
 4 touch with the Department. Though the  
 5 communications from other regional health  
 6 authorities may be needed as well, further  
 7 checking with them is necessary, first to  
 8 determine whether any of the cases noted above  
 9 are truly 'missed'--'missed cases' or whether  
 10 they were not sent for retesting based on  
 11 valid reasons. As well, the list of October  
 12 26th, cases for which patient contact is  
 13 unknown, may contain some cases from the other  
 14 regional health authorities. Until we know  
 15 from Eastern Health which of these cases were  
 16 not contacted by Eastern Health, we will not  
 17 know which cases to send to the other regional  
 18 health authorities with the same question."

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

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1 and who arguably, perhaps, should have been.

2 DR. MACDONALD:

3 A. Yes, that's -

4 COFFEY, Q.C.:

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

6 DR. MACDONALD:

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

25 COFFEY, Q.C.:

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1 Q. I take it in identifying--investigatory  
 2 identifying role and then an intermediary  
 3 role, if necessary, between the authorities?  
 4 DR. MACDONALD:  
 5 A. Yeah. We were in the best position to know  
 6 what the question was and try to get the  
 7 answer, and we would go to the sources and  
 8 sometimes we would bounce around a bit until  
 9 we actually found the source.  
 10 COFFEY, Q.C.:  
 11 Q. If we could, in relation to this, P-1026,  
 12 please, 10-26? This is an e-mail of October  
 13 27th from Mr. Thompson to yourself, Mr.  
 14 MacDonald. Subject is draft notes and he says  
 15 "Don and Reza, I need to know when you were  
 16 first advised that the Carbonear specimens had  
 17 indeed been sent for retesting. The October  
 18 24th spreadsheet says they were sent to Mount  
 19 Sinai on September 27th. Was this spreadsheet  
 20 the first time we knew? My reason for asking  
 21 is that I'm puzzled why Eastern Health is only  
 22 now contemplating making phone calls to these  
 23 people and did not do so at the same time as  
 24 samples sent to Mount Sinai. My question does  
 25 not reflect upon you at all. I just want to

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

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

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1 had all gone through, you discovered that  
 2 there were patients who A. were not on your  
 3 list, and B. would seem to meet the criteria  
 4 for retesting?  
 5 DR. ALAGHEHBANDAN:  
 6 A. That's correct.  
 7 THE COMMISSIONER:  
 8 Q. So you asked the question as to what happened  
 9 to these folks?  
 10 DR. ALAGHEHBANDAN:  
 11 A. That's correct.  
 12 THE COMMISSIONER:  
 13 Q. And learned that it had been -  
 14 DR. ALAGHEHBANDAN:  
 15 A. Following to that letter, they basically  
 16 compiled the list and sent them to Mount  
 17 Sinai.  
 18 THE COMMISSIONER:  
 19 Q. Okay. That was the order. It was not that  
 20 they were just late doing them.  
 21 DR. ALAGHEHBANDAN:  
 22 A. No.  
 23 THE COMMISSIONER:  
 24 Q. It was on the basis, it was your letter -  
 25 DR. ALAGHEHBANDAN:

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1 A. The letter generated -  
 2 THE COMMISSIONER:  
 3 Q. - that moved people to ask questions about  
 4 these particular individuals and, in fact,  
 5 take the action of sending the -  
 6 DR. ALAGHEHBANDAN:  
 7 A. The letter prompted the action actually.  
 8 THE COMMISSIONER:  
 9 Q. Thank you.  
 10 DR. ALAGHEHBANDAN:  
 11 A. You're welcome.  
 12 COFFEY, Q.C.:  
 13 Q. Now just, because again, so in respect of when  
 14 I say non-Eastern Health, I mean, non St.  
 15 John's, okay, for all the hospitals outside  
 16 St. John's, and I'll come back to Clarendville  
 17 eventually, remember to do that, but for  
 18 Carbonear, for Gander, Grand Falls, Corner  
 19 Brook and St. Anthony, you got, you  
 20 understood, all of the pathology reports,  
 21 positive and negatives?  
 22 DR. ALAGHEHBANDAN:  
 23 A. Negatives.  
 24 COFFEY, Q.C.:  
 25 Q. Negatives. Did you ever get the positives?

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1 DR. ALAGHEHBANDAN:  
 2 A. No, we didn't ask for positives. We asked for  
 3 negatives.  
 4 COFFEY, Q.C.:  
 5 Q. Negatives. And do you define what negatives  
 6 were in asking for them?  
 7 DR. ALAGHEHBANDAN:  
 8 A. I'm just trying to think when we requested  
 9 that. I think we requested that through the  
 10 Department of Health back in July '07 asking  
 11 for all pathology reports with ER/PR negative,  
 12 negative ER/PR. I'm not sure if we--in that  
 13 e-mail, we defined negativity per se, but I  
 14 can recall that we requested that through the  
 15 Department, asking for all negative ER/PR  
 16 pathology reports from the regions.  
 17 COFFEY, Q.C.:  
 18 Q. So have you ever looked through the St. John's  
 19 pathology reports?  
 20 DR. ALAGHEHBANDAN:  
 21 A. The answer is yes and no.  
 22 COFFEY, Q.C.:  
 23 Q. I mean, on -  
 24 DR. ALAGHEHBANDAN:  
 25 A. I have to explain.

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

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



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1 '99 negative, I'm sorry, a five, an '05 a  
 2 negative, an '04 a negative, a '99 a 10 to 20,  
 3 and we get further down though, you get into  
 4 like 2003, a 20 to 30. A 2004 case, a 20 to  
 5 30; a 2003 case, 20 to 30. Just wondering, if  
 6 you asked that people send you the negatives -  
 7 DR. ALAGHEHBANDAN:  
 8 A. We did.  
 9 COFFEY, Q.C.:  
 10 Q. Why were you getting all these 20s to 30s?  
 11 DR. ALAGHEHBANDAN:  
 12 A. I don't know. It was basically sent to us. I  
 13 don't know what criteria they chose to select  
 14 their pathology reports, but we simply asked  
 15 for negative ER/PR pathology reports.  
 16 COFFEY, Q.C.:  
 17 Q. Now up until September, and you're involved in  
 18 this exercise with Ms. Pilgrim, were you aware  
 19 of any patients having self-identified up to  
 20 that point?  
 21 DR. ALAGHEHBANDAN:  
 22 A. I was aware of the fact that there were a  
 23 number of patients who called in and self-  
 24 identified themselves to Eastern for the  
 25 matter of retesting, and that group of people,

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1 their samples were sent to Mount Sinai, if I'm  
 2 understanding it correctly--if I recall it  
 3 correctly, back in July '07. There were a  
 4 number of patients, I would say less than ten  
 5 patients, during the course of ER/PR, I  
 6 recall, after August '05, up to that point.  
 7 COFFEY, Q.C.:  
 8 Q. Did you say '07 or--the self-identified ones,  
 9 '08, actually?  
 10 DR. ALAGHEHBANDAN:  
 11 A. '07, July, '07, their samples were sent to  
 12 Mount Sinai because there were two sets of  
 13 self-identified patients. One set between '05  
 14 and '07.  
 15 COFFEY, Q.C.:  
 16 Q. Okay.  
 17 DR. ALAGHEHBANDAN:  
 18 A. And then we had a group of self-identified  
 19 patients in '08. I'm speaking to the first  
 20 group.  
 21 COFFEY, Q.C.:  
 22 Q. Yes.  
 23 DR. ALAGHEHBANDAN:  
 24 A. We were not involved with that. That occurred  
 25 prior to July '07.

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1 COFFEY, Q.C.:  
 2 Q. Did you get an explanation as to how they had  
 3 been missed?  
 4 DR. ALAGHEHBANDAN:  
 5 A. I spoke to Mr. Gulliver and the main reason  
 6 was that ER/PR entry code was not basically  
 7 entered into that appropriate box within  
 8 Meditech when the test was ordered, however,  
 9 the test was performed, yet the test was not  
 10 ordered technically within the Meditech  
 11 system.  
 12 COFFEY, Q.C.:  
 13 Q. So really in '07--when you first got involved,  
 14 really in the first two months, you realized  
 15 speaking to Mr. Gulliver that not all the time  
 16 that an ER/PR test was actually done, was the  
 17 appropriate box checked in Meditech?  
 18 DR. ALAGHEHBANDAN:  
 19 A. That's correct.  
 20 COFFEY, Q.C.:  
 21 Q. And if it wasn't checked in Meditech, he  
 22 hadn't found it?  
 23 DR. ALAGHEHBANDAN:  
 24 A. Because he searched by ER and PR procedure  
 25 codes, so he would not have been able to

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1 capture them through that exercise.  
 2 COFFEY, Q.C.:  
 3 Q. And so you understood that back -  
 4 DR. ALAGHEHBANDAN:  
 5 A. That was a limitation back then.  
 6 COFFEY, Q.C.:  
 7 Q. Limitation back then.  
 8 DR. ALAGHEHBANDAN:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And that has resurfaced again now in 2008.  
 12 DR. ALAGHEHBANDAN:  
 13 A. That's right.  
 14 COFFEY, Q.C.:  
 15 Q. And we'll talk about that a bit. Was it  
 16 pursued any further at the time in 2007? I  
 17 mean, that limitation--I mean, if Mr. Gulliver  
 18 is telling you, look, Dr. Reza, I got about  
 19 ten or so patients who somebody didn't check  
 20 the right box, therefore, I, Mr. Gulliver,  
 21 didn't find them, was that pursued any further  
 22 at that time?  
 23 DR. ALAGHEHBANDAN:  
 24 A. I believe--well, first of all, I shared that  
 25 with Mr. Thompson's group, and also I believe

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1 Mr. Gulliver shared that with his group at  
 2 Eastern Health. So that's something wasn't  
 3 unknown to anyone, it was known. As you  
 4 mentioned, again it resurfaced and prompted us  
 5 to a new search.  
 6 COFFEY, Q.C.:  
 7 Q. At the time, I take it, initially it wasn't  
 8 pursued, at least in '07?  
 9 DR. ALAGHEHBANDAN:  
 10 A. That's correct.  
 11 THE COMMISSIONER:  
 12 Q. Can I take it that Meditech does not have one  
 13 of those irritating little systems that  
 14 refuses to take any information unless you  
 15 fill in all those boxes?  
 16 DR. ALAGHEHBANDAN:  
 17 A. I understand that's a fairly accurate  
 18 statement. As a matter of fact, if you don't  
 19 fill that ER/PR procedure code, it wouldn't  
 20 give you an alarm, for example, window saying  
 21 that, okay, you can't proceed because you  
 22 haven't entered it into that system, and  
 23 that's how we have some basically self-  
 24 identified new patients because they were not  
 25 captured at the beginning through that ER/PR

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1 search strategy.  
 2 DR. MACDONALD:  
 3 A. It is a limitation to the lab system. We had  
 4 spoken to Eastern Health about that, that they  
 5 can actually enter a pathology report without  
 6 an order being included in the Meditech. They  
 7 recognize that now as a weakness.  
 8 COFFEY, Q.C.:  
 9 Q. So we've heard from a patient named Elizabeth  
 10 White as having been a person who self-  
 11 identified from Carbonear in the summer of  
 12 2007. Were you aware--were you made aware of  
 13 her at that time, in the summer of 2007, do  
 14 you recall?  
 15 DR. ALAGHEHBANDAN:  
 16 A. If we were notified of that individual,  
 17 definitely the patient would have been--the  
 18 patient's information entered into the  
 19 database, but I just don't have the detailed  
 20 recollection of that specifically.  
 21 COFFEY, Q.C.:  
 22 Q. Your memory of Carbonear, such as it is, is  
 23 that when Carbonear sent you a listing of  
 24 pathology reports, as we can see here, you  
 25 noticed, well, I don't have any retest results

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1 for a whole bunch of these?  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's correct.  
 4 COFFEY, Q.C.:  
 5 Q. And made the inquiry.  
 6 DR. ALAGHEHBANDAN:  
 7 A. And prompted us to write that letter.  
 8 COFFEY, Q.C.:  
 9 Q. So in coming--if we could look, please, at  
 10 Exhibit P-1028. Actually, no, I apologize. Go  
 11 right to P-1032, please. This is a letter of  
 12 October 29th, 2007. It's to Boyd Rowe, CEO,  
 13 Labrador Grenfell. It's from Mr. Thompson,  
 14 but I take it that in effect, Mr. MacDonald,  
 15 and Dr. Reza, this is--these are questions  
 16 that your organization wanted answered? Mr.  
 17 Thompson wanted them answered too, but, in  
 18 effect, you posed the questions?  
 19 DR. ALAGHEHBANDAN:  
 20 A. That's right.  
 21 COFFEY, Q.C.:  
 22 Q. And here then you have a List One attached  
 23 that you want answers to, and a List Two as  
 24 well attached, and there are people fall into  
 25 different categories there. I'm not going to

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1 take you--take the Commissioner through those  
 2 here in detail, but there are certain things  
 3 or information that you needed clarified or  
 4 provided from Labrador Grenfell. If we could  
 5 look at Exhibit P-1033. This is a letter of  
 6 the same date, October 29th, 2007. It's to  
 7 Karen McGrath, the CEO in Central, and again a  
 8 similar sort of exercise, a set of lists, and  
 9 questions associated with them.  
 10 DR. ALAGHEHBANDAN:  
 11 A. That's right.  
 12 COFFEY, Q.C.:  
 13 Q. That NLCHI needed information for. Exhibit P-  
 14 1035, please. Here is a letter of the same  
 15 date to Ms. Susan Gillam, the CEO of Western,  
 16 again the same thing, lists one and two  
 17 attached, and questions posed for information.  
 18 Just here, and I'll just use this one as an  
 19 example, at the bottom of the first page here  
 20 on your List One, this list contains patients  
 21 who were identified by Western to NLCHI as  
 22 having negative ER/PR results from '97 to '05  
 23 and also sent for retesting '05/'06. NLCHI  
 24 has been unable to find information with  
 25 Eastern Health's information systems, or in a

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

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1 DR. ALAGHEHBANDAN:  
 2 A. That's right.  
 3 COFFEY, Q.C.:  
 4 Q. That you wanted information in relation to.  
 5 DR. ALAGHEHBANDAN:  
 6 A. After we had the database, we could cross-  
 7 reference and link with other sources, so we  
 8 could compile this list as whether they had  
 9 been retested or whether they had been  
 10 communicated with.  
 11 COFFEY, Q.C.:  
 12 Q. And then, Mr. MacDonald, your organization  
 13 then was letting Mr. Thompson know there are  
 14 certain patients that we've identified that we  
 15 can't find any record that they were retested  
 16 or whatever, if they were communicated with,  
 17 and so on--I mean, there's a number of  
 18 different questions, particularly they weren't  
 19 tested or whether they were tested, retested,  
 20 whether they had been told about it. You  
 21 provided that to Mr. Thompson?  
 22 DR. MACDONALD:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. And the idea that--because here he is, in

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

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1 DR. ALAGHEHBANDAN:  
 2 A. Yes, we did receive responses from the  
 3 regions.  
 4 COFFEY, Q.C.:  
 5 Q. Yes, and addressing, I take it, whatever the  
 6 particular question was for particular  
 7 patients?  
 8 DR. ALAGHEHBANDAN:  
 9 A. We received responses from the regions. We  
 10 reviewed the responses. If we had questions,  
 11 we went back to the regions to clarify them.  
 12 Once we were comfortable with the information,  
 13 then we entered them into the database.  
 14 COFFEY, Q.C.:  
 15 Q. Now you recall we looked at September 20th  
 16 letter to Ms. Pilgrim, which again had five  
 17 lists on it. What happened with respect to  
 18 the response to that?  
 19 DR. ALAGHEHBANDAN:  
 20 A. We had that meeting that we just reviewed.  
 21 COFFEY, Q.C.:  
 22 Q. October 20th.  
 23 DR. ALAGHEHBANDAN:  
 24 A. We basically discussed the tables, and we  
 25 wanted to make sure that everyone understands

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1 what these tables are about and everyone is on  
 2 the same page, and there was further  
 3 discussion as how to proceed with the process.  
 4 COFFEY, Q.C.:  
 5 Q. And did you ever receive a response?  
 6 DR. ALAGHEHBANDAN:  
 7 A. We received a response from Eastern Health as  
 8 well.  
 9 COFFEY, Q.C.:  
 10 Q. And in relation then to the September 20th  
 11 letter, were all of those--eventually all of  
 12 those matters dealt with one way or the other  
 13 between yourself and Eastern Health?  
 14 DR. ALAGHEHBANDAN:  
 15 A. That's correct. If there was a matter of  
 16 clarity, again as I mentioned, we had to go  
 17 back to Eastern Health, to certain  
 18 individuals, to confirm or clarify the matter.  
 19 COFFEY, Q.C.:  
 20 Q. Okay. Mr. MacDonald, from your perspective  
 21 then, after that--when we get into late  
 22 October, 2007, from your perspective as the  
 23 director, how did this unfold? What's kind of  
 24 your next involvement in this?  
 25 DR. MACDONALD:

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1 A. With respect to the expanding role of -  
 2 COFFEY, Q.C.:  
 3 Q. Yes.  
 4 DR. MACDONALD:  
 5 A. We were asked to actually take a bigger role  
 6 other than just create the data, and we  
 7 certainly saw that we could provide that  
 8 expertise to both the task force and the  
 9 ministry, so--as I've said a couple of times,  
 10 it certainly--our role did expand and evolve  
 11 beyond just the creation of the database where  
 12 we became more, in some cases, a conduit to  
 13 the system, to make sure appropriate patient  
 14 care had been provided in some cases that may  
 15 have been missed, or certainly we would  
 16 investigate further with the system to ensure  
 17 that there was a valid reason why a person  
 18 wasn't tested. So it was expected that we  
 19 would do that, and we did it.  
 20 COFFEY, Q.C.:  
 21 Q. If you could look, please, at Exhibit 3499.  
 22 Now this is a document entitled  
 23 "Interpretation of statistical tables from  
 24 ER/PR database", draft, January 28th, 2008,  
 25 and then it's an introduction; total cases,

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1 there's a comparison of Eastern Health's  
 2 November 23rd, 2006, briefing for the Minister  
 3 with the new database results, there's at  
 4 paragraph four, a time frame for retesting,  
 5 including the number of cases by year of  
 6 original test, and I take it this was the  
 7 draft and you can see somebody has marked up  
 8 parts of it, handwriting. Paragraph five,  
 9 positivity rates, and then there's a table  
 10 there, and--Table A, B, C. Paragraph six,  
 11 changes in ER/PR scores after retesting.  
 12 Table D, Table E, change rate by region, and  
 13 then changes by site, paragraph seven, and  
 14 then it's a Table G. I may have skipped some  
 15 of the tables here, and then there's an  
 16 addendum with variation between reported data  
 17 and NLCHI database, the positivity rate, and  
 18 false negatives. Sir, what was going on here,  
 19 Mr. MacDonald, what was the reason for this  
 20 document being prepared, at whose request, and  
 21 who prepared it?  
 22 DR. MACDONALD:  
 23 A. The Centre's role in this document was to  
 24 provide the task force with an analysis. So  
 25 basically our role stopped after we provided

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1 the task force with the tables. We were asked  
 2 to review some of the content prepared and to  
 3 provide comments back, but this was an  
 4 initiative undertaken by the task force, and  
 5 my understanding is that it will be provided  
 6 to the Commission.  
 7 COFFEY, Q.C.:  
 8 Q. So the tables--Dr. Reza, you're nodding. The  
 9 tables were prepared at the request of the  
 10 task force, like, if they ask for a table of  
 11 whatever?  
 12 DR. MACDONALD:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. Of a particular type, "x" versus "y" or  
 16 whatever the data was. Asking for a  
 17 particular--something that could be provided  
 18 in a table.  
 19 DR. MACDONALD:  
 20 A. Yeah, and really it kind of grew, a few  
 21 questions, a few tables, okay, let's do these  
 22 tables, so we didn't really get a specific--  
 23 here's one stop shopping, do all that, it was  
 24 kind of an innovative thing that went back and  
 25 forth between us and the task force.

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1 COFFEY, Q.C.:

2 Q. But the editorial--I shouldn't say editorial,

3 the text comment here, was NLCHI involved in

4 that? Like, for example, introduction, this

5 note provides a summary interpretation of

6 statistical tables from NLCHI ER/PR database,

7 the tables address clinical issues only,

8 communications data will be forthcoming, and

9 it goes on from there. Would NLCHI have

10 prepared this?

11 DR. MACDONALD:

12 A. No.

13 COFFEY, Q.C.:

14 Q. That's just something that the--in your

15 understanding, the task force -

16 DR. MACDONALD:

17 A. We would certainly have reviewed it, but it

18 would have been written by the task force, and

19 we would have certainly--we wouldn't approve

20 it now, but we certainly would have reviewed

21 it before it went out.

22 COFFEY, Q.C.:

23 Q. And if you were asked to review and make--

24 asked for your input or commentary upon it,

25 you would have provided that?

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1 DR. MACDONALD:

2 A. Oh, yes.

3 COFFEY, Q.C.:

4 Q. Okay, and it's apparent when we look at this,

5 that some people have marked it up with

6 handwriting and so on. If we could look,

7 please, at Exhibit P-3500. This is a document

8 entitled "Interpretation of statistical tables

9 from the ER/PR database, draft, January 31st,

10 2008", and again just looking at this, for

11 example, this particular copy printed out has

12 the tracking changes. You can actually follow

13 it because of the way it's printed out here.

14 So--and it's got--now utilizing footnotes. If

15 we can go then, please, to Exhibit P-3501.

16 This is again an interpretation of statistical

17 tables from ER/PR database, draft, February

18 4th, 2008. This particular one, at page two

19 of it, you'll notice there are a number of

20 footnotes. See that, numbers one to four, and

21 number four footnote is the definition of

22 negative between '97 and 2000. It gives the

23 cutoff score of 30 percent, and after 2000, it

24 gives a cutoff score of 10 percent. "This is

25 consistent with the letter, September 6th,

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1 2005, from Dr. Cook to lab directors and

2 medical directors throughout the province, in

3 which instructions were given for the

4 selection of samples for retesting at Mount

5 Sinai. It's also consistent with Dr.

6 Khalifa's proposed cutoff as communicated in

7 his letter to pathologists on February 16th,

8 1998". I'm going to ask you, both of you, for

9 example, that sort of comment here on footnote

10 four, would NLCHI have provided that?

11 DR. ALAGHEHBANDAN:

12 A. We -

13 COFFEY, Q.C.:

14 Q. I'm not suggesting it's not accurate. I'm

15 just asking if you provided it.

16 DR. ALAGHEHBANDAN:

17 A. No, I understand your question. With respect

18 to this specific footnote, I believe this is

19 backed up by the letter from Dr. Cook to the

20 regions. We were asked about this--if we were

21 asked about this, probably we would have

22 provided the task force and Mr. Thompson's

23 group with e-mails and communications and

24 information that we received from Eastern

25 Health or other individuals. So--and we were

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1 basically, I guess, supporting the document or

2 providing input for the document--to the

3 document.

4 COFFEY, Q.C.:

5 Q. Exhibit P-3502, please, and there's an

6 interpretation of statistical tables from

7 estrogen receptor database, draft, February

8 5th, 2008. Now here if we could look, please,

9 at page seven, there are a series of

10 appendices and tables here, and this

11 particular one, for example, Appendix I,

12 results tables, based on NLCHI database

13 results in Appendix 3. So Table "A", entitled

14 "Number and percentage of original negative ER

15 tests and cases by year". So this is a sort

16 of data or data table that NLCHI would have

17 provided, Mr. MacDonald?

18 DR. MACDONALD:

19 A. That's correct.

20 COFFEY, Q.C.:

21 Q. And this would have been based upon,

22 presumably, a printout of what was in the, as

23 it then was, the SPSS database?

24 DR. MACDONALD:

25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. And Table "B", the positivity rate for ER

3 testing by year is there. Table "C",

4 positivity rate for original ER testing by

5 cutoff point by year. Table "D", change rates

6 of original negative ER tests as compared to

7 Mount Sinai results by year. Table "E",

8 change rates of original negative ER tests as

9 compared to Mount Sinai results by cutoff

10 point and by year. Table "F", retest results

11 and change rate of ER negative patients by

12 time period by region. Table "G", change rate

13 of ER negative patients by site of original

14 test, and then Appendix 2, variations between

15 reported data and the NLCHI database. This is

16 an analysis, I take it, or a comparison of

17 certain documents that Eastern Health had

18 utilized before the Commission was established

19 or before NLCHI ever got involved, and things

20 that you were finding in your database?

21 DR. ALAGHEHBANDAN:

22 A. I'm sorry?

23 COFFEY, Q.C.:

24 Q. This is a comparison -

25 DR. ALAGHEHBANDAN:

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1 A. This comparison is based on Mr. Gulliver's

2 calculation of positivity, and the other one,

3 I believe that comes from another individual,

4 and these numbers are not coming from the

5 database.

6 COFFEY, Q.C.:

7 Q. Okay, these are not from--yes, these are May

8 10th, 2007, data from Eastern Health, and May

9 16th, 2007, data from Dr. Hutton, and there's

10 a reference to false negatives. it goes on

11 then at some length with a number of other

12 tables. Now the request then for these

13 particular tables originated with whom?

14 DR. MACDONALD:

15 A. The task force.

16 COFFEY, Q.C.:

17 Q. Which would be Mr. Thompson, I take it?

18 DR. MACDONALD:

19 A. Yes.

20 COFFEY, Q.C.:

21 Q. Or somebody on his behalf?

22 DR. MACDONALD:

23 A. Yes. I would like to point out, though, that

24 myself, Reza, and Tracy Chislett, another

25 epidemiologists that worked closely on this,

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1 worked very closely with the task force and we

2 had many meetings, so a lot of questions would

3 have been generated out of our joint

4 discussions. I don't want to give the

5 impression that the Centre was just doing--

6 just doing the doings. We were actively

7 involved in trying to figure out how to answer

8 some questions that are being posed by

9 government, and again that gets into the

10 database management, information management,

11 and epidemiology, trying to answer a question

12 that probably is not very clear. So we played

13 an active role in trying to refine questions

14 and support analysis for it.

15 COFFEY, Q.C.:

16 Q. Mr. MacDonald, what did you understand in

17 really a summary form the questions that were

18 sought to be answered? What was your

19 understanding?

20 DR. MACDONALD:

21 A. Well, ultimately what we really wanted to

22 answer, and as you noted, tables go on at

23 length, and I suppose at that point we're

24 probably just looking under a whole bunch of

25 different rocks trying to answer the ultimate

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1 questions, have we identified each and every

2 patient affected by this testing, and have

3 they been communicated with, and has proper

4 treatment; if it had not been provided, is it

5 being provided now. Those were basically

6 what--the whole mandate we evolved towards.

7 So whether there was 20 different questions

8 coming out of those, those were the main ones.

9 COFFEY, Q.C.:

10 Q. Now there are tables, we've heard just in

11 passing, to comparisons of, for example,

12 retest results by region.

13 DR. MACDONALD:

14 A. Yes.

15 COFFEY, Q.C.:

16 Q. At times, I take it, there were questions

17 raised about, well, is this confined to a

18 particular region in particular time periods?

19 DR. MACDONALD:

20 A. The question or whether it was systemic across

21 the system or whether it was focused in on a

22 particular area had come up, yes.

23 COFFEY, Q.C.:

24 Q. And you've had, I take it, a fair amount of

25 time to consider various tables and so on.

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1 DR. MACDONALD:  
 2 A. There's been considerable analysis done, yes.  
 3 COFFEY, Q.C.:  
 4 Q. Was it confined to any one point in time,  
 5 first of all, any one point in time?  
 6 DR. MACDONALD:  
 7 A. I don't think we have a definite answer for  
 8 that. I think that question has been raised  
 9 now as to points along the continuum of '97 to  
 10 2005, there were some pinnacle points along  
 11 that line, and that it is possible that some  
 12 decisions made at certain points may have  
 13 impacted on what we're finding today. I don't  
 14 think we have an answer to that yet. We  
 15 haven't really delved into that analysis.  
 16 That's one of the things Eastern Health has  
 17 asked us to look at.  
 18 COFFEY, Q.C.:  
 19 Q. How about the regions, any particular--the  
 20 same question in relation to the regions?  
 21 DR. MACDONALD:  
 22 A. I don't think that has had the same focus as  
 23 the time continuum. We haven't really  
 24 concentrated much on the regional perspective  
 25 at all.

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

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1 1000 is 50. We would be concerned with the  
 2 500 out of 1000. So we didn't really have  
 3 numbers to substantiate some of the results we  
 4 found.  
 5 COFFEY, Q.C.:  
 6 Q. You might be into a situation, I take it, to  
 7 use the vernacular, that the sample size in a  
 8 particular region was so small that it  
 9 wouldn't be necessarily representative of the  
 10 quality of the work or the quality of the  
 11 output?  
 12 DR. MACDONALD:  
 13 A. And certainly, you know, we also--it's not  
 14 really a sample--it is a sample because we  
 15 didn't look at positives, and that's certainly  
 16 a limitation to our database. We've only  
 17 looked at negatives. So we do have a  
 18 population of negatives to the extent that we  
 19 are moving towards identifying each and every  
 20 patients. So in that sense, it's not a  
 21 sample. So from a pure statistical sense,  
 22 people would suggest you're using a census,  
 23 not a sample, and, therefore, what you find is  
 24 what you find, but nevertheless, because of  
 25 the small number of tests being performed in

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

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1 have a clear denominator. We don't have  
 2 something--what's the total number of cases.  
 3 I just mentioned that we have the total  
 4 population of negatives, but we don't have the  
 5 total population of ER/PR. So we've only got  
 6 a sample of the ER/PRs, albeit the population  
 7 of the negatives, if you can understand my  
 8 train of thought there.  
 9 COFFEY, Q.C.:  
 10 Q. Uh-hm.  
 11 DR. MACDONALD:  
 12 A. We don't know what the false negative or false  
 13 positive rate of the positives are and how  
 14 that would relate or correlate to the false  
 15 negative and positive of the negative, ER  
 16 negative. So it's--we don't have the complete  
 17 picture.  
 18 COFFEY, Q.C.:  
 19 Q. And I take it, at least up to this point in  
 20 time, I take it that's--well, amongst perhaps  
 21 other reasons, that's because you were never  
 22 asked to generate it?  
 23 DR. MACDONALD:  
 24 A. We certainly had some early discussions.  
 25 COFFEY, Q.C.:

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1 Q. Yes.  
 2 DR. MACDONALD:  
 3 A. But we -  
 4 COFFEY, Q.C.:  
 5 Q. Just chose, for practical reasons -  
 6 DR. MACDONALD:  
 7 A. It was--a pragmatic decision was made.  
 8 THE COMMISSIONER:  
 9 Q. Mr. Coffey, we are going to have to take that  
 10 luncheon break now.  
 11 COFFEY, Q.C.:  
 12 Q. Yes, thank you, Commissioner.  
 13 THE COMMISSIONER:  
 14 Q. We'll met again at ten after two. Thank you.  
 15 (LUNCH BREAK)  
 16 THE COMMISSIONER:  
 17 Q. Mr. Coffey.  
 18 COFFEY, Q.C.:  
 19 Q. Thank you, Commissioner. Welcome back,  
 20 gentlemen. If we could look, please, at  
 21 Exhibit--I believe we've done P-3503. If we  
 22 could look, please, at Exhibit P-3505, 3505.  
 23 Gentlemen, this is entitled "Technical brief  
 24 on statistical tables from estrogen  
 25 receptor/progesterone receptor ER/PR

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1 database", draft, February 29th, 2008, and  
 2 again I take it that this is one of--one of  
 3 the copies of an evolving document. Dr. Reza,  
 4 the Commissioner has heard testimony  
 5 concerning the conversion rate in the sense of  
 6 how it was talked about publicly, particularly  
 7 going back to May of 2007 before you were ever  
 8 envisaged being involved, and the rate talked  
 9 about publicly and through some of the  
 10 documents here, is 40/42 percent, depending  
 11 upon which one you look at. Bearing in mind  
 12 these tables, and the data in the tables, and  
 13 your overall knowledge of this, that 40/42  
 14 percent figure, did you come across that  
 15 figure at times, you know, when you were doing  
 16 your calculations?  
 17 DR. ALAGHEHBANDAN:  
 18 A. We were asked by the task force office to  
 19 create those tables and present them with  
 20 numbers, and based on the calculation, that  
 21 was our understanding at the time.  
 22 COFFEY, Q.C.:  
 23 Q. In terms of--I take it that that figure--and I  
 24 appreciate it's off by at times a fraction of  
 25 a percent and so on, but 42 percent, give or

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1 take a little bit, for the province was the  
 2 conversion rate using 30 and 10 cutoffs?  
 3 DR. ALAGHEHBANDAN:  
 4 A. That's right.  
 5 COFFEY, Q.C.:  
 6 Q. For the time period--that's the rough rule of  
 7 thumb?  
 8 DR. ALAGHEHBANDAN:  
 9 A. Based on the what the database contained.  
 10 COFFEY, Q.C.:  
 11 Q. And that's based upon the database, such as  
 12 NLCHI developed it finally. It's about  
 13 roughly just over 40 percent of the samples  
 14 that were retested had -  
 15 DR. ALAGHEHBANDAN:  
 16 A. Had the changed result.  
 17 COFFEY, Q.C.:  
 18 Q. Had a changed result based upon the 30/10  
 19 cutoff?  
 20 DR. ALAGHEHBANDAN:  
 21 A. That's correct.  
 22 COFFEY, Q.C.:  
 23 Q. Okay. So, in effect, really you -  
 24 THE COMMISSIONER:  
 25 Q. Changed results are?



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

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1 should be seen carefully and interpreted  
 2 carefully because there are multiple factors  
 3 involved with respect to a change results. It  
 4 could be a clinical condition situation, it  
 5 could be technical condition situation, and so  
 6 on and so forth. So the database does not  
 7 include clinical components and data, does not  
 8 include technical data, and that's what we  
 9 have to be aware of before putting any context  
 10 around it. So when we say, yes, there was a  
 11 conversion of about 40 percent across the  
 12 province, that's just a raw number, that  
 13 number may not tell us a lot, but that's what  
 14 we can get out of database, but again how that  
 15 can be seen, I mean, it's a different--it's a  
 16 separate story.  
 17 COFFEY, Q.C.:  
 18 Q. And just as an illustration of this, in this  
 19 exhibit, if we could look at page nine,  
 20 please. Actually--yes. This is a heading,  
 21 "Change Rate False Negatives, See Tables F to  
 22 I", and then there's a summary of ER/PR, Mount  
 23 Sinai retest data, and change rates, 1995 to  
 24 2005 by cutoff point, and there's a row  
 25 entitled "Cutoff points percentage, 30/10",

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1 which I take it is using a 30/10 cutoff as of  
 2 December 31st, 2000, and then cutoff point  
 3 using 10 percent, and a cutoff point using 1  
 4 percent. Then we look, the text below reads,  
 5 "Using a clinical cutoff of 30 percent/ 10  
 6 percent, the number of original ER negative  
 7 tests between 1997 and 2005 dropped from 1089  
 8 to 623 after being retested at Mount Sinai  
 9 Hospital. Thus the change rate was 43 percent  
 10 of the total ER negative tests for the whole  
 11 period. Removing the ER negative/PR positive  
 12 tests from this group and assigning them as  
 13 ER/PR positive, the change rate was 33  
 14 percent. In other words, even though the  
 15 proportion of false ER negatives was 43  
 16 percent, a more inclusive definition of  
 17 positive, incorporating the ER negative/PR  
 18 positive tests, means that the false negative  
 19 rate from a clinical perspective was 33  
 20 percent". That's the way the text reads, and  
 21 then you go on to talk about a 10 percent  
 22 cutoff and a 1 percent cutoff.  
 23 DR. ALAGHEHBANDAN:  
 24 A. Uh-hm.  
 25 COFFEY, Q.C.:

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1 Q. You can see that on the screen there now. In  
 2 terms of a false negative rate from a clinical  
 3 perspective being 33 percent, okay, I take it  
 4 that that--the underlying assumption there is  
 5 that a person who is ER negative/PR positive,  
 6 as long as the PR positivity was over the  
 7 cutoff point, using that cutoff of 30 and 10,  
 8 as long as there was PR--number was higher  
 9 than 30 at one point, or higher than 10 at  
 10 another, that the conversion or change rate,  
 11 of course, would change, and it did change.  
 12 DR. ALAGHEHBANDAN:  
 13 A. It did change, yes.  
 14 COFFEY, Q.C.:  
 15 Q. It went from 43 to 33. Did that mean, in  
 16 effect, Dr. Reza, that there were a number of  
 17 patients for whom the original tests were ER  
 18 negative, PR positive, and on retest, there  
 19 was a not inconsiderable number that were ER  
 20 positive, PR positive?  
 21 DR. ALAGHEHBANDAN:  
 22 A. So basically that's what exactly it says. It  
 23 says that from ER negative, considering PR as  
 24 positive, they changed to ER positive.  
 25 COFFEY, Q.C.:

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1 Q. There were -  
 2 DR. ALAGHEHBANDAN:  
 3 A. And that's what basically the sentence is--and  
 4 this is coming from the database, and the  
 5 database can only describe what it is, and  
 6 doesn't put reason behind it why that  
 7 happened. So my point being, yes, it says that  
 8 33 percent, one third of that whole cohort,  
 9 changed from ER negative, while being positive  
 10 for PR, to ER positive.  
 11 COFFEY, Q.C.:  
 12 Q. And we've heard a phrase used by one of the  
 13 witnesses here, I believe an oncologist, to  
 14 describe it "saved by the PRs" was the way  
 15 that it was--something that she and her fellow  
 16 physicians apparently had a phrase they used  
 17 to describe the situation when it became--the  
 18 results started to come back and they realized  
 19 what had happened, which is that an awful lot  
 20 of people were already on Tamoxifen because of  
 21 the PR results, original PR results, and that  
 22 was consistent with here, this 33 to 43  
 23 percent change.  
 24 DR. ALAGHEHBANDAN:  
 25 A. My understanding is that--again it depends on

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

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1 Q. And that, I take it, is this figure, in  
 2 effect, right here, the 42.8? That's -  
 3 DR. ALAGHEHBANDAN:  
 4 A. ER negative change rate.  
 5 COFFEY, Q.C.:  
 6 Q. That's that 42.8 is the 43 percent you're -  
 7 DR. ALAGHEHBANDAN:  
 8 A. I was not in charge of developing this  
 9 specific table, and we provided task force  
 10 office with raw numbers. I believe Mr.  
 11 Thompson himself created a table and  
 12 calculated rates.  
 13 COFFEY, Q.C.:  
 14 Q. And now, Mr. MacDonald, let me ask you,  
 15 because you referred this morning to the fact  
 16 that NLCHI has epidemiologists available to it  
 17 and, in fact, working for you?  
 18 DR. MACDONALD:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. For your Centre. Were there epidemiologists  
 22 involved in this?  
 23 DR. MACDONALD:  
 24 A. No.  
 25 COFFEY, Q.C.:

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1 Q. And why is that?  
 2 DR. MACDONALD:  
 3 A. This is not epidemiology. This is just  
 4 straightforward math.  
 5 COFFEY, Q.C.:  
 6 Q. Yes.  
 7 DR. MACDONALD:  
 8 A. You know, we certainly work with the task  
 9 force in the analysis, as I mentioned earlier,  
 10 but there was--there was some numbers that  
 11 were generated from the task force for their  
 12 own purposes included in the report that we  
 13 were not involved in.  
 14 COFFEY, Q.C.:  
 15 Q. And was it your understanding because, of  
 16 course, you interacted with the task force  
 17 personnel, that they have epidemiologists  
 18 involved?  
 19 DR. MACDONALD:  
 20 A. The task force?  
 21 COFFEY, Q.C.:  
 22 Q. Yes, did you understand that they did or  
 23 didn't?  
 24 DR. MACDONALD:  
 25 A. Oh, that they didn't.

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1 COFFEY, Q.C.:

2 Q. They did not. Can you tell the Commissioner

3 why NLCHI did not utilize any epidemiologist

4 in this?

5 DR. MACDONALD:

6 A. It wasn't a task for an epidemiologist. It's

7 straightforward calculations. What an

8 epidemiologist tries to do is--in the research

9 arena is try to link--especially in our area

10 of expertise, which is population based, is to

11 link interventions to an outcome. So, for

12 example, the implementation of a policy or

13 program, what impact that have on health and

14 population. So there's many tools available

15 to an epidemiologist, many statistical tools,

16 test of association, cause and effect, to some

17 extent, surveys are used quite a lot in

18 epidemiology, focus groups, interviews. None

19 of these tools are employed in this particular

20 exercise we see here with this report. This

21 report is basically just taking some numbers

22 and giving a percent or an average. So there

23 was no need to bring in epidemiologists to

24 actually generate these tables. This is a

25 straightforward math exercise.

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1 COFFEY, Q.C.:

2 Q. Yes.

3 DR. MACDONALD:

4 A. We're not trying to find out--epidemiology

5 would try to find out why, in fact, there was

6 a change.

7 COFFEY, Q.C.:

8 Q. Yes. Now, Dr. Reza, in looking at the data,

9 and again based upon some tables and

10 spreadsheets that the Commissioner has seen in

11 exhibit that were prepared very early on by

12 Mr. Gulliver, for example, okay, there's some

13 exhibits the Commissioner has seen, the

14 positivity rate, at least as Mr. Gulliver at

15 the time calculated it, changed significantly

16 I'm going to suggest--at least changed, you

17 know, in 2003, 2004--2004/2005, like, that

18 idea that it went from a lower number to a

19 relatively speaking higher number, went into

20 the 80s, okay. Were you ever aware in looking

21 at the data over the time frame that the

22 positivity rates changed in the original data?

23 DR. ALAGHEHBANDAN:

24 A. You see, my main responsibility and my main

25 role and concern was to develop the database,

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1 to ensure that we build a database that we can

2 answer those two initial questions that we

3 had.

4 COFFEY, Q.C.:

5 Q. Uh-hm.

6 DR. ALAGHEHBANDAN:

7 A. Yes, I was aware of the positivity rate, but

8 it wasn't part of my role to interpret that,

9 and I never had enough expertise in order to

10 be able to make an interpretation of that.

11 COFFEY, Q.C.:

12 Q. If we could, just looking at page 12 of this

13 exhibit, this is a table, Table "E", original

14 ER/PR test results at Eastern Regional Health

15 Authority on positivity rates, 1997 to 2005.

16 Now would this be just Eastern Health, or

17 would this be the entire province?

18 DR. ALAGHEHBANDAN:

19 A. The total number is 815, I believe -

20 COFFEY, Q.C.:

21 Q. Yes, total ER negative -

22 DR. ALAGHEHBANDAN:

23 A. That says that Eastern -

24 COFFEY, Q.C.:

25 Q. Actually, I'm going to go up because that's a

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1 different cutoff than the one I want to refer

2 to. This is just a -

3 DR. ALAGHEHBANDAN:

4 A. The number is high. Seems to be for the total

5 province--for the entire province.

6 COFFEY, Q.C.:

7 Q. Okay. In any case, looking at it, and I

8 appreciate it wasn't your job, but when you

9 looked at the kind of output that you were

10 seeing from creating these tables, was there

11 the--you did notice a particular point in time

12 where the positivity rate kind of--it stands

13 out it changes?

14 DR. ALAGHEHBANDAN:

15 A. That's right. Yes, I noticed that and I

16 became aware of that, but again you had to put

17 it into context whether there was a technical

18 reason behind it or clinical reason behind it.

19 I didn't have enough--it wasn't, you know, my

20 expertise to make an interpretation of that,

21 or I didn't have enough resources and tools to

22 be able to assess that.

23 COFFEY, Q.C.:

24 Q. If we could, please--Commissioner, I'm going

25 to ask that a new exhibit be entered. It's P-

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1 3565.  
 2 THE COMMISSIONER:  
 3 Q. Entered.  
 4 EXHIBIT P-3565 MARKED AND ENTERED  
 5 THE COMMISSIONER:  
 6 Q. Is there another one?  
 7 REGISTRAR:  
 8 Q. There is one, 35 -  
 9 THE COMMISSIONER:  
 10 Q. 3559 perhaps?  
 11 COFFEY, Q.C.:  
 12 Q. Yes, please.  
 13 THE COMMISSIONER:  
 14 Q. All right, they're both entered.  
 15 EXHIBIT P-3559 MARKED AND ENTERED  
 16 COFFEY, Q.C.:  
 17 Q. 3565, please. Now this is a letter dated  
 18 March 14th, 2008. It's addressed to myself  
 19 and Ms. Chaytor. It's from Mr. Thompson. It  
 20 says, "Please find enclosed a draft copy of  
 21 the technical briefing on the ER/PR database.  
 22 The report is a short order review of key  
 23 results and methodological issues. The main  
 24 report consists of appendices which contains  
 25 statistical tables provided by NLCHI based on

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

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1 "It's important to bear in mind that out of  
 2 317 patients that had "change results" as  
 3 reported by Eastern Health to the Minister on  
 4 November 23rd, 2006, 117 were recommended for  
 5 a change in treatment".  
 6 DR. ALAGHEHBANDAN:  
 7 A. Uh-hm, that's right.  
 8 COFFEY, Q.C.:  
 9 Q. Now has it ever come to your attention that  
 10 that 117 figure -  
 11 DR. ALAGHEHBANDAN:  
 12 A. I'm sorry?  
 13 COFFEY, Q.C.:  
 14 Q. Has it ever come to your attention that that  
 15 117 figure is probably not accurate?  
 16 DR. ALAGHEHBANDAN:  
 17 A. It was accurate based on what we had in the  
 18 database, and this report is--has been  
 19 prepared based on the database. So having  
 20 that in my mind, I was fairly confident that  
 21 117 is a confident--I'm confident that 117 is  
 22 an accurate figure, given the fact that  
 23 whatever data we had at that time.  
 24 COFFEY, Q.C.:  
 25 Q. The 117, how were they identified--how did you

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1 identify who the 117 were?  
 2 DR. ALAGHEHBANDAN:  
 3 A. The main source for identifying those patients  
 4 were panel letters, actually.  
 5 COFFEY, Q.C.:  
 6 Q. Uh-hm.  
 7 DR. ALAGHEHBANDAN:  
 8 A. So if a patient had a change in results,  
 9 automatically went to the panel tumour board,  
 10 and tumour board reviewed the whole medical  
 11 chart and decided whether a treatment change--  
 12 a treatment being offered or not, and we used  
 13 those panel letters and generated this number  
 14 for this report.  
 15 COFFEY, Q.C.:  
 16 Q. And based upon the panel letters?  
 17 DR. ALAGHEHBANDAN:  
 18 A. That's correct.  
 19 COFFEY, Q.C.:  
 20 Q. That you had copies of?  
 21 DR. ALAGHEHBANDAN:  
 22 A. That's correct.  
 23 COFFEY, Q.C.:  
 24 Q. Now what about a panel letter that said that a  
 25 patient had a retest result, the result

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

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

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1 the original score, this is the retested  
 2 score, and here what we offer--recommend.  
 3 COFFEY, Q.C.:  
 4 Q. So that in this context here, and I appreciate  
 5 you may not have actually drafted the wording,  
 6 but to be precise, they would be 117 were  
 7 recommended the physician review panel to have  
 8 a change in treatment?  
 9 DR. ALAGHEHBANDAN:  
 10 A. That's right.  
 11 COFFEY, Q.C.:  
 12 Q. Not that 117 people had a change in treatment  
 13 as a result of the retests? Do you understand  
 14 the distinction, because you here--Ms. Predham  
 15 was here in the past couple of days.  
 16 DR. ALAGHEHBANDAN:  
 17 A. Right.  
 18 COFFEY, Q.C.:  
 19 Q. And she's told us--told the Commissioner that  
 20 there were some patients that she was aware of  
 21 that the panel did not recommend treatment  
 22 change because a day before or a week before  
 23 an oncologist had already changed the  
 24 treatment.  
 25 DR. ALAGHEHBANDAN:

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1 A. We would not have been aware of that.  
 2 COFFEY, Q.C.:  
 3 Q. So you weren't aware of that.  
 4 DR. ALAGHEHBANDAN:  
 5 A. No.  
 6 COFFEY, Q.C.:  
 7 Q. So, therefore, when one says 117 were  
 8 recommended for a change in treatment, in your  
 9 world you're telling the Commissioner, I'm  
 10 satisfied that having reviewed all those panel  
 11 letters -  
 12 DR. ALAGHEHBANDAN:  
 13 A. That's right.  
 14 COFFEY, Q.C.:  
 15 Q. I can create a pile for you that has 117 in  
 16 it, or at least say treatment change  
 17 recommended?  
 18 DR. ALAGHEHBANDAN:  
 19 A. Treatment change offered, yes.  
 20 COFFEY, Q.C.:  
 21 Q. By the panel?  
 22 DR. ALAGHEHBANDAN:  
 23 A. That's right.  
 24 COFFEY, Q.C.:  
 25 Q. Okay, but that's not the same thing as saying

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1 there's only 117 people as a result of this  
 2 whole process who had their treatment changed?  
 3 DR. ALAGHEHBANDAN:  
 4 A. No, it's based on panel letters, it's based on  
 5 tumour board review.  
 6 DR. MACDONALD:  
 7 A. The panel letter played two roles here, and it  
 8 gets back again to how the database was  
 9 created and why it was created, and we saw the  
 10 panel letters as another source. One was it  
 11 was our only source of any treatment change  
 12 had occurred because we did not do a chart  
 13 review, so it's important to recognize that.  
 14 So from the database perspective, the only  
 15 really practical source for us to even look at  
 16 a cursory level at treatment was the panel  
 17 letter, and so--as Reza just mentioned, that  
 18 it would recommend a treatment change based on  
 19 the panel would recommend that. Another piece  
 20 to the panel letter that we used was if, in  
 21 fact, the panel letter was generated, we would  
 22 assume that it went to the physician and the  
 23 physician had met with the patient to discuss  
 24 the results. So we used it also as a  
 25 communication source, but it does have

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1 significant limitations with respect to the  
 2 clinical side.  
 3 THE COMMISSIONER:  
 4 Q. I'm sorry, that last point, you're saying that  
 5 if a panel letter went out, you accepted that  
 6 as more or less proof that the patient in  
 7 question had been communicated with?  
 8 DR. ALAGHEHBANDAN:  
 9 A. As a mode of communication, actually, one of  
 10 the modes of communication. That means--the  
 11 way we have said it in reports, we said that a  
 12 panel letter was sent to the most responsible  
 13 physician.  
 14 THE COMMISSIONER:  
 15 Q. Uh-hm.  
 16 DR. ALAGHEHBANDAN:  
 17 A. Not saying that the patient was notified of  
 18 the results via panel letter. What we said,  
 19 that the most responsible physician was  
 20 notified via panel letter.  
 21 THE COMMISSIONER:  
 22 Q. Okay.  
 23 DR. ALAGHEHBANDAN:  
 24 A. And one would assume that every health care  
 25 professional would share the results with the

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1 patient once they receive them.  
 2 THE COMMISSIONER:  
 3 Q. Okay.  
 4 COFFEY, Q.C.:  
 5 Q. Did you ever become aware that that wasn't  
 6 always the case, that, in fact, for some  
 7 patients, they didn't get told at least -  
 8 DR. ALAGHEHBANDAN:  
 9 A. Right, being in charge of creating a database,  
 10 we had to be quite objective in this matter,  
 11 and then as I mentioned, all we could say at  
 12 the time that a letter was issued by the  
 13 tumour board, sent to the physician. The rest  
 14 of it, we wouldn't know for sure whether that  
 15 occurred between that most responsible  
 16 physician and the patient, but at a later time  
 17 Eastern Health actually did a audit review,  
 18 and then clarified that matter as well.  
 19 DR. MACDONALD:  
 20 A. We did come to the conclusion that we could  
 21 not guarantee the patient had been contacted  
 22 just because a panel letter had been  
 23 generated.  
 24 COFFEY, Q.C.:  
 25 Q. And that's really what I was--and as this

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1 evolved more and more, you came to that  
 2 conclusion?  
 3 DR. MACDONALD:  
 4 A. But we still used it as one of our sources of  
 5 communication, but it certainly wasn't--  
 6 wouldn't be what we would call a gold  
 7 standard.  
 8 COFFEY, Q.C.:  
 9 Q. Now if we could, please--and that is--that  
 10 database is kind of, and report, as it were,  
 11 that database, the report is mid March. If we  
 12 could look, please, at Exhibit P-3508. Now  
 13 this is an e-mail from Ms. Chislett, Tracy  
 14 Chislett. She is -  
 15 DR. MACDONALD:  
 16 A. An epidemiologist in the department.  
 17 COFFEY, Q.C.:  
 18 Q. In your Centre?  
 19 DR. MACDONALD:  
 20 A. Yes, yes.  
 21 COFFEY, Q.C.:  
 22 Q. Okay, and it's dated April 7th, 2008, and it's  
 23 to Deborah Gregory and Robert Thompson. Who's  
 24 Ms. Gregory?  
 25 DR. MACDONALD:

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1 A. Works in Robert Thompson's office, senior  
 2 researcher.  
 3 COFFEY, Q.C.:  
 4 Q. And copied to both of you gentlemen. "Patient  
 5 who"--the subject is "patient who self-  
 6 identified." She begins, "Debbie, as per our  
 7 discussion. Patient who self-identified late  
 8 March which led us to meet regarding how to  
 9 ensure that we have all," and all is  
 10 italicized and bolded, "patients will not  
 11 become part of the database. Because the  
 12 patient was originally negative, she should  
 13 have been part of the recall, but because in  
 14 Meditech the order was not entered, she was  
 15 missed when Eastern did their review. This  
 16 patient will not become part of the database  
 17 as of now because she has not been sent to  
 18 Mount Sinai for retesting. Had she been sent  
 19 for retesting, she would have been part of the  
 20 database and the number would have changed.  
 21 But because Eastern Health decided to retest  
 22 the patient on Ventana and not send for  
 23 retesting to Mount Sinai, she will not be  
 24 included in the database. If you have any  
 25 questions, please let me know."

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1 Now perhaps I'll ask you, Mr. MacDonald,  
 2 if you know. Well, how then did this evolve?  
 3 How did this come about and then how did it  
 4 evolve?  
 5 DR. MACDONALD:  
 6 A. Well certainly, it was still around those  
 7 days, and this is fairly recent, where the  
 8 criteria for inclusion/exclusion into the  
 9 database was still evolving. We were still--  
 10 there was many different caveats as to the  
 11 criteria around exclusion and the main one was  
 12 that you retested at Mount Sinai. So this  
 13 particular case was brought to the attention  
 14 of the Task Force because, in fact, it didn't  
 15 meet one of the main criteria of being  
 16 retesting, but it was certainly a patient of  
 17 interest from the database perspective.  
 18 COFFEY, Q.C.:  
 19 Q. And then what--what then happened with respect  
 20 to whether or not the patient, that patient  
 21 and there'll turn out to be others as we get  
 22 into this, did they end up in the database  
 23 eventually?  
 24 DR. ALAGHEHBANDAN:  
 25 A. If they were retested at Mount Sinai, they

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1 would have, and if they didn't, then they  
 2 would have been separately identified in a  
 3 separate set. But as a core set of the  
 4 database, we would include only those who were  
 5 retested at Mount Sinai. This specific  
 6 individual was identified and, self-identified  
 7 and then tested in house. That's why she did  
 8 not meet the criteria.  
 9 COFFEY, Q.C.:  
 10 Q. And Dr. Reza -  
 11 DR. MACDONALD:  
 12 A. Actually, these are too, Mr. Coffey, that  
 13 earlier in our testimony we noted that there's  
 14 many different cohorts in the database. So  
 15 you would actually--when we were talking about  
 16 its complexity, that you would actually have  
 17 to know which actually patient cohort you want  
 18 to select. I would suggest this lady is in  
 19 our database, but you have--you would have to  
 20 select a particular criteria to segregate her  
 21 out from the main core, because she was not  
 22 tested at Mount Sinai.  
 23 COFFEY, Q.C.:  
 24 Q. And I take it, Dr. Reza, if at some point she  
 25 was retested at Mount Sinai -

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1 DR. ALAGHEHBANDAN:  
 2 A. She would have been -  
 3 COFFEY, Q.C.:  
 4 Q. - and NLCHI found out the results -  
 5 DR. ALAGHEHBANDAN:  
 6 A. She would have been a part of the core set,  
 7 yes.  
 8 COFFEY, Q.C.:  
 9 Q. Okay. But if she wasn't retested at Mount  
 10 Sinai, she would end up in the database, but  
 11 not in the retest Mount Sinai database?  
 12 DR. ALAGHEHBANDAN:  
 13 A. The core set, yes.  
 14 COFFEY, Q.C.:  
 15 Q. Okay. If we could go to, yes, 3506, please?  
 16 Now Ms. Chislett had referred to events in the  
 17 latter part of March. Here, there's an e-mail  
 18 from yourself, Dr. Reza, to Mr. Thompson and  
 19 Mr. MacDonald, copied to a number of  
 20 individuals, March 28th, 2008. Meditech  
 21 search for missing patients. And you begin by  
 22 saying "hi all. Terry, Tracy and I met this  
 23 afternoon to discuss potential options for  
 24 identifying missing breast cancer patients  
 25 with negative ER/PR who may not have been

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1 retested. Terry has performed various search  
 2 protocols in the Meditech system for the year  
 3 2002, searching approximately 90,000  
 4 specimens, and below is a summary of them for  
 5 your consideration. One, using Snomed  
 6 terminology, the code for breast was searched.  
 7 776 pathology reports related to breast  
 8 specimens were captured. This means that  
 9 pathology reports were either directly related  
 10 to breast patients or indirectly related. For  
 11 instance, a lymph node or a skin biopsy was  
 12 taken and potential primary breast involvement  
 13 was mentioned in the pathology report."  
 14 And then it goes on, "A. this has been  
 15 further searched based on tumor markers. This  
 16 means only breast specimens that were coded as  
 17 cancer would be captured. Out of 776 breast  
 18 related specimens, 282 of those recorded as  
 19 breast cancer."  
 20 There's another paragraph, two,  
 21 "Searching the pathology module for the word  
 22 'breast' 1,027 pathology reports were  
 23 identified in which the word 'breast' had been  
 24 mentioned in the report. Regardless of  
 25 whether or not it was--regardless of whether

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1 it was in the clinical history or even  
 2 statements such as 'not primary breast'.  
 3 Paragraph A. this 1,027 was further searched  
 4 using tumor markers for breast cancers. 370  
 5 pathology reports were identified." And then  
 6 little i, "this 370 was even further searched  
 7 using 'ER/PR ordered' 161 were captured." And  
 8 then "B. the 1,027 was searched again using  
 9 'ER/PR ordered' 178 were identified."  
 10 Paragraph three, "Searching the pathology  
 11 module for all tumor markers. This means all  
 12 cancers were captured regardless of their  
 13 original. The total number captured was  
 14 3,720."  
 15 You go on to write then, "please note  
 16 that this is a preliminary search analysis for  
 17 2002 and that each option has its own  
 18 advantages and limitations. For instance,  
 19 using option two, breast as a key word will  
 20 give us the most comprehensive list of breast  
 21 related specimens in the pathology module. On  
 22 the other hand, there may be a significant  
 23 proportion of them not related to the purpose  
 24 of the exercise. It is believed that any of  
 25 these options may still not provide us with

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1 100 percent confidence that every ER/PR  
 2 negative specimen would be found. For time  
 3 line purposes, it is estimated that one could  
 4 review a pathology report with an average  
 5 speed of three minutes per report. This may  
 6 be an underestimation as the reports are not  
 7 consistently formatted. Further, additional  
 8 time would be required to organize, count, and  
 9 cross reference them against existing sources,  
 10 such as NLCHI ER/PR database. Also, please  
 11 note that in 2005, the original search used by  
 12 Terry was done using 'ER/PR ordered'. It came  
 13 up with 189." Signed Reza.  
 14 So I take it then that, Dr. Reza, that  
 15 this is your at least initial inquiry and  
 16 thoughts following this one self-identified  
 17 patient in March?  
 18 DR. ALAGHEHBANDAN:  
 19 A. Right. So basically, Eastern Health knew that  
 20 there was an issue ER/PR ordered entry and  
 21 they had a number of patients back then, back  
 22 in '07, and I became aware of it in early days  
 23 of getting involved with this exercise and  
 24 that became a part of the knowledge that I  
 25 had, which I shared that knowledge later in

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1 early 2008 with Mr. Thompson's group, and this  
 2 e-mail and the exercise that we performed with  
 3 Mr. Gulliver and Ms. Chislett came after the  
 4 fact that there was another case who basically  
 5 self-identified herself and we look at the  
 6 reason for that matter and the reason was the  
 7 fact that ER/PR test was performed. However,  
 8 the code or the procedure code was not  
 9 ordered. Therefore, in 2005, when Eastern  
 10 Health performed their search, they could not  
 11 capture this individual through their  
 12 exercise.  
 13 We look at a number of options here and I  
 14 basically categorize them in three groups.  
 15 Number one, using Snomed. Snomed is a  
 16 terminology, quite extensive, having about  
 17 half million terms in an environment of all  
 18 medical terminologies and using that, we  
 19 basically came up with a certain number. It  
 20 had its own limitations and advantages as  
 21 well.  
 22 Then we use only word 'breast'. That  
 23 means searching the pathology module,  
 24 searching for breast. So it could have been  
 25 this phrase in the pathologist saying that not



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1 primarily breast. So that means, for example,  
 2 the sample was not really breast. So you  
 3 would have captured a number of pathology  
 4 reports. Some may not have been really related  
 5 to breast, but again, you would have had a  
 6 comprehensive list.  
 7 The third one was basically looking at  
 8 tumor markers. As you know, a sample could  
 9 have been malignant or benign, and so if the  
 10 tumor or the sample was benign, then it would  
 11 not get that tumor marker code assigned to it,  
 12 and if it had, then it would have.  
 13 Going through this and for each option,  
 14 searching them down by, for example, Snomed  
 15 and then going to tumor marker and then going  
 16 down further, search by ER/PR entry code, we  
 17 concluded that it would be better to go with  
 18 word "breast" for the search strategy. Yet we  
 19 indicated it in the e-mail that even this  
 20 would not give you 100 percent level of  
 21 confidence that you would basically pick up  
 22 all the patients through this exercise. And  
 23 also, coming out of this, we identified the  
 24 fact that after searching, one has to go  
 25 through a manual review and search basically.

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1 You search the Meditech system. You print  
 2 them all and go one by one. So there are a  
 3 number of steps into this exercise when  
 4 someone has to go to do it.  
 5 COFFEY, Q.C.:  
 6 Q. And here, in fact, Mr. Miller, Wayne Miller,  
 7 on March 28th, sent an e-mail to Pat Pilgrim.  
 8 He says "this"--in commenting upon your e-mail  
 9 we just looked at, "this is still a manual  
 10 process. It is different than doing a word  
 11 search," and he's described as the Senior  
 12 Director, Corporate Strategy and Research,  
 13 Eastern Health. So have you had dealings with  
 14 Mr. Miller yourself?  
 15 DR. ALAGHEHBANDAN:  
 16 A. I'm sorry?  
 17 COFFEY, Q.C.:  
 18 Q. Have you had dealings in connection with this  
 19 with Mr. Miller yourself?  
 20 DR. ALAGHEHBANDAN:  
 21 A. I'm sorry, I didn't hear.  
 22 COFFEY, Q.C.:  
 23 Q. Have you had dealings with Mr. Miller?  
 24 DR. ALAGHEHBANDAN:  
 25 A. With this exercise?

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1 COFFEY, Q.C.:  
 2 Q. Yes, or any other.  
 3 DR. ALAGHEHBANDAN:  
 4 A. In the past, on a number of occasions on  
 5 different items, yes, with respect to ER/PR.  
 6 COFFEY, Q.C.:  
 7 Q. Okay, and so the idea of him describing it as  
 8 a manual process, I take it is--it would  
 9 involve -  
 10 DR. ALAGHEHBANDAN:  
 11 A. Well, as a matter of fact, first it's a  
 12 technical process. Then you had to print all  
 13 those pathology reports and go through them  
 14 manually. So it's not purely manual. It's a  
 15 combination of both technical IT and then  
 16 manual.  
 17 DR. MACDONALD:  
 18 A. I think this is important to understand, at  
 19 this point in the development of the database,  
 20 we came to a point where "where do we stop  
 21 doing the database management and do the  
 22 information management?" and if I might just  
 23 clarify where this e-mail is coming from. We  
 24 were proposing that the most comprehensive  
 25 search that--when we talked to the people in

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1 the lab that you search for breast and then  
 2 you do a manual search on all those pathology  
 3 reports to identify those that had an ER/PR  
 4 test. So that would be the first filter. All  
 5 breast, then who had ER/PR done.  
 6 On the IT side, they were--they felt that  
 7 you could use more filters. So that's what  
 8 Mr. Miller is getting to, in that it's still a  
 9 manual search. But we had decided that  
 10 that's--we felt really more comfortable doing  
 11 a manual search than asking Meditech to say  
 12 first search breast, then search tumor breast  
 13 or tumor marker, then search this. So the  
 14 computer would actually be doing a lot of the  
 15 filtering, and ultimately, at the end of the  
 16 day, from 3,000 pathology reports, you would  
 17 end up with 185 ER/PR breast tests, and we  
 18 didn't feel that--we didn't feel comfortable  
 19 going down that road. We felt we were--it  
 20 should be breast and then we'd do a review of  
 21 the hard copy reports. So that's what Mr.  
 22 Miller is stating there around it's still a  
 23 manual process. He was stating the obvious.  
 24 COFFEY, Q.C.:  
 25 Q. And now, Dr. Reza, as you indicated to the

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1 Commissioner, you first became aware of this  
 2 back in July of 2007.  
 3 DR. ALAGHEHBANDAN:  
 4 A. That's right. Probably -  
 5 COFFEY, Q.C.:  
 6 Q. August.  
 7 DR. ALAGHEHBANDAN:  
 8 A. - August.  
 9 COFFEY, Q.C.:  
 10 Q. August, okay, some time in the summer.  
 11 DR. ALAGHEHBANDAN:  
 12 A. In summer '07.  
 13 COFFEY, Q.C.:  
 14 Q. Yes. Did you bring that to Mr. Thompson's  
 15 attention at the time?  
 16 DR. ALAGHEHBANDAN:  
 17 A. Well, at the time, we didn't, and that  
 18 happened in early '08.  
 19 COFFEY, Q.C.:  
 20 Q. Okay, so around the time of this?  
 21 DR. ALAGHEHBANDAN:  
 22 A. Probably.  
 23 COFFEY, Q.C.:  
 24 Q. Okay, so this problem or potential problem  
 25 with the search approach used by Eastern

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1 Health internally using Meditech -  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's right.  
 4 COFFEY, Q.C.:  
 5 Q. - they hadn't checked the particular work  
 6 order. You're aware of it. You understood a  
 7 number of patients had self-identified back in  
 8 the summer of '07. Why didn't you pursue it  
 9 further at the time?  
 10 DR. ALAGHEHBANDAN:  
 11 A. At the time, our first priority was to capture  
 12 a list of all those patients who were retested  
 13 at Mount Sinai. We were still struggling with  
 14 that. We had a number of sources. We had a  
 15 great challenge in terms of reconciling all  
 16 those data sources. So that was our priority,  
 17 as opposed to going and doing further search,  
 18 because yet we didn't know what we have in  
 19 house.  
 20 COFFEY, Q.C.:  
 21 Q. Now when Mr. Thompson was told, in early 2008,  
 22 about this -  
 23 DR. ALAGHEHBANDAN:  
 24 A. We had a discussion regarding this around  
 25 probably earlier than this e-mail. I don't

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1 know, a week or so.  
 2 COFFEY, Q.C.:  
 3 Q. When this patient had first -  
 4 DR. ALAGHEHBANDAN:  
 5 A. Right.  
 6 COFFEY, Q.C.:  
 7 Q. - self-identified.  
 8 DR. ALAGHEHBANDAN:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And what do you recall about what Mr.  
 12 Thompson's response was?  
 13 DR. ALAGHEHBANDAN:  
 14 A. He was quite concerned and he asked us to  
 15 basically investigate the matter in the sense  
 16 that what would be the best option in terms of  
 17 capturing missing patients within Meditech,  
 18 and his comment prompted us to go with Mr.  
 19 Gulliver and Ms. Chislett to basically perform  
 20 this exercise.  
 21 COFFEY, Q.C.:  
 22 Q. This meeting that's referred to here came out  
 23 of that?  
 24 DR. ALAGHEHBANDAN:  
 25 A. That's correct.

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1 COFFEY, Q.C.:  
 2 Q. Okay.  
 3 THE COMMISSIONER:  
 4 Q. Do I take it from what you're saying that in  
 5 2007, you were concentrating on the people who  
 6 have been retested -  
 7 DR. ALAGHEHBANDAN:  
 8 A. And also -  
 9 THE COMMISSIONER:  
 10 Q. - following them through the system?  
 11 DR. ALAGHEHBANDAN:  
 12 A. That's right.  
 13 THE COMMISSIONER:  
 14 Q. Those who'd gone to Mount Sinai.  
 15 DR. ALAGHEHBANDAN:  
 16 A. The Mount Sinai and their communication.  
 17 THE COMMISSIONER:  
 18 Q. They were your--yes, and following them  
 19 through from results coming back to being  
 20 retested, and the self-identifiers were not in  
 21 your current group. They might be a problem,  
 22 but they were not in the group that you were  
 23 assigned to follow?  
 24 DR. ALAGHEHBANDAN:  
 25 A. Well, the missing patients who--the self-

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1 identified patients, let's put it this way,  
 2 the first group and the second group. First  
 3 group, those that were self-identified  
 4 themselves in '05, '06 and '07 to Eastern  
 5 Health. They were a part of--always a part of  
 6 the database and there was no question about  
 7 it.  
 8 THE COMMISSIONER:  
 9 Q. But because of the way that they were dealt  
 10 with?  
 11 DR. ALAGHEHBANDAN:  
 12 A. That's right. They became a part of the  
 13 database. They were counted and with regard  
 14 to their communication, we always had them  
 15 equally treated, equal to other group. That  
 16 means those that we captured them through the  
 17 exercise. With respect to this patient and  
 18 this group of patients that came later  
 19 actually, that's what, you know, basically  
 20 prompted us to go and do this exercise with  
 21 respect to see what would be the best option  
 22 to capture those potential missing patients in  
 23 the system.  
 24 DR. MACDONALD:  
 25 A. The fact that we had identified the patients

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1 was the core. The fact that they were self-  
 2 identified wasn't really core at the time.  
 3 COFFEY, Q.C.:  
 4 Q. In the early stages for you.  
 5 DR. MACDONALD:  
 6 A. In the early stages, yes. I mean, obviously  
 7 then as time went on, we thought that this  
 8 might be an issue that actually we had to  
 9 address in more detail than what we had  
 10 originally done in our searches.  
 11 COFFEY, Q.C.:  
 12 Q. And we're going to see now in P-3511, please?  
 13 3511. 3511, thank you. We haven't--  
 14 mercifully, we may never make it to 35,000.  
 15 REGISTRAR:  
 16 Q. Too many numbers.  
 17 COFFEY, Q.C.:  
 18 Q. This is a series of e-mails. Mr. MacDonald,  
 19 the first of them is from yourself to Mr.  
 20 Thompson and others, including Dr. Reza, on  
 21 May 9th, 2008. You write "Robert, Terry  
 22 mentioned to Reza and Tracy yesterday," which  
 23 would be Thursday, "that some new cases had  
 24 been recently sent to Mount Sinai," MS Mount  
 25 Sinai. "Positives and possible newly

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1 identified. I have left a phone message with  
 2 Pat's secretary and sent her an e-mail in an  
 3 effort to confirm that this is in fact the  
 4 case. I've yet to hear from Pat, but if  
 5 confirmed, the database will need to be  
 6 updated to reflect these new cases." And then  
 7 he responded, Mr. Thompson responded, he is  
 8 saying "thanks, Don. Please advise as soon as  
 9 you know."  
 10 So Mr. MacDonald then, if we look then at  
 11 P-3512? This is an e-mail from yourself of  
 12 May 14th, 2008 to Mr. Thompson, again copied  
 13 to a number of individuals, including Dr.  
 14 Reza. You write "I spoke with Pat and it  
 15 appears there are a few new cases to consider.  
 16 Pat has asked Heather for a list of all  
 17 individuals identified since the end of  
 18 October. This work is expected to be  
 19 completed by the end of the week. The Centre  
 20 will be provided a copy of this list when  
 21 complete."  
 22 Now, I take it then that--do these e-  
 23 mails reflect then when this became really  
 24 kind of to the fore with NLCHI?  
 25 DR. MACDONALD:

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1 A. I think this is when this would certainly be  
 2 the genesis of more than just one patient,  
 3 yes. At a meeting into my previous e-mail  
 4 that we had been attended to, Terry Gulliver  
 5 had indicated that there had been some new  
 6 patients and the reason I would go back to Pat  
 7 is because there were so many players  
 8 involved, both involved in development of the  
 9 database. Pat and I were basically the  
 10 conduit by which information flowed between  
 11 Eastern and the Centre. So that's why I  
 12 wanted confirmation from her.  
 13 COFFEY, Q.C.:  
 14 Q. Yes.  
 15 DR. MACDONALD:  
 16 A. I think it's a fair comment to say that this  
 17 was really, I would think, the start of really  
 18 realizing that we had to do a further look at  
 19 our search.  
 20 COFFEY, Q.C.:  
 21 Q. If we could, please, Exhibit P-3513? This is  
 22 a couple of e-mails. One, Dr. Reza, from  
 23 yourself to Mr. MacDonald on May 23rd, 2008.  
 24 The subject is list of self-identified  
 25 patients. You write "Tracy and I reviewed the

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1 list of self-identified breast cancer  
 2 patients, N equals eight, sent by Eastern  
 3 Health. It appears that two of these patients  
 4 had been retested on Ventana at Eastern  
 5 Health. Therefore, they would not meet the  
 6 inclusion criteria to be included in the  
 7 database, and the other six, the info provided  
 8 is not clear for two patients." Their names  
 9 are redacted. For one of them it states that  
 10 "Dr. Neil following up to see if this patient  
 11 requires retesting" and for the other patient,  
 12 it says that "'Dr. Neil states that this was  
 13 done in April 1997 and outside the testing  
 14 period and will not be retested.' I think  
 15 further clarification is needed before we  
 16 process this information." And then Mr.  
 17 MacDonald, having received that, you sent--  
 18 forwarded it to Mr. Thompson, same day, saying  
 19 "for your information. We will be following  
 20 up on this on Monday."  
 21 First of all, Dr. Reza, I take it then by  
 22 May 23rd, it was eight people?  
 23 DR. ALAGHEHBANDAN:  
 24 A. We received a letter from Eastern Health  
 25 including eight people and we reviewed the

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1 information and for further clarification, we  
 2 had to go back to Eastern Health to clarify on  
 3 those two patients and the comments that were  
 4 made. We were not able to make a conclusion  
 5 for those two patients. So this is a follow  
 6 up with regard to the meeting that we had with  
 7 Mr. Gulliver.  
 8 COFFEY, Q.C.:  
 9 Q. Now, I'm going to ask you this, Mr. MacDonald,  
 10 the reference here to "Dr. Neil states this  
 11 was done in April '97 outside the testing  
 12 period."  
 13 DR. MACDONALD:  
 14 A. Um-hm.  
 15 COFFEY, Q.C.:  
 16 Q. And you referred to that earlier, the idea of  
 17 January '97, January 1/97 onward as opposed to  
 18 April or May or May 1st, 1997 onward.  
 19 DR. MACDONALD:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. You had, I take it, yourself initially  
 23 cautioned or put forward the suggestion that  
 24 the database go all the way back to the  
 25 beginning of '97?

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1 DR. MACDONALD:  
 2 A. January.  
 3 COFFEY, Q.C.:  
 4 Q. January 1st.  
 5 DR. MACDONALD:  
 6 A. And to the end of 2005.  
 7 COFFEY, Q.C.:  
 8 Q. And sir -  
 9 DR. ALAGHEHBANDAN:  
 10 A. August 2005.  
 11 COFFEY, Q.C.:  
 12 Q. August, yes. So with respect to this,  
 13 whichever of you is the most knowledgeable  
 14 perhaps can answer it, what happened with  
 15 respect to those first four months of 1997?  
 16 DR. MACDONALD:  
 17 A. I'll try to answer that first and certainly  
 18 Reza can add to it. Certainly we did look at  
 19 the April 1997 to August 2005 time frame  
 20 originally and that had been communicated, I  
 21 believe, to the authorities from Eastern  
 22 Health in respect to the delivery of  
 23 specimens. When we went back and we got  
 24 involved, we kind of--Robert's office, the  
 25 Task Force, on a communication to the regional

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1 authorities for some further information,  
 2 requested that the time change now and they go  
 3 back to January, and I believe I recall this  
 4 one was--this particular e-mail with Dr. Neil  
 5 was solved fairly quickly because it went--  
 6 reiterated it is part of the continuum we were  
 7 looking for. So yes, in the initial stages of  
 8 some of the activity in Eastern Health, it was  
 9 April. When we got involved, we went back to  
 10 January. So there was a bit of an over--or a  
 11 time when there was a bit of miscommunication  
 12 of what the time frame was.  
 13 COFFEY, Q.C.:  
 14 Q. I take it that was followed up with, to your  
 15 understanding, with the health authorities?  
 16 DR. MACDONALD:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. Exhibit P-3516, please? Actually, if I could,  
 20 I apologize, 3515, page two of this? It's an  
 21 e-mail from Tracy Chislett of July 22nd, 2008  
 22 to yourself, Mr. MacDonald, and copied to you,  
 23 Dr. Reza. She writes "Don, we had a phone  
 24 call from Dr. Somers, a pathologist from  
 25 Central. She was reading some testimony from

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1 the Inquiry and wanted to let us know that  
 2 they had a patient originally negative and on  
 3 retest was found to be positive. She wanted  
 4 us to know this information. During the same  
 5 phone call, I received a call from Sherry  
 6 Freake from Central as well. I suspect that  
 7 she is calling to give us this updated  
 8 information."  
 9 So I take it then that, Mr. MacDonald,  
 10 that as May became June became July, there  
 11 were other patients or at least some patients  
 12 self-identified not only from St. John's, but  
 13 elsewhere, or that you became aware of?  
 14 DR. MACDONALD:  
 15 A. If I'm not mistaken, I believe we had to do  
 16 some further work to see if these patients  
 17 were actually included in the original eight.  
 18 COFFEY, Q.C.:  
 19 Q. Okay.  
 20 DR. MACDONALD:  
 21 A. I think there is some correspondence where  
 22 Tracy clarified that. Reza?  
 23 DR. ALAGHEHBANDAN:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And what I'm getting at is this, and I'm not  
 2 going to trace through every individual  
 3 patient, because we'll be here a long time.  
 4 DR. MACDONALD:  
 5 A. Oh no. No, no, I understand.  
 6 COFFEY, Q.C.:  
 7 Q. But in terms of as anything came up, I take  
 8 it, it was addressed? It was kind of inquired  
 9 into and you were satisfied one way or the  
 10 other?  
 11 DR. MACDONALD:  
 12 A. Yeah, each and every case that came across to  
 13 us, we fully investigated to the satisfaction  
 14 of what our mandate was.  
 15 COFFEY, Q.C.:  
 16 Q. Again, I started to refer to Exhibit P-3516,  
 17 please, and this is, again, a couple of e-  
 18 mails of July 23rd, 2008. The one at the  
 19 bottom of the page here is from Dianne Smith,  
 20 Eastern Health, of July 23rd, to yourself, Mr.  
 21 MacDonald. It says "response from Pat  
 22 Pilgrim." She says "Hi, Don. Spoke to Pat  
 23 yesterday afternoon and her answer to your  
 24 question is yes, the four patients recently  
 25 identified from Central as being missed will

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1 be included in the update she will be sending  
 2 to NLCHI." So again, that's just an example  
 3 of, I take it, some patients being added into  
 4 the database.  
 5 DR. ALAGHEHBANDAN:  
 6 A. That's right.  
 7 COFFEY, Q.C.:  
 8 Q. Now in relation to this idea of doing this  
 9 search and Dr. Reza, your e-mail had referred  
 10 to three possible ways of doing it, to try and  
 11 identify patients who should have been  
 12 retested perhaps. Mr. MacDonald, how did that  
 13 then play itself out in the spring of 2008?  
 14 The proposal was there. Dr. Reza had put  
 15 forward the proposal.  
 16 DR. MACDONALD:  
 17 A. The three search?  
 18 COFFEY, Q.C.:  
 19 Q. Yes, how did that then--what happened then  
 20 with respect to that?  
 21 DR. MACDONALD:  
 22 A. Well, I'll try to recollect now what happened.  
 23 I remember having a meeting at which Robert  
 24 had proposed a comprehensive search using  
 25 breast, and representatives from Eastern

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

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1 back in the spring and the summer, even though  
 2 things slowed down a bit in the summer  
 3 normally, there was a recognition that a  
 4 further search would be required.  
 5 COFFEY, Q.C.:  
 6 Q. And I'll be coming a bit more to that shortly.  
 7 Exhibit P-3517, please? Now this is an e-mail  
 8 from yourself, Mr. MacDonald, July 24th, 2008  
 9 to Mr. Pritchard. It's copied to Mr. Thompson  
 10 and others. It's involving the NLCHI database.  
 11 You say "there have been some very minor  
 12 updates to the information since the last  
 13 update on when/how the patient was contacted  
 14 on the retest results. We estimate these  
 15 changes at about one percent of what was  
 16 previously provided. However, we are  
 17 expecting a set of data from Eastern on  
 18 Friday," which is then tomorrow, "that has  
 19 major updates to contact information for  
 20 patients currently in the database,  
 21 information on the DCIS patients, and number  
 22 equals 52, information on the 'no tumors' and  
 23 information on approximately 12 positives who  
 24 called in and requested that they be  
 25 retested." And you write "perhaps Sandy may

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1 wish to wait until this data is received and  
 2 entered," and this had arisen out of a request  
 3 for information from Ms. Chaytor?  
 4 DR. MACDONALD:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. So Dr. Reza, what had happened then with  
 8 respect to this DCIS patients? How had they  
 9 been dealt with initially?  
 10 DR. ALAGHEHBANDAN:  
 11 A. I believe Eastern Health decided to review  
 12 those patients with diagnosis of DCIS and then  
 13 to basically identify whether they were  
 14 initially diagnosed properly or not and that  
 15 was one of the initiatives that Eastern Health  
 16 was undertaking. The second one is no tumors.  
 17 Those are the patients that basically did not  
 18 have sufficient sample on their blocks and  
 19 again, the question was whether we can go back  
 20 to original slides and determine whether there  
 21 is any change to results or not. For example,  
 22 we could have just simply destain and stain  
 23 the original slides, given the fact that there  
 24 was not much tumor left on the blocks.  
 25 With respect to the first item, Eastern

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1 Health decided to go and do an extensive audit  
 2 with respect to contact information. So  
 3 basically, they started chart reviewing, going  
 4 to physicians and finally to the patients,  
 5 whether they could find any information on  
 6 that within the chart, or the second level  
 7 would have been contacting the most  
 8 responsible physician, and if not, they  
 9 finally basically contacted the patient. So  
 10 that was a way of ensuring that everyone had  
 11 been communicated with regarding the results.  
 12 THE COMMISSIONER:  
 13 Q. That was the people they knew about.  
 14 DR. ALAGHEHBANDAN:  
 15 A. I'm sorry?  
 16 THE COMMISSIONER:  
 17 Q. That was the people that were known about.  
 18 DR. ALAGHEHBANDAN:  
 19 A. Right.  
 20 COFFEY, Q.C.:  
 21 Q. And in the meantime, I take it back in May or  
 22 June, Mr. Thompson, the time you watched Mr.  
 23 Thompson make a pitch, as it were, or  
 24 suggestion, a strong suggestion to Eastern  
 25 Health about trying to identify all the

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1 patients through this usage of the term breast  
 2 that Dr. Reza had referred to?  
 3 DR. MACDONALD:  
 4 A. As I see -  
 5 COFFEY, Q.C.:  
 6 Q. So these are kind of going on simultaneously,  
 7 I take it. There's a suggestion out there  
 8 about breast, and had not been acted upon.  
 9 I'm correct on that?  
 10 DR. MACDONALD:  
 11 A. Only to the extent that we felt it was the  
 12 most comprehensive search that we could do.  
 13 COFFEY, Q.C.:  
 14 Q. Yes, but it had not been acted upon?  
 15 DR. MACDONALD:  
 16 A. No, it has not.  
 17 COFFEY, Q.C.:  
 18 Q. And in the meantime, there is new data coming  
 19 in and you've described, Dr. Reza, that this  
 20 is here, plus there had been some self-  
 21 identified patients who are being retested and  
 22 that data is coming in as well.  
 23 DR. ALAGHEHBANDAN:  
 24 A. So the issue basically resurfaced and that  
 25 prompted basically to go and perform the new

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1 search.  
 2 COFFEY, Q.C.:  
 3 Q. Now if we could look, please, at Exhibit P-  
 4 3520? This is an e-mail of August 6th, 2008  
 5 from Deborah Gregory to Mr. Thompson, but it's  
 6 copied to Dr. Reza and Mr. MacDonald here.  
 7 "Chronology of events. New patients in ER/PR  
 8 database." And she writes "Robert, I compiled  
 9 a chronology of events related to 'newly  
 10 identified patients' since March 2008.  
 11 Added/to be added to the ER/PR database. If  
 12 anyone has anything to add to the table,  
 13 please forward the information to me and I  
 14 will insert the additions. I have also  
 15 compiled a chronology of events related to  
 16 'newly identified patients' since October 2007  
 17 when this became a concern of ours. I will  
 18 forward it if you think it will be helpful set  
 19 in the context for the management of newly  
 20 identified patients. You will note that I  
 21 have started to address the questions put  
 22 forward by Sandra Chaytor, but I would prefer  
 23 confirmation from you/NLCHI that I have not  
 24 omitted any relevant details, e-mails,  
 25 telephone conversations, etcetera." So I take

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

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

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

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1 asked by Robert Thompson to look into the  
 2 matter of various search strategies, perhaps  
 3 initially doing a small pilot concerning one  
 4 of the below options and assessing whether we  
 5 are able to capture known self-identifiers. I  
 6 understand you are on vacation, but I would  
 7 appreciate it if you would give me or Tracey a  
 8 call to discuss this in further detail." And  
 9 so, Dr. Reza then, what happened with this at  
 10 that time?  
 11 DR. ALAGHEHBANDAN:  
 12 A. So basically we had a number of newly self  
 13 identified patients. The question was, the  
 14 search strategies that we proposed back in,  
 15 back in March, whether those search strategies  
 16 could capture one of these patients as an  
 17 example as a pilot and we tested that pilot,  
 18 we took one of the patients, I think from 2002  
 19 and used those options, search strategies we  
 20 proposed and the patient basically could have  
 21 been found every time using each of those, you  
 22 know, options. So all of those options simply  
 23 worked.  
 24 COFFEY, Q.C.:  
 25 Q. If we could look, please, at Exhibit P-3534?

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1 This is an e-mail of August 14th, 2008 from  
 2 yourself, Dr. Reza, to Mr. Thompson and  
 3 others, saying "Tracey and I met with Barry  
 4 this morning and performed the pilot using  
 5 various search strategies. We searched for  
 6 one of the patients who was on the list of  
 7 eight patients recently sent to us by Eastern  
 8 Health. Using the following search  
 9 strategies, the self identified patient from  
 10 the Health Sciences Centre from the year 2000  
 11 was found: One, searching pathology module  
 12 using Snomed; two, searching pathology module  
 13 using tumour marker; three, searching the  
 14 pathology module using the word "breast". In  
 15 speaking with Barry, he indicated that using  
 16 the word "breast" may be one of the most  
 17 comprehensive search strategies with a high  
 18 level of certainty in capturing breast cancer  
 19 patients at each LIS." And what is a LIS?  
 20 DR. ALAGHEHBANDAN:  
 21 A. Lab Information System.  
 22 COFFEY, Q.C.:  
 23 Q. Okay. "Please note that any of the above  
 24 options requires a manual review of the path  
 25 reports." So that's the meeting or the

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1 searches activity that you just referred to.  
 2 DR. ALAGHEHBANDAN:  
 3 A. That's right. So we examined all these  
 4 options against that case and every time she  
 5 could have been found, so she was found  
 6 through each of them.  
 7 COFFEY, Q.C.:  
 8 Q. And what then happened? So you figured out  
 9 that it might work -  
 10 DR. ALAGHEHBANDAN:  
 11 A. So this pilot was suggested by Mr. Thompson  
 12 and we performed the pilot, we reported it  
 13 back to Mr. Thompson and then we had a  
 14 discussion as to what would be the next  
 15 system. So the next system was decided to be  
 16 for the centre contact in the regions and  
 17 asking them what was the search strategy they  
 18 used back in 2005 in terms of identifying  
 19 their breast cancer patients to be a part of  
 20 the ER/PR recall. Then we created basically a  
 21 questionnaire and Mr. Thompson contacted the  
 22 CEOs in the regions and we had either in  
 23 person or on the phone interview with the most  
 24 responsible individuals at the regions and  
 25 documented what and how they performed their

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1 searches and some other questions again  
 2 related to this matter.  
 3 COFFEY, Q.C.:  
 4 Q. Now, do you have any understanding, Mr.  
 5 MacDonald that Mr. Thompson has pursued this  
 6 further in the sense of with the CEO's of  
 7 these health authorities?  
 8 DR. MACDONALD:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And Mr. Thompson, I tell the Commissioner, of  
 12 course, Mr. Thompson will be here tomorrow and  
 13 I will say right now, Commissioner and let  
 14 counsel know that, although before when Mr.  
 15 Thompson was last here, I had actually  
 16 concluded my questioning, there's a fair  
 17 amount that has happened since, including  
 18 since the day he testified, and there's  
 19 certainly, in terms of taking up chronology as  
 20 to what's happened, I'm going to ask leave of  
 21 yourself tomorrow to ask him some questions  
 22 about what's happened since, in terms of -  
 23 BRAZIL, Q.C.:  
 24 Q. I'm sorry, did you say you were going to  
 25 question him or you were going to ask -



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1 COFFEY, Q.C.:

2 Q. No, I'm going to ask the Commissioner leave

3 for me to -

4 THE COMMISSIONER:

5 Q. He said he was going to ask for leave to

6 question him on the events that occurred since

7 he was here.

8 BRAZIL, Q.C.:

9 Q. Right.

10 COFFEY, Q.C.:

11 Q. So with that -

12 THE COMMISSIONER:

13 Q. I doubt it's going to come as a big surprise

14 to Mr. Thompson.

15 BRAZIL, Q.C.:

16 Q. It's not a surprise.

17 COFFEY, Q.C.:

18 Q. She just mis-heard me, she thought I was -

19 BRAZIL, Q.C.:

20 Q. No, I thought that if we were going back to

21 Ms. Pendergast (phonetic) -

22 COFFEY, Q.C.:

23 Q. No, no, not at all. Mr. Thompson will be here

24 because I've asked--the Commissioner has asked

25 him to come. So I appreciate I will be asking

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1 Mr. Thompson a little bit more about this

2 tomorrow, but in terms of, you understood, I

3 take it, Mr. MacDonald that Mr. Thompson has

4 pursued it with the CEO since?

5 DR. MACDONALD:

6 A. Yes, he has asked the centre, following the

7 interviews that Reza has noted that the Centre

8 did with the authorities, we prepared a

9 summary of those interviews with some options

10 as to how to address the issue of missing

11 applications.

12 COFFEY, Q.C.:

13 Q. And I'm going to take that up with Dr. Reza

14 because he actually was involved, I think, in

15 the interviews.

16 DR. ALAGHEHBANDAN:

17 A. Sure.

18 COFFEY, Q.C.:

19 Q. But again, while that's going on, in the

20 meantime, if we could look, please, at Exhibit

21 P-3539? Actually go to page two of it,

22 there's an e-mail there of August 15th, 2008

23 from Dr. Reza to Mr. MacDonald and others and

24 Mr. Thompson is saying, "Wayne Miller and Dr.

25 Denic called today and requested information

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1 on IC, internal control and F/P, fixation and

2 processing from Mount Sinai's spreadsheet,

3 Excel file, to be added to the ER/PR database.

4 Eastern Health wants to perform analysis on

5 frequency of internal control and fixation and

6 processing by site/facility/years, as well as

7 examining the relationship between internal

8 control, fixation and processing with the

9 conversion rates. We told him that an

10 official request needs to be sent from Pat or

11 Louise to the Centre re: this request.

12 Estimated timeline for this piece of work is

13 to be determined by us. Commission of Inquiry

14 will also receive a copy of the database once

15 the new information is included. Please let

16 me know if you have any questions." Now, Mr.

17 MacDonald, what happened then with respect to

18 this?

19 DR. MACDONALD:

20 A. Louise Jones, CEO of Eastern Health, sent a

21 formal request to, I believe to me, I'm not

22 sure, asking that this work be carried out.

23 COFFEY, Q.C.:

24 Q. And what was utilized then--perhaps I'll ask

25 you, Dr. Reza, what actual electronic data was

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1 utilized and what then happened?

2 DR. ALAGHEHBANDAN:

3 A. So in middle of August, '08, I received a call

4 from Mr. Miller and Dr. Denic and they're

5 simply requesting for a comparison between

6 internal control and fixation status from

7 Mount Sinai spreadsheet and I'm going to speak

8 to that, with the, basically, analysis, I'm

9 sorry, another comparison. Our understanding

10 at the time was the fact that these are the

11 ones that have been captured and reported in

12 original Mount Sinai file back in 2005 and

13 '06. Later we learned that pathologists at

14 Mount Sinai was asked to review the original

15 slides and comment on internal control and

16 fixation and processing. At the time that we

17 received this call, we did not have that

18 information, we were not possession of that

19 information, so our understanding was that

20 they're referring to the retesting, actually

21 internal control and fixation process

22 retesting, not original testing. We performed

23 and we did the request for them and we sent it

24 to Eastern Health. I believe Dr. MacDonald

25 later contacted them and informed them that we

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1 are now in the position of this data, we  
 2 received it from the Commission of Inquiry and  
 3 now we -  
 4 COFFEY, Q.C.:  
 5 Q. That's the data, Dr. Mullen's data from April  
 6 of 2008?  
 7 DR. ALAGHEHBANDAN:  
 8 A. That's right and we received the data from the  
 9 Commission's office and incorporated with the  
 10 database and we'll be doing that for Eastern  
 11 Health and this e-mail is about that.  
 12 COFFEY, Q.C.:  
 13 Q. So the request that Ms. Jones had forwarded  
 14 along, now that you have the actual -  
 15 DR. ALAGHEHBANDAN:  
 16 A. Actual data, we would be able to do the  
 17 analysis.  
 18 COFFEY, Q.C.:  
 19 Q. How long will that take?  
 20 DR. ALAGHEHBANDAN:  
 21 A. The data that we received from Dr.--actually  
 22 the data that you received from Dr. Mullen,  
 23 being linked to the database, however, we  
 24 learned that there was some challenges with  
 25 respect to that data. There was some

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1 inconsistencies between original that compiled  
 2 the original scores compiled by your office  
 3 and the ones that's being basically added by  
 4 Mount Sinai. Also we came across some scores,  
 5 some ER/PR scores that we were not matching  
 6 original pathology reports that we have at the  
 7 Centre. Once we addressed those issues, I  
 8 don't see any huge amount of effort to be done  
 9 for this request.  
 10 COFFEY, Q.C.:  
 11 Q. And the request is, in effect, to do what,  
 12 what sorts of things, what sorts of  
 13 information did they want?  
 14 DR. ALAGHEHBANDAN:  
 15 A. It's simply asking for, looking at internal  
 16 control and also fixation status for those  
 17 original slides and the other one is that I  
 18 believe it crossed -  
 19 COFFEY, Q.C.:  
 20 Q. I take it they wanted, a cross by what?  
 21 DR. ALAGHEHBANDAN:  
 22 A. A cross, I believe I have to look at the  
 23 reports actually, but I can recall I think the  
 24 cross tab between internal control--I'm sorry,  
 25 the cross tab between, the second opinion by

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1 Dr. Mullen and original opinion by our  
 2 pathologist here in the province, looking at  
 3 the original slide.  
 4 COFFEY, Q.C.:  
 5 Q. And so -  
 6 DR. ALAGHEHBANDAN:  
 7 A. I'm sorry, that's not the request at Eastern  
 8 Health's request, that's not the question that  
 9 you requested, the request from Eastern Health  
 10 is regarding a cross tab between internal  
 11 control for those who converted from negative  
 12 to positive and also fixation process, again  
 13 for those who changed.  
 14 THE COMMISSIONER:  
 15 Q. I'm sorry, I'm still not sure it is what you  
 16 wanted, you're being asked to do. Presumably  
 17 you take those who changed, the 317?  
 18 DR. ALAGHEHBANDAN:  
 19 A. I believe five hundred and some odd patients  
 20 who were originally negative, being sent to--  
 21 who reported as negative, being sent to Mount  
 22 Sinai for Dr. Mullen to review, the original  
 23 slides. That information came back to your  
 24 office.  
 25 THE COMMISSIONER:

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1 Q. Uh-hm.  
 2 DR. ALAGHEHBANDAN:  
 3 A. That information came back to your office, so  
 4 we received that information, we entered it  
 5 into the database, we link it to the database.  
 6 Now we have two requests, one is from your  
 7 office, one is from Eastern Health.  
 8 THE COMMISSIONER:  
 9 Q. Uh-hm.  
 10 DR. ALAGHEHBANDAN:  
 11 A. From your office, I'm not going to discuss it,  
 12 and from Eastern Health the question would be,  
 13 give us the, actually, simply the frequency of  
 14 internal control, how many did you have, how  
 15 many you didn't have, also the fixation  
 16 process, whether there was adequate fixation  
 17 or wasn't, so give them a general view of how  
 18 it was reported for six hundred and something  
 19 patients or five hundred and something  
 20 patients.  
 21 THE COMMISSIONER:  
 22 Q. Is that just simply a matter of in effect  
 23 entering into a column Dr. Mullen's comment?  
 24 DR. ALAGHEHBANDAN:  
 25 A. That's right.

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

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1 A. That's right, which we did not have at that  
 2 time, middle of August.  
 3 COFFEY, Q.C.:  
 4 Q. Yes. Now, and that's in the process?  
 5 DR. ALAGHEHBANDAN:  
 6 A. It is in the process actually.  
 7 THE COMMISSIONER:  
 8 Q. Wherever you can find a spot, Mr. Coffey,  
 9 we'll take the break.  
 10 COFFEY, Q.C.:  
 11 Q. Thank you. Right here will be fine,  
 12 Commissioner, and come back and finish -  
 13 THE COMMISSIONER:  
 14 Q. All right, we'll take the afternoon break.  
 15 (RECESS)  
 16 THE COMMISSIONER:  
 17 Q. Please be seated. Mr. Coffey.  
 18 COFFEY, Q.C.:  
 19 Q. Now, Dr. Reza, I understand there was  
 20 something that you wanted to comment upon?  
 21 DR. ALAGHEHBANDAN:  
 22 A. With respect to--I just want to clarify this  
 23 point, with respect to data on date samples  
 24 sent to Mount Sinai and also data on the date  
 25 that we entered the data into Meditech. There

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

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

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

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

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

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

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1 or the regions.  
 2 COFFEY, Q.C.:  
 3 Q. And if we could look, please, at Exhibit P-  
 4 3564? Now here, this is a letter of August  
 5 22nd, 2008, it's addressed to myself and Ms.  
 6 Chaytor, it's from Mr. Pritchard, signed, I  
 7 believe on his behalf by Ms. Brazil, saying,  
 8 "Re: disclosure of Her Majesty in Right of  
 9 Newfoundland and Labrador, enclosed please  
 10 find attached volume 17 of the disclosure of  
 11 Her Majesty. At Tabs 75 to 81, you'll find  
 12 drafts of the technical briefing that was  
 13 forwarded to the Commission of Inquiry on  
 14 March 18th, 2008--I believe that's probably  
 15 supposed to be March 14th, but anyway, "that  
 16 report was the last version of many drafts  
 17 compiled over a period of three months. We  
 18 provided the March 18th, 2008 report to the  
 19 Commission with a hope that it would be  
 20 valuable to it when examining issues such as  
 21 positivity change rates, geographic variations  
 22 and changes over time. The tables attached to  
 23 the final report were designed to enable such  
 24 an analysis. In earlier drafts of the report,  
 25 we attempted some of this analysis ourselves,

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

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1 attached to the report so the Commission, with  
 2 its own scientific advisors, could interpret  
 3 the data as deemed necessary. I trust that  
 4 this is satisfactory." Now I appreciate this  
 5 is drafted for Mr. Pritchard's signature, but  
 6 I very much suspect that, unless he has  
 7 talents that I'm not aware of.  
 8 BRAZIL, Q.C.:  
 9 Q. That's my signature.  
 10 MS. NEWBURY:  
 11 Q. That's Jackie's signature.  
 12 COFFEY, Q.C.:  
 13 Q. It's her signature, but it's drafted for Mr.  
 14 Pritchard's signature is what I said and I  
 15 appreciate it's Ms. Brazil's signature.  
 16 BRAZIL, Q.C.:  
 17 Q. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. That in terms of the issue about the tables,  
 20 did you have any input, Mr. MacDonald into  
 21 that and kind of coming to this kind of  
 22 conclusion here?  
 23 DR. MACDONALD:  
 24 A. Well I mean, what it gets down to is the  
 25 interpretation of what the analysis meant--not

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1 so much the analysis, anyone can crunch  
 2 numbers, you don't need an epidemiologist to  
 3 crunch numbers, but as I said, I think I've  
 4 clarified the difference between database  
 5 management and information management and the  
 6 role of an epidemiologist in that. The Centre  
 7 did not have any expertise in the epidemiology  
 8 of breast cancer. We have expertise in the  
 9 epidemiology of perinatal care, aboriginal  
 10 research, all different types of areas, but  
 11 not breast cancer and that's what we conveyed  
 12 to the task force is that we can't really say  
 13 what it means by the numbers that we were  
 14 generating and I think in the early days we  
 15 probably thought that that might be possible,  
 16 but very early on we realized it's too complex  
 17 of an area for us to try to interpret the  
 18 analysis.  
 19 COFFEY, Q.C.:  
 20 Q. Mr. MacDonald, in relation to that, have you  
 21 ever been told by an epidemiologist that  
 22 without the positive--the results involving  
 23 the original positives, without that data,  
 24 that it's difficult for an epidemiologist to  
 25 really say anything about this?

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

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1 terms of tables.  
 2 DR. ALAGHEHBANDAN:  
 3 A. For retro converters?  
 4 COFFEY, Q.C.:  
 5 Q. For retro converters?  
 6 DR. ALAGHEHBANDAN:  
 7 A. Well we created so many tables, I can't recall  
 8 whether one of those would have been on retro  
 9 converters, so that's for someone like me or  
 10 someone else to go back to the draft reports  
 11 and search them.  
 12 COFFEY, Q.C.:  
 13 Q. I take it it was never a focus of the analysis  
 14 in particular, in terms of -  
 15 DR. ALAGHEHBANDAN:  
 16 A. Well, let me put it this way, the database was  
 17 created to, again, I mentioned this earlier  
 18 but I would like to re-emphasize that the  
 19 database was created to answer two questions.  
 20 Number one, whether everyone got retested at  
 21 Mount Sinai; number two, whether everyone got  
 22 communicated with. Now, along the way we -  
 23 COFFEY, Q.C.:  
 24 Q. With everyone who was negative.  
 25 DR. ALAGHEHBANDAN:

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

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1 Q. Now in this regard in terms of, perhaps  
 2 outside factors, kind of cut off dates, you,  
 3 for example, in terms of the communication  
 4 issues, were asked to look at the number of  
 5 deceased as of November 23rd, 2006 in the  
 6 mortality database. Well, I'm going to ask  
 7 you the following, as of May 2nd, 2003, okay,  
 8 in relation to the ER and PR test results that  
 9 are in that database as originally reported,  
 10 are you able to differentiate in relation to  
 11 2003 whether the test occurred before May 2nd,  
 12 '03 or after?  
 13 DR. ALAGHEHBANDAN:  
 14 A. For the deceased group?  
 15 COFFEY, Q.C.:  
 16 Q. No, deceased or otherwise, anyone.  
 17 DR. ALAGHEHBANDAN:  
 18 A. That means making a distinction between two  
 19 groups, one pre and one post at a certain  
 20 point of time, yes, it is easy to do that.  
 21 COFFEY, Q.C.:  
 22 Q. Okay, so the data -  
 23 DR. ALAGHEHBANDAN:  
 24 A. If you have the date, if you have the date the  
 25 test was performed. We do have the date based

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1 on only year the test was performed, not based  
 2 on the month or the exact date.  
 3 COFFEY, Q.C.:  
 4 Q. And that's what I was asking about, within  
 5 2003 you could say, well Mr. Coffey, I can  
 6 give you all the '03s and they'll be all  
 7 listed out there, okay.  
 8 DR. ALAGHEHBANDAN:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. But within 2003, whether it's January,  
 12 February or March or April -  
 13 DR. ALAGHEHBANDAN:  
 14 A. The data exists, actually it's in the  
 15 pathology report, it doesn't -  
 16 COFFEY, Q.C.:  
 17 Q. Yes, I know, I appreciate that, but within  
 18 your own database as it is right now, it  
 19 doesn't distinguish, just year and year alone,  
 20 it doesn't distinguish about what time of year  
 21 in the sense of you can't tell if a particular  
 22 patient was January or -  
 23 DR. ALAGHEHBANDAN:  
 24 A. Based on month or -  
 25 COFFEY, Q.C.:

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1 Q. Yes.  
 2 DR. ALAGHEHBANDAN:  
 3 A. I know it's based on year, I've got to check  
 4 back whether it's based on month or not, but  
 5 I'm pretty sure that we do have it based on  
 6 years, so we can do analysis based on year,  
 7 actually whether it's happening in '02 or '03  
 8 or so on and so forth.  
 9 COFFEY, Q.C.:  
 10 Q. Even the basis for the year, let's take 2003.  
 11 DR. ALAGHEHBANDAN:  
 12 A. Right.  
 13 COFFEY, Q.C.:  
 14 Q. Was that determined based upon the date of the  
 15 pathology report or the date of the surgical  
 16 number?  
 17 DR. ALAGHEHBANDAN:  
 18 A. Based on the--the date that we captured,  
 19 extracted from was based on specimen number,  
 20 surgical number, so if an operation happened,  
 21 let's say on December 31st, 2002 and the  
 22 pathology testing was performed, let's say in  
 23 January of next year, I guess there is a big  
 24 difference between the two, even by one or two  
 25 days, so the date that we captured is based on

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1 surgical numbers.  
 2 COFFEY, Q.C.:  
 3 Q. That little two digit code for year.  
 4 DR. ALAGHEHBANDAN:  
 5 A. That's right, indicates the year that  
 6 operation -  
 7 COFFEY, Q.C.:  
 8 Q. And in relation to, for example, the date of  
 9 April 1st, 2004, which again, I don't know how  
 10 certain the Commissioner might find that that  
 11 date was, but we understand that around April  
 12 1st, 2004, the Ventana machine came into  
 13 utilization. Are you able to distinguish  
 14 within 2004 between old tests that occurred  
 15 before April 1 and after April 1? I take it  
 16 you can't right now.  
 17 DR. ALAGHEHBANDAN:  
 18 A. Right, Eastern Health provided us with some  
 19 information on the system, either DAKO or  
 20 Ventana, whether it was performed on the old  
 21 one or the new one, so we do have that  
 22 information in the database and basically for  
 23 each specimen, we know whether this happened  
 24 based on DAKO or that happened based on  
 25 Ventana.

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1 COFFEY, Q.C.:  
 2 Q. Okay, so you can do that?  
 3 DR. ALAGHEHBANDAN:  
 4 A. You can do that, analysis is possible.  
 5 COFFEY, Q.C.:  
 6 Q. So if the database does capture whether or not  
 7 -  
 8 DR. ALAGHEHBANDAN:  
 9 A. What system was used for performing the test.  
 10 COFFEY, Q.C.:  
 11 Q. Okay. So one would be able to distinguish,  
 12 presumably, the pre Ventana from the post or  
 13 the current Ventana days.  
 14 DR. ALAGHEHBANDAN:  
 15 A. It's possible to do that.  
 16 COFFEY, Q.C.:  
 17 Q. But back in 2003 in particular, Dr. Ejeckam's  
 18 intervention as it is referred to here -  
 19 DR. ALAGHEHBANDAN:  
 20 A. That's right.  
 21 COFFEY, Q.C.:  
 22 Q. There's no distinguishing there, you would  
 23 have to actually go into the pathology reports  
 24 and get the dates?  
 25 DR. ALAGHEHBANDAN:

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1 A. With respect to year, I'm pretty sure that we  
 2 have it by year. With respect to month, I  
 3 think we do have it in the database. I've got  
 4 to check that, but I'm kind of confident that  
 5 we do have it by month and year, definitely  
 6 not by day.  
 7 COFFEY, Q.C.:  
 8 Q. And if it isn't there, in fact by searching  
 9 the pathology reports, you could -  
 10 DR. ALAGHEHBANDAN:  
 11 A. Yes, now I can recall right now that we do  
 12 have that by month as well. And if we don't,  
 13 that's simply go back and capture it from the  
 14 pathology reports, but I believe we do have  
 15 it.  
 16 COFFEY, Q.C.:  
 17 Q. And then in terms of, for example, if one  
 18 wanted to ascertain whether there was any  
 19 significant difference between the period  
 20 before Dr. Ejeckam's intervention and  
 21 afterward, you'd have to ensure that that was  
 22 able to be broken down that way?  
 23 DR. ALAGHEHBANDAN:  
 24 A. Now I can recall that we received a request  
 25 from Eastern Health asking us for a similar

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1 analysis, pre and post Dr. Ejeckam's letter  
 2 and at the time we indicated that we don't  
 3 have such information in the database. So the  
 4 request was sent to us and we replied to that.  
 5 Based on that request, that information was  
 6 captured by month for each year and was sent  
 7 to us and we entered it into the database. So  
 8 the date based on year and month exists for  
 9 each specimen within the database.  
 10 COFFEY, Q.C.:  
 11 Q. And when was that done?  
 12 DR. ALAGHEHBANDAN:  
 13 A. I can't recall exactly, but a few months ago.  
 14 COFFEY, Q.C.:  
 15 Q. Has there been any analysis done of that?  
 16 DR. ALAGHEHBANDAN:  
 17 A. Based on that, I don't recall, I don't think  
 18 so.  
 19 COFFEY, Q.C.:  
 20 Q. And when I say has any been done, I take it  
 21 I'm asking you in relation has NLCHI done any?  
 22 DR. ALAGHEHBANDAN:  
 23 A. Well whatever analysis we've done was at the  
 24 request of either Mr. Thompson's office or  
 25 Eastern Health.

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1 COFFEY, Q.C.:  
 2 Q. So there hasn't been any analysis -  
 3 DR. ALAGHEHBANDAN:  
 4 A. I don't recall any analysis being done on  
 5 that.  
 6 COFFEY, Q.C.:  
 7 Q. How about in terms of the Ventana versus the  
 8 DAKO?  
 9 DR. ALAGHEHBANDAN:  
 10 A. It has been done. I think we have seen a  
 11 table or two within one of these exhibits this  
 12 morning.  
 13 COFFEY, Q.C.:  
 14 Q. If we could, please, I'm going to ask you,  
 15 Registrar, to bring up Exhibit P-3555. Now  
 16 this is an e-mail from - well, it's two e-  
 17 mails; one from Ms. Chislett to Mr. Thompson,  
 18 October 2nd, 2008, and then from Mr. Thompson  
 19 to Lorraine Barrett of October 17th, and the  
 20 attachment is "A summary of interviews.doc",  
 21 and Ms. Chislett has attached a summary table  
 22 of interviews that Dr. Reza and Ms. Chislett  
 23 have conducted with the regions regarding  
 24 their search strategies. "If you have any  
 25 questions, please, call. Please let me know".

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1 So this is this series of interviews you  
 2 referred to earlier, Dr. Reza?  
 3 DR. ALAGHEHBANDAN:  
 4 A. That's right.  
 5 COFFEY, Q.C.:  
 6 Q. I take it then your purpose in conducting  
 7 these interviews in September of 2008 was to  
 8 ascertain, as it were, from the source as to  
 9 what had or hadn't happened in relation to the  
 10 searches from time to time that they had  
 11 conducted to identify patients?  
 12 DR. ALAGHEHBANDAN:  
 13 A. That's correct, to document it basically.  
 14 COFFEY, Q.C.:  
 15 Q. Document it.  
 16 DR. ALAGHEHBANDAN:  
 17 A. Describe it.  
 18 COFFEY, Q.C.:  
 19 Q. And I'm going to ask you, in terms of the  
 20 material in this, I take it that - would it be  
 21 appropriate for me to assume that as best - to  
 22 your knowledge, as best you and Ms. Chislett  
 23 could do it, that this accurately reflects  
 24 what you were told?  
 25 DR. ALAGHEHBANDAN:



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

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1 You've got here written "Carbonear", first  
 2 hospital - I apologize, Commissioner, I'll  
 3 just come up - right there. September 9th,  
 4 2008, and you would have interviewed Dr.  
 5 Baker. I take it that's - here. How many  
 6 LIS, are they interconnected; one LIS system,  
 7 Meditech, first specimens only in Carbonear,  
 8 skin biopsies, others may come from other  
 9 hospitals, Old Perlican, Placentia, and  
 10 Whitbourne". I take it that's the areas that  
 11 they -  
 12 DR. ALAGHEHBANDAN:  
 13 A. That's right.  
 14 COFFEY, Q.C.:  
 15 Q. Collect samples from.  
 16 DR. ALAGHEHBANDAN:  
 17 A. Cover by Carbonear.  
 18 COFFEY, Q.C.:  
 19 Q. And the question, "How were pathology reports  
 20 stored; pathology module only installed up and  
 21 running since 2004. Before that, hard copies  
 22 were kept in binders by year. 1997 to 2003,  
 23 hard copies for all. 2004 onward, hard copies  
 24 kept electronically". Then in relation to  
 25 when did the search begin, "Received memo from

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

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

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1 I have some questions about Clarenville. Now  
 2 you had understood what about Clarenville?  
 3 DR. ALAGHEHBANDAN:  
 4 A. In terms of?  
 5 COFFEY, Q.C.:  
 6 Q. Your involvement, yes.  
 7 DR. ALAGHEHBANDAN:  
 8 A. I'm just going to go through that report. That  
 9 would be -  
 10 COFFEY, Q.C.:  
 11 Q. Okay, what I'll do is I'll take you through it  
 12 then because this may refresh your memory as  
 13 we're going, okay. The question - you spoke  
 14 to Kathy Escott, the lab tech, Meditech  
 15 support specialist, and Jim Humble, Director  
 16 for Peninsulas Labs, and that was September  
 17 10th, 2008, and September 16th, 2008. How  
 18 many LIS, "Meditech in region since 2000.  
 19 Prior to that, had another electronic Health  
 20 Vision System. When old system was converted  
 21 to Meditech, some data was lost". Now had you  
 22 been aware before that?  
 23 DR. ALAGHEHBANDAN:  
 24 A. No, that was the first time I came to learn  
 25 that.

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1 COFFEY, Q.C.:  
 2 Q. That was brought to your attention in  
 3 September of this year?  
 4 DR. ALAGHEHBANDAN:  
 5 A. That's correct.  
 6 COFFEY, Q.C.:  
 7 Q. And then the question, How are pathology  
 8 reports stored, "No hard copy, back up to old  
 9 system, or Meditech that they knew of". So  
 10 there was literally no back up copy?  
 11 DR. ALAGHEHBANDAN:  
 12 A. So that was a major challenge. The challenge  
 13 was that when they switched from old system to  
 14 new technology, obviously some information,  
 15 some data got lost".  
 16 COFFEY, Q.C.:  
 17 Q. And they didn't create a hard copy of the  
 18 report?  
 19 DR. ALAGHEHBANDAN:  
 20 A. No, so they did not have hard copy backup at  
 21 the time. I asked them whether it would be a  
 22 way to go back and somehow capture that  
 23 information. Of course, there is a way, and  
 24 that would be going back to original medical  
 25 charts because once you have a pathology

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1 report, you generate it, you send a copy to  
 2 most responsible physician. That was a  
 3 challenge with respect to Clarenville search.  
 4 COFFEY, Q.C.:  
 5 Q. And then when did the search begin in  
 6 Clarenville, "Only search performed was when  
 7 the pathologist asked for list of patients who  
 8 had specimens sent to St. John's for ER/PR.  
 9 List was sent to Clarenville from St. John's  
 10 and they pulled reports based on that list.  
 11 This was a list of specimens that St. John's  
 12 received from Clarenville". See that, and  
 13 then did you limit it by gender, age, etc,  
 14 "Limited years for April, 2000, to December,  
 15 2005. Prior to 2000, searched data during  
 16 conversion and pulled out a couple, but  
 17 probably not complete as some data was lost".  
 18 What was that about, do you recall?  
 19 DR. ALAGHEHBANDAN:  
 20 A. Again the same issue of converting from old  
 21 system to new system. So they had that concern  
 22 and they said that we may not have had  
 23 basically captured everyone.  
 24 COFFEY, Q.C.:  
 25 Q. In relation to this then, they were limited to

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1 the years from April, 2000, to December, 2005.  
 2 I take it that's what this is saying. That's  
 3 your understanding?  
 4 DR. ALAGHEHBANDAN:  
 5 A. Limited years for April, 2000, to December,  
 6 2005.  
 7 COFFEY, Q.C.:  
 8 Q. So prior to 2000, they just couldn't search  
 9 without going through every chart?  
 10 DR. ALAGHEHBANDAN:  
 11 A. This is how things happened, actually. So  
 12 they switched from old system to new system.  
 13 Their concern was pre 2000 because pre 2000  
 14 was the old system. So now here they are  
 15 saying that we're not quite confident about  
 16 pre 2000, whether we lost any data, and if we  
 17 did, whether that would have been an ER/PR  
 18 negative breast cancer patient. That's what  
 19 they're saying.  
 20 COFFEY, Q.C.:  
 21 Q. And who performed the search?  
 22 DR. ALAGHEHBANDAN:  
 23 A. Ms. Kathy -  
 24 COFFEY, Q.C.:  
 25 Q. Kathy Escott?

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

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1 COFFEY, Q.C.:  
 2 Q. In terms of were searches done to look for  
 3 others, you've noted, "A few months ago did  
 4 another search to see if they missed anybody  
 5 the first time. Used the same strategy, and  
 6 picked up one extra". Was a manual review of  
 7 pathology reports done after electronic and  
 8 you've noted, "No hard copies that Kathy knew  
 9 of". In other words, they didn't have any  
 10 paper?  
 11 DR. ALAGHEHBANDAN:  
 12 A. No, they didn't.  
 13 COFFEY, Q.C.:  
 14 Q. And then was cross-referencing done to ensure  
 15 completeness, "No cross-referencing with first  
 16 search and second search because didn't have  
 17 the results of the first search. It wasn't an  
 18 organized search".  
 19 DR. ALAGHEHBANDAN:  
 20 A. That's right.  
 21 COFFEY, Q.C.:  
 22 Q. That's what she told you?  
 23 DR. ALAGHEHBANDAN:  
 24 A. That's correct.  
 25 COFFEY, Q.C.:

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

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1 A. That's correct.  
 2 COFFEY, Q.C.:  
 3 Q. That's what you were told. Here is an entry  
 4 for St. John's. The people you spoke to were  
 5 Mr. Gulliver and Mr. Dyer, September 10th,  
 6 2008. How many LIS, "There were three  
 7 systems, the Health Sciences Centre, St.  
 8 Clare's, and the Grace, connected in 1999.  
 9 Now one system as old Health Sciences Centre  
 10 became St. John's system. Any patient record  
 11 from Health Sciences Centre not affected, but  
 12 for Grace and St. Clare's, records were  
 13 transferred over to new system, demographic  
 14 info transfer, but maybe not all of record,  
 15 i.e. info before 1999 at those hospitals, but  
 16 can still access old systems to get that  
 17 info". So I take it you understood that they  
 18 were able to get all this electronically?  
 19 DR. ALAGHEHBANDAN:  
 20 A. So after 2000, they could do one search within  
 21 Meditech for the entire St. John's region.  
 22 Prior to 2000, they had to identify those  
 23 patients who had ER/PR testing at Health  
 24 Sciences Centre, and then going back to the  
 25 old systems and looking at their ER/PR scores.

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1 COFFEY, Q.C.:

2 Q. And here, how are pathology reports stored,

3 and the answer, "Meditech at St. Clare's from

4 1986, at the Health Sciences Centre from 1987,

5 and from Grace, 1994/1995, but Grace didn't

6 use MCP number".

7 DR. ALAGHEHBANDAN:

8 A. And that was a great challenge because if you

9 don't have MCP number, then you have to go by

10 name, and that caused some issues.

11 COFFEY, Q.C.:

12 Q. "And Grace and St. Clare's did keep hard

13 copies. St. Clare's still printed hard copies

14 with slides up until four to five years ago".

15 So did you actually - but you didn't actually

16 go to look at the hard copies yourselves?

17 DR. ALAGHEHBANDAN:

18 A. No.

19 COFFEY, Q.C.:

20 Q. You described that to us.

21 DR. ALAGHEHBANDAN:

22 A. There was no need of that because in Health

23 Sciences Centre you can simply access the old

24 system, whether that would be old Grace or St.

25 Clare's.

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1 COFFEY, Q.C.:

2 Q. And when did the search begin, you noted,

3 "Told to do search by Dr. Williams and saw

4 memo from Dr. Cook. Searched in early/mid

5 July, 2005. Done because Dr. Carter needed a

6 list of all patients because she was going to

7 do the review. Interested in the positivity

8 rate". In terms of limited, "Search males and

9 females, all ages for 1997 to 2005". Who

10 performed the search, "Terry performed one

11 search, Barry performed another". Then

12 details about the search, "Search done by

13 procedure, ER/PR ordered, because they were

14 asked to find patients that had ER/PR. This

15 search gave info and results for patients from

16 Health Sciences Centre system in 1997. For

17 Grace and St. Clare's, only got number

18 assigned to do, that ER/PR was done and that

19 it was sent back for interpretation. Then

20 would have to go into the old system and get

21 the results. Got names from "big" system, and

22 then went in old system to get reports. After

23 systems merged, it didn't make a difference

24 where the specimen was from as all info was in

25 the one system. Printed all reports and made

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1 spreadsheets of neg and weak positives. Told

2 by oncologist to assume all positives were

3 treated, but also gave list of weak positives,

4 "greater than zero, but less than the clinical

5 guidelines". So this is what Mr. Gulliver -

6 DR. ALAGHEHBANDAN:

7 A. That's right again.

8 COFFEY, Q.C.:

9 Q. And Mr. Dyer told you. Then in terms of were

10 other searches done to look for others, you've

11 noted here, "For out of town's or the other

12 hospitals, couldn't search by word "breast",

13 but could search by procedure ordered. There

14 was no text, no codes, in those referred to

15 Health Sciences Centre, just that Health

16 Sciences Centre was asked to do procedure.

17 Grace didn't even use MCP. So then went into

18 Grace system to pull report, had to cross-

19 reference by the Health Sciences Centre

20 surgical number. Did have other options in

21 mind initially, but chose to do order entry

22 because of their experience with

23 documentation. Wanted oncologist to provide

24 list of patients, but Dr. Laing said their

25 system wasn't able to do it. Health Sciences

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1 Centre was only site in Newfoundland and

2 Labrador that performed ER/PR no matter where

3 specimen was from. Wouldn't change the way

4 the review was done. Still the way of getting

5 the highest confidence of capturing the

6 patients, starting with a broader search at

7 the beginning, for example, all specimens with

8 word "breast" and narrowed down from there

9 would still not be comprehensive. The only

10 way would be to print all breast specimens and

11 have someone review all". So this is what

12 they -

13 DR. ALAGHEHBANDAN:

14 A. And that's what we're in the process of doing.

15 COFFEY, Q.C.:

16 Q. And then here, was it a manual review, and

17 you've noted, "Electronic search provided a

18 list of reports to print out. Then reports

19 would have been reviewed manually, but no

20 manual search was done without first narrowing

21 it down electronically". This would be in

22 St. John's. You've noted here, was cross-

23 referencing done to ensure completeness, and

24 the response is, "No cross-referencing done

25 with St. John's patients. Cross-referencing

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1 could/should be done with the out of town  
 2 specimens by cross-referencing the out of town  
 3 lists with the outside St. John's patients in  
 4 the database".  
 5 DR. ALAGHEHBANDAN:  
 6 A. And that's another initiative that we're  
 7 taking right now.  
 8 COFFEY, Q.C.:  
 9 Q. Could you tell the Commissioner about that,  
 10 what's that about?  
 11 DR. ALAGHEHBANDAN:  
 12 A. Sure. So out of town facilities, when the  
 13 breast sample comes in, basically they create  
 14 their blocks. The blocks get sent down to,  
 15 say, Health Sciences for creating ER/PR  
 16 slides, and those slides go back again to the  
 17 requesting authority, for example, Western,  
 18 Central, or whoever that would be. At each  
 19 region, we have a list of those patients who  
 20 were sent for retesting at St. Clare - at  
 21 Eastern Health, actually St. John's -  
 22 specifically Health Sciences. We have a list  
 23 of those requests that came in from the  
 24 regions for staining. So we can cross-  
 25 reference this to a list. So we can create a

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1 list of those procedure requested by each  
 2 region, and then sending it back to the  
 3 regions and asking them to cross-reference  
 4 with their own list, whether there is any  
 5 missing patients or not.  
 6 COFFEY, Q.C.:  
 7 Q. I take it that's in the process of being done?  
 8 DR. ALAGHEHBANDAN:  
 9 A. We are in the process of developing a  
 10 protocol. Dr. MacDonald and officials at  
 11 Eastern Health met this week and last week,  
 12 and we are in the process of doing that.  
 13 COFFEY, Q.C.:  
 14 Q. For the out of St. John's -  
 15 DR. ALAGHEHBANDAN:  
 16 A. Creating a list for out of town, actually.  
 17 THE COMMISSIONER:  
 18 Q. I just want to make sure I'm clear again. So  
 19 you're taking the list created by the region  
 20 of what they sent?  
 21 DR. ALAGHEHBANDAN:  
 22 A. That's correct.  
 23 THE COMMISSIONER:  
 24 Q. And comparing that to a list created within  
 25 Eastern Health of what it received?

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1 DR. ALAGHEHBANDAN:  
 2 A. That's correct. So they received -  
 3 THE COMMISSIONER:  
 4 Q. Originally.  
 5 DR. ALAGHEHBANDAN:  
 6 A. They received for testing staining. We create  
 7 that list. We send it back to the regions,  
 8 asking them to cross-reference with the list  
 9 that they basically they came up with with  
 10 respect to their search and see whether there  
 11 is any discrepancy.  
 12 COFFEY, Q.C.:  
 13 Q. Would that be to make sure that everyone on  
 14 this list St. John's sent them -  
 15 DR. ALAGHEHBANDAN:  
 16 A. Exactly.  
 17 COFFEY, Q.C.:  
 18 Q. Grand Falls is told what St. John's -  
 19 DR. ALAGHEHBANDAN:  
 20 A. That's right.  
 21 COFFEY, Q.C.:  
 22 Q. We have a record that all these patients we  
 23 did a test for?  
 24 DR. ALAGHEHBANDAN:  
 25 A. For example -

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1 COFFEY, Q.C.:  
 2 Q. And would you check -  
 3 DR. ALAGHEHBANDAN:  
 4 A. Central sent ten patients to St. John's. Now  
 5 in St. John's Meditech, we do have a list of  
 6 these ten patients who had an ER/PR testing  
 7 performed on them. So we have a list from St.  
 8 John's because Central send ten patients. In  
 9 Central, we have, for example, list of nine  
 10 patients who are sent to Mount Sinai. Now we  
 11 have to cross-reference this list and the  
 12 other one. So we come across this patient who  
 13 is on St. John's list for testing, but it is  
 14 not on Central list for being sent to Mount  
 15 Sinai. Based on the search they performed  
 16 back in 2005, each region has a list, and I'm  
 17 referring to that list.  
 18 THE COMMISSIONER:  
 19 Q. I didn't -  
 20 COFFEY, Q.C.:  
 21 Q. Perhaps you can -  
 22 THE COMMISSIONER:  
 23 Q. Well, it's just - I just thought that I had  
 24 this vague memory, and I can't remember which  
 25 of the pathologists it was when they were here

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1 giving evidence was talking about just that,  
 2 about how valuable it would have been -  
 3 COFFEY, Q.C.:  
 4 Q. Yes.  
 5 THE COMMISSIONER:  
 6 Q. - had they--and I thought one of them had  
 7 actually raised it at the time, but perhaps  
 8 I've got the wrong tense. I thought it had  
 9 been done for one reason, but I know that--  
 10 think more than one said it would have been  
 11 valuable to know what Eastern Health thought  
 12 they should have in their records.  
 13 BROWNE, Q.C.:  
 14 Q. Yes, and I believe it was Dr. Neil.  
 15 COFFEY, Q.C.:  
 16 Q. Yes, he did.  
 17 THE COMMISSIONER:  
 18 Q. I frankly don't remember which of the  
 19 pathologists it was, but it was one of the  
 20 pathologists.  
 21 BROWNE, Q.C.:  
 22 Q. Yes, I think Dr. Neil spoke to that, but I  
 23 could be wrong.  
 24 THE COMMISSIONER:  
 25 Q. I believe one of the ones from Central did as

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1 well.  
 2 COFFEY, Q.C.:  
 3 Q. And in fact, Commissioner, and if I recall  
 4 correctly, I think Mr. Dyer and certainly Mr.  
 5 Gulliver did say that, in fact, it would have  
 6 been a good idea to have done it, you know, in  
 7 terms of that.  
 8 THE COMMISSIONER:  
 9 Q. Yes, okay.  
 10 COFFEY, Q.C.:  
 11 Q. Back then, but -  
 12 DR. ALAGHEHBANDAN:  
 13 A. So now we are in the process.  
 14 COFFEY, Q.C.:  
 15 Q. In the process of -  
 16 DR. ALAGHEHBANDAN:  
 17 A. Performing that.  
 18 COFFEY, Q.C.:  
 19 Q. And here, the last note, in terms of  
 20 commentary from St. John's, "after all systems  
 21 were merged, the search was more  
 22 straightforward. Almost all that were missed  
 23 were from 1997 to 1999 because of the  
 24 complexities of the systems before they became  
 25 one. One thing they didn't do was send out a

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1 list to other regions of the specimens done  
 2 for that region for them to cross reference."  
 3 DR. ALAGHEHBANDAN:  
 4 A. And again, he's referring to the point that we  
 5 just discussed.  
 6 COFFEY, Q.C.:  
 7 Q. And dealing with, if we could, because  
 8 Central, of course, is actually two different,  
 9 Central East and Central West. Central East  
 10 would be Gander. You dealt with, I take it,  
 11 on September 16th of this year, Ms. Freake and  
 12 Dr. Gallagher, Sherry Freake?  
 13 DR. ALAGHEHBANDAN:  
 14 A. That's right.  
 15 COFFEY, Q.C.:  
 16 Q. And "they had two LIS systems in Central,  
 17 separate with minimal connections." I take it  
 18 that's one in Gander and one in Grand Falls?  
 19 DR. ALAGHEHBANDAN:  
 20 A. Um-hm.  
 21 COFFEY, Q.C.:  
 22 Q. "The reports were electronic since 1995, still  
 23 have paper based printed for patients charts."  
 24 I apologize, yes, that's it. Page three, in  
 25 terms of how did--"when did the search begin,

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1 a letter from Dr. Cook sent to the lab  
 2 director, June 14th, 2005. Dr. Gallagher  
 3 received the September '05 letter requesting  
 4 all ERS/PRs." And then "did you limit it?  
 5 January 1997 to August 2005, ages zero to 100.  
 6 Initially limited to females, but redid the  
 7 search to include males as well."  
 8 Commissioner, you'll recall Dr. Gallagher made  
 9 a comment about that.  
 10 Then it says "Dr. Gallagher performed the  
 11 search and spoke to IT to get advice on how to  
 12 do it." That's in terms of who performed the  
 13 search. Then in terms of the details about  
 14 the search, you've noted "did the search in  
 15 'miscellaneous' and searched for various  
 16 words: 1. breast, 2. breast plus carcinoma, 3.  
 17 breast plus carcinoma plus hormone receptor.  
 18 Pathology prefix S and retrieved surgical  
 19 report in its entirety. A miscellaneous  
 20 search is a way to do a search that is not set  
 21 up already. Printed all reports that the  
 22 search provided. A minimum of nine searches  
 23 done, maybe more, but searches aren't stored  
 24 in the system, so unable to go back to get  
 25 them, but know there were at least nine

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1 searches because in October '05 sent an e-mail  
 2 saying he," that is Dr. Gallagher, "had done  
 3 nine searches and wanted to make sure that he  
 4 had them all. Carcinoma of breast was a  
 5 search routine set up already, so he wanted to  
 6 ask IT about that search."  
 7 And then here in terms of "were other  
 8 searches done to look for others?" and you've  
 9 noted here he told you "redid the search to  
 10 look for any males that may have been missed.  
 11 ER and PR also searched based on text, but Dr.  
 12 Gallagher can't remember what the search  
 13 turned up." And then there was a manual  
 14 review of pathology reports performed.  
 15 "Reports were reviewed manually," you were  
 16 told.  
 17 And then finally, "was cross referencing  
 18 done to ensure completeness?" You've written  
 19 "established a master list and compared master  
 20 with more inclusive multiple searches so would  
 21 see if there were more they had to include.  
 22 Master list was done of ER negative cases as  
 23 defined by Dr. Cook. Most of the manual work  
 24 and cross referencing was done by Dr. Somers.  
 25 Dr. Gallagher did some as well."

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1 So in relation to Central West, I take it  
 2 again Ms. Freake is being interviewed, as well  
 3 as Glenn Moulard and Evelyn Saunders from  
 4 Grand Falls, that would be, October 1st?  
 5 DR. ALAGHEHBANDAN:  
 6 A. That's right.  
 7 COFFEY, Q.C.:  
 8 Q. And "how many LIS? One Meditech system with  
 9 pathology module implemented in November 2001.  
 10 Before that, used a locally developed program  
 11 called Medicus, somewhat similar to Meditech,  
 12 and when went to Meditech merged the two  
 13 systems. We're told all reports were now  
 14 stored in Meditech, as Medicus data converted  
 15 to Meditech data. Hard copy is kept up to  
 16 November 2001. Some challenges with merge.  
 17 Initially contracted company to do it, but  
 18 some difficulties with that, so was done by IT  
 19 people in Central West. Confident the data  
 20 was transmitted, but there were occasional  
 21 files with problems. Most are okay. Having  
 22 hard copies increases the confidence because  
 23 come across any issues, able to go back  
 24 through hard copies."  
 25 And then in terms of when the search

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1 began, "in 2005, when Dr. Cook memo came out.  
 2 Did you limit it? Search for ages zero to  
 3 120, males and females, 1997 to 2005.  
 4 Initially didn't look for breast related but  
 5 new review in spring '08 did include those.  
 6 Who performed the search? Told Evelyn, manual  
 7 log book search, and Glenn, the Meditech  
 8 search." That's all for Grand Falls.  
 9 Then there's, in terms of the details  
 10 about the search, "Had log booked the recorded  
 11 blocks, slides, ER/PR, etcetera of those that  
 12 were sent out. Included 1999 to 2005 onwards.  
 13 Identified patients that way. After manual  
 14 log book search, Glenn search in Meditech for  
 15 breast and carcinoma and checked that against  
 16 the log book. Each specimen was assigned the  
 17 nature of the specimen--has a sign," I'm  
 18 sorry, "nature of specimen has it's own data  
 19 field and he looked for carcinoma in  
 20 diagnosis, coded as carcinoma in final  
 21 diagnosis, so anything coded as carcinoma  
 22 would have been picked up because after sign  
 23 out computer automatically codes."  
 24 And then in terms of this, "were other  
 25 searches done to look for others?" in terms of

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1 Grand Falls. You've noted "after Sherry  
 2 contacted about a new patient identified in  
 3 the spring of '08, repeated search and printed  
 4 every nature of specimen for 1997 to 2001.  
 5 Greater than 20,000 surgical specimens. Four  
 6 people to review. Anything related to breast  
 7 was counted and looked up. Finished this on  
 8 April 30th, 2008. Electronic search was done  
 9 again for 2001-2005 and manual search for 1997  
 10 to 2001. Found three new cases, including the  
 11 one that called in. Couldn't find them in  
 12 2005 because one wasn't in log book and one  
 13 must have been overlooked."  
 14 And then "was a manual review done?  
 15 Manual log book search done." And then  
 16 there's, in terms of "was cross referencing  
 17 done?" It's noted "cross referencing between  
 18 log book and Meditech and found a couple that  
 19 the log book didn't find." Finally "anything  
 20 to add? Had to make note of those cases that  
 21 were written as ER positive but number given  
 22 as less than ten for example. Some things  
 23 were confusing and made things complex. The  
 24 way of reporting ER/PR was not standardized  
 25 and this may have caused a lot of problems.

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1 If other regions limited search to ER  
 2 negative, they may have missed cases that were  
 3 clinically negative but written in report as  
 4 positive. Always had to check reports for the  
 5 year to see if they were negative or positive  
 6 according to clinical guidelines."  
 7 So in terms of to complete this request  
 8 here, you interviewed Dr. Neil and Dr. Jenkins  
 9 and Hedy Dalton Kenny and Donna Hicks on  
 10 September 30th, 2008. "Have two LIS systems,  
 11 1989 to 1990/1990 to '99. Was a primitive  
 12 computer system, was not searchable. 1999  
 13 onward is Meditech, is searchable. Contains  
 14 all Western for lab and pathology. How are  
 15 they stored? Electronically in old system  
 16 until 1999, then Meditech." Then you've  
 17 written "when did the search begin? Search  
 18 was done when received Dr. Cook memo." It's  
 19 indicated "looked at everything, primary  
 20 breast and all breast related specimens.  
 21 Everything with an ER/PR ordered, male and  
 22 females, all ages. Included deceased when  
 23 asked to do so."  
 24 Now in relation to this, I want to ask  
 25 you about this. Do you have any reason to

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1 believe that any of the regions outside St.  
 2 John's were sending in non-breast--ER/PRs but  
 3 non-breast?  
 4 DR. ALAGHEHBANDAN:  
 5 A. To Eastern Health for being sent to Mount  
 6 Sinai?  
 7 COFFEY, Q.C.:  
 8 Q. Yes.  
 9 DR. ALAGHEHBANDAN:  
 10 A. I can't really comment on that. What I can  
 11 say is that there were two, I guess,  
 12 screening, a screening process here. One at  
 13 each site and one at Eastern Health. So even  
 14 if they sent a non-breast sample to St.  
 15 John's, one would have picked up on that, and  
 16 if they sent a non-breast sample to Mount  
 17 Sinai, Mount Sinai would have reported it.  
 18 COFFEY, Q.C.:  
 19 Q. And here then, in terms of "who performed the  
 20 search? Evelyn, manual long book search and"  
 21 -I'm sorry, I apologize. "Search was done by  
 22 a technologist who looks after pathology  
 23 module here, in Corner Brook."  
 24 THE COMMISSIONER:  
 25 Q. Sorry.

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1 COFFEY, Q.C.:  
 2 Q. Yes, go ahead, Commissioner.  
 3 THE COMMISSIONER:  
 4 Q. But that just reminded me of something.  
 5 There's a reference to primary breast and all  
 6 breast related -  
 7 COFFEY, Q.C.:  
 8 Q. Yes, turn back.  
 9 THE COMMISSIONER:  
 10 Q. - I think searched primary breast. Yeah, I  
 11 think so.  
 12 COFFEY, Q.C.:  
 13 Q. There it is, Commissioner. "Looked at  
 14 everything, primary breast and all breast  
 15 related specimens."  
 16 THE COMMISSIONER:  
 17 Q. Right, and all breast related specimens. Do  
 18 you know whether or not that is consistent  
 19 with what was done elsewhere or were there -  
 20 DR. ALAGHEHBANDAN:  
 21 A. Originally, that wasn't a part of our  
 22 interview. During the course of the  
 23 interviews, we received a suggestion from Mr.  
 24 Thompson's office regarding including this  
 25 basically question with our interviews, and

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1 that's why we asked the questions from  
 2 officials at Western.  
 3 THE COMMISSIONER:  
 4 Q. Okay.  
 5 DR. ALAGHEHBANDAN:  
 6 A. And I believe that -  
 7 THE COMMISSIONER:  
 8 Q. So it wasn't part of what you asked the  
 9 others?  
 10 DR. ALAGHEHBANDAN:  
 11 A. No, but I believe that at some point we will  
 12 be asking the other regions the same question,  
 13 just to be consistent across the board.  
 14 THE COMMISSIONER:  
 15 Q. Thank you.  
 16 DR. ALAGHEHBANDAN:  
 17 A. You're welcome.  
 18 COFFEY, Q.C.:  
 19 Q. Here then, page four, here in terms of  
 20 "details about the search" you've told them  
 21 "Western used ER"--apologize, just come across  
 22 here. "Used ER/PR immunohistochemical order  
 23 sheet. When pathologists wanted ER/PR stains  
 24 done on a specimen, secretary sends it to St.  
 25 John's and keeps requisition form, so able to



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1 search all hard copy requisition forms for  
 2 1997 to 2005. Asked the Newfoundland Cancer  
 3 Treatment Research Foundation for all cases  
 4 over the years, '97 to '05, by place of  
 5 residence for Western. Found this helpful.  
 6 Searched Meditech from 1999 onwards. Tumor  
 7 markers placed in system individually marked  
 8 and technologists provided list of cases for  
 9 1999 to 2005. Tumor markers specifically for  
 10 ER/PR were used to search Meditech.  
 11 Automatically assigns an ER/PR marker to every  
 12 malignant breast tumor. After diagnosis made,  
 13 it automatically attaches the tumor markers  
 14 and then searched for those markers."  
 15 And then continuing on, in terms of "were  
 16 other searches done?" Western told you  
 17 "double checked first method with requisition  
 18 forms. Have a record book, manual lists to  
 19 say that something was sent out to St.  
 20 John's." And then in terms of "was a manual  
 21 review of pathology reports done?" It's noted  
 22 "printed reports that electronic search  
 23 provided and Dr. Jenkins reviewed them all.  
 24 Spreadsheets detailed this and Commission of  
 25 Inquiry has those spreadsheets." And "was

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1 cross referencing done to ensure  
 2 completeness?" Noted "cross referenced lists,  
 3 double check using record book saying that  
 4 something was sent out to St. John's."  
 5 "Anything to add?" You've noted,  
 6 "Stephenville and Corner Brook are two areas  
 7 that do breast specimens for Stephenville.  
 8 They are put in formalin and in fridge and  
 9 transported to Corner Brook same day or next  
 10 day." So that's what you were told there?  
 11 DR. ALAGHEHBANDAN:  
 12 A. That's right.  
 13 COFFEY, Q.C.:  
 14 Q. And finally then, in terms of -  
 15 THE COMMISSIONER:  
 16 Q. I'm sorry, Mr. Coffey, but before you move on.  
 17 COFFEY, Q.C.:  
 18 Q. Yes.  
 19 THE COMMISSIONER:  
 20 Q. Dr. Reza or Dr. MacDonald, I don't know who  
 21 would best answer this, but are all Meditech  
 22 systems created equal that are used in this  
 23 province?  
 24 DR. MACDONALD:  
 25 A. They're all bought from the same company.

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1 THE COMMISSIONER:  
 2 Q. Um-hm.  
 3 DR. MACDONALD:  
 4 A. So they all use the same technology and the  
 5 same modules, but it's up to the regions to  
 6 standardize their own programs. So where the  
 7 difference occurs is around how they enter in  
 8 their data into the Meditech.  
 9 THE COMMISSIONER:  
 10 Q. Because when you're looking at something like  
 11 this where it's all sort of lined up together,  
 12 it would appear that while I understand that  
 13 some regions got Meditech at different times  
 14 than others did, but it would also appear that  
 15 the use of it, for this purpose, varied a  
 16 great deal across the regions and the  
 17 perceived capability of Meditech was  
 18 different. At least I'm gleaning that from  
 19 witnesses.  
 20 DR. MACDONALD:  
 21 A. That is true. We have--I don't know how many  
 22 Meditechs we have. I'm going to guess here  
 23 it's six, eight maybe. They don't talk to  
 24 each other.  
 25 THE COMMISSIONER:

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1 Q. Um-hm.  
 2 DR. MACDONALD:  
 3 A. So they're silos, and they use different  
 4 standards, different--you know, everything is--  
 5 it's up to the regions when they generated  
 6 their own modules for service providing care,  
 7 it was up to them how they wanted to design  
 8 it. So for example, a region may say, you  
 9 know, order entry, put in ER/PR. Another one  
 10 might set it up, you have to spell it out.  
 11 Some use drop down windows, so you don't have  
 12 to worry about spelling or inconsistencies.  
 13 So it is really very much a silo type of  
 14 information system across our regions.  
 15 THE COMMISSIONER:  
 16 Q. Okay. So I could not, for example, assume  
 17 because Meditech exists in a particular region  
 18 that there is a capability just because it  
 19 happens to be--Meditech happens to be capable  
 20 of making a search on a certain basis in  
 21 another region?  
 22 DR. MACDONALD:  
 23 A. Yeah, you know, for example, if you had a test  
 24 done in St. John's and you're living out in  
 25 Gander and went to your hospital and did a

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1 search on that test, they won't get it.  
 2 COFFEY, Q.C.:  
 3 Q. Or even if the same search was--a particular  
 4 search was done, Meditech existed in Gander  
 5 and existed in St. John's, and you adopted a  
 6 particular approach, for example, the tumor  
 7 markers one we just referred to there. Some  
 8 Meditech systems, I take it, might code by  
 9 that and some might not?  
 10 DR. MACDONALD:  
 11 A. Well, yes, it's how you design your own lab  
 12 system, and let's not forget, there's a lot  
 13 different modules in Meditech than lab.  
 14 COFFEY, Q.C.:  
 15 Q. Yes.  
 16 DR. MACDONALD:  
 17 A. So this is not just an issue for our labs.  
 18 THE COMMISSIONER:  
 19 Q. Yes, the search fields could be different in  
 20 different places, etcetera, etcetera. So just  
 21 because it's all called Meditech, we can't  
 22 make assumptions about what it -  
 23 DR. MACDONALD:  
 24 A. Yeah, I mean -  
 25 THE COMMISSIONER:

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1 Q. - is set up to do, as opposed to what it might  
 2 be capable of doing?  
 3 DR. MACDONALD:  
 4 A. - an authority, when they were first  
 5 purchasing Meditech years ago, would decide  
 6 how much they want to expend on it and what  
 7 modules, what they want, what functionality  
 8 they want. So they would cherry pick from the  
 9 list available, functionality, and build it.  
 10 So it's--the fact that you have Meditech here  
 11 and Meditech there does not imply -  
 12 THE COMMISSIONER:  
 13 Q. Doesn't tell you anything.  
 14 DR. MACDONALD:  
 15 A. No.  
 16 THE COMMISSIONER:  
 17 Q. Okay, thank you.  
 18 DR. MACDONALD:  
 19 A. And just to follow up on that, it presented  
 20 much challenges for us in developing the  
 21 database because we had to deal with  
 22 individual Meditechs and the inconsistencies  
 23 around standards.  
 24 COFFEY, Q.C.:  
 25 Q. Here, in terms of Labrador Grenfell, Dr. Reza,

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1 I take it, on September 3rd, 2008, you  
 2 interviewed Dr. Dankwa?  
 3 DR. ALAGHEHBANDAN:  
 4 A. That's right.  
 5 COFFEY, Q.C.:  
 6 Q. And it says he told you "one LIS system  
 7 Meditech introduced in July '03. From '97 to  
 8 2005, patient info typed into computer and  
 9 hard copies kept. '03 onward, Meditech was  
 10 used with electronic info available. July ' 03  
 11 onward, had both hard copies and electronic  
 12 Meditech info available." And in terms of  
 13 "when the search began? They did initial  
 14 search in 2005 when the letter came from Dr.  
 15 Cook regarding all ER negative patients." And  
 16 reference, "did you limit the search? First  
 17 letter came saying only 2002 patients. No  
 18 Meditech system then, so went through all  
 19 reports manually to find ER negative for 2002.  
 20 Then 2005 letter required all cases from ' 97  
 21 to '05." And then there's reference to "who  
 22 performed the search? Dr. Dankwa and clerical  
 23 staff. Whatever clerical staff weren't sure  
 24 about, they would bring to Dr. Dankwa's  
 25 attention."

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

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1 Q. So what Dr. Dankwa says happened here was he  
 2 asked St. John's to send him out a list -  
 3 DR. ALAGHEHBANDAN:  
 4 A. To cross reference with his own list that he  
 5 created. That's right, I believe so.  
 6 THE COMMISSIONER:  
 7 Q. Well, yes, to help -  
 8 COFFEY, Q.C.:  
 9 Q. "Asked St. John's to help by asking for a list  
 10 of all breast specimens that went to St.  
 11 John's from '97 to '05."  
 12 DR. ALAGHEHBANDAN:  
 13 A. That's correct.  
 14 COFFEY, Q.C.:  
 15 Q. All that went from his shop to St. John's.  
 16 DR. ALAGHEHBANDAN:  
 17 A. His region to St. John's.  
 18 THE COMMISSIONER:  
 19 Q. So that's the kind of nature of the kind of  
 20 thing that you're now anticipated in respect  
 21 of all other centres?  
 22 DR. ALAGHEHBANDAN:  
 23 A. That's correct.  
 24 THE COMMISSIONER:  
 25 Q. All right, thank you.

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1 DR. ALAGHEHBANDAN:  
 2 A. You're welcome.  
 3 COFFEY, Q.C.:  
 4 Q. And the next page, Commissioner, here in terms  
 5 of "were other searches done to look for  
 6 others?" You were told "when the Centre  
 7 requested ER/PR cases, they went through  
 8 everything again. This time, went through  
 9 everything manually, approximately 2,000  
 10 reports a year, went through" and this is  
 11 underlined and italicized, "every report." So  
 12 in terms of that, what was Dr. Dankwa telling  
 13 you then about that?  
 14 DR. ALAGHEHBANDAN:  
 15 A. Extensive effort.  
 16 COFFEY, Q.C.:  
 17 Q. When they were asked to -  
 18 DR. ALAGHEHBANDAN:  
 19 A. Went through all those pathology reports  
 20 himself.  
 21 COFFEY, Q.C.:  
 22 Q. When they were asked, in 2008, by yourselves  
 23 to look at this again, he went through  
 24 everything?  
 25 DR. ALAGHEHBANDAN:

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1 A. Everything.  
 2 COFFEY, Q.C.:  
 3 Q. Every -  
 4 DR. ALAGHEHBANDAN:  
 5 A. Every pathology report.  
 6 COFFEY, Q.C.:  
 7 Q. - pathology report.  
 8 DR. ALAGHEHBANDAN:  
 9 A. Within his region.  
 10 COFFEY, Q.C.:  
 11 Q. In that time frame?  
 12 DR. ALAGHEHBANDAN:  
 13 A. That's right.  
 14 COFFEY, Q.C.:  
 15 Q. And has any other region done that, to your  
 16 knowledge?  
 17 DR. ALAGHEHBANDAN:  
 18 A. Dr. Baker.  
 19 COFFEY, Q.C.:  
 20 Q. In Carbonear?  
 21 DR. ALAGHEHBANDAN:  
 22 A. Carbonear. Central done manual work using  
 23 word press (phonetic) and Western as well,  
 24 some manual work too.  
 25 COFFEY, Q.C.:

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1 Q. But in terms of actually sitting down and  
 2 getting all your pathology reports and looking  
 3 through them all, Dr. Dankwa is the only one  
 4 who has actually done that?  
 5 DR. ALAGHEHBANDAN:  
 6 A. Dr. Dankwa, yes, that's right.  
 7 COFFEY, Q.C.:  
 8 Q. And here, "was cross referencing done to  
 9 ensure completeness?" You've noted "yes, when  
 10 the Centre requested the reports," he told  
 11 you. And then "anything to add?" You note  
 12 he's told you "wrote to CEO about the time it  
 13 would take to go through the reports again in  
 14 2007, but did it manually because they wanted  
 15 to be able to stand behind their search."  
 16 DR. ALAGHEHBANDAN:  
 17 A. That's right.  
 18 COFFEY, Q.C.:  
 19 Q. Indicated to you. Now, having conducted all  
 20 those interviews, created your chart here, did  
 21 you have then any concerns?  
 22 DR. ALAGHEHBANDAN:  
 23 A. My first concern would be with the potential  
 24 data got missed during the transfer from old  
 25 system to new system in Clarenville. So, that

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1 would be major concern, if I would look at  
 2 this report. Within St. John's region, we did  
 3 the search based on ER/PR procedure code. So,  
 4 that would be another area of concern because  
 5 now we learn that there are some patients out  
 6 there who got missed through the initial  
 7 search because the ER/PR entry code was not  
 8 added into the system. The rest of the  
 9 regions basically, I must say, that they would  
 10 be, felt sufficient to create a cross-check  
 11 list from St. John's area, Health Sciences  
 12 Lab, sending it to the regions and they can  
 13 cross-reference with their own list. So, that  
 14 would be hopefully sufficient enough to give  
 15 better level of confidence.  
 16 COFFEY, Q.C.:  
 17 Q. And if I could, could I see Exhibit P-2152,  
 18 please? And I appreciate you've probably--  
 19 I'll ask you, I don't know if you've seen  
 20 this, page 8 please. Dr. Reza, this is just  
 21 the one copy of all the--just go back a page,  
 22 this is on the back of this page.  
 23 DR. ALAGHEHBANDAN:  
 24 A. That's right.  
 25 COFFEY, Q.C.:

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1 Q. Original sheet of paper. Have you seen a form  
 2 like this, this sort of print out before, in  
 3 the context of the special procedure request  
 4 forms.  
 5 DR. ALAGHEHBANDAN:  
 6 A. I have never seen this form, this page.  
 7 COFFEY, Q.C.:  
 8 Q. Have you seen anything like it?  
 9 DR. ALAGHEHBANDAN:  
 10 A. No, not that I can recall.  
 11 COFFEY, Q.C.:  
 12 Q. Okay. So, we're told, advised by a witness  
 13 that--because you can read here, it's an  
 14 immunohistochemical report. This is of  
 15 probably May 6, 1998, the patient's name is  
 16 not filled in, but there's a case number,  
 17 surgical number there, the doctor is indicated  
 18 to be Khalifa. The technician is Peggy. The  
 19 institution is the Health Sciences Centre.  
 20 There's a slide number spelled out here. This  
 21 happens to be number 19 and 20, the antibody  
 22 is estrogen receptor, 1--50, 30 minutes.  
 23 Progesterone receptor, 1--10, 30 minutes.  
 24 Protocol is all spelled out here. And  
 25 staining--there's a space for staining, see

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1 note, noise, and commentary. We're advised  
 2 that this was produced by a DAKO computer,  
 3 related to the DAKO machine.  
 4 DR. ALAGHEHBANDAN:  
 5 A. Right.  
 6 COFFEY, Q.C.:  
 7 Q. That's what we understand. If this sort of  
 8 data had been, as it was being generated over  
 9 the years, days and years as tests were going  
 10 on, was being generated and stored in the  
 11 DAKO, if it had been and that was available to  
 12 you, would that have been of assistance  
 13 perhaps in identifying exactly when a  
 14 particular test was done?  
 15 DR. ALAGHEHBANDAN:  
 16 A. I guess I would question one point here,  
 17 whether DAKO system read the slide.  
 18 COFFEY, Q.C.:  
 19 Q. Oh, no, no, it didn't read the slide.  
 20 DR. ALAGHEHBANDAN:  
 21 A. No, -  
 22 COFFEY, Q.C.:  
 23 Q. This is just -  
 24 DR. ALAGHEHBANDAN:  
 25 A. This is just the DAKO system stored it.

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1 COFFEY, Q.C.:  
 2 Q. Yes, it just simply--the DAKO system, we  
 3 understand, in slot number 19, there was an ER  
 4 slide processed with that -  
 5 DR. ALAGHEHBANDAN:  
 6 A. Yes, well that's one thing. The second this is  
 7 let's look at the specimen. I don't know  
 8 whether this is a lung specimen, this is an  
 9 ovary specimen, this is a breast specimen. I  
 10 don't know what specimen is this. And  
 11 normally when you look at a pathology report,  
 12 it contains two major sections, gross and  
 13 microscopy. So, you simply explain what you  
 14 have right now. For example, I have a breast  
 15 specimen with this size and these are the  
 16 characteristics of this and then I go into  
 17 microscopy and I describe what kind of cells I  
 18 see. Here I just see two numbers, it sounds  
 19 like an addendum to me, that someone performed  
 20 the ER/PR testing and reported it as what -  
 21 COFFEY, Q.C.:  
 22 Q. No, no, this is not a report.  
 23 DR. ALAGHEHBANDAN:  
 24 A. This is just -  
 25 COFFEY, Q.C.:

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

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1 of the database at the time. So, again, with  
 2 respect to the database, I don't see any value  
 3 of that at this moment.  
 4 DR. MACDONALD:  
 5 A. So, Bernard, would you be asking if we  
 6 actually had in our database, protocols -  
 7 COFFEY, Q.C.:  
 8 Q. Oh yes, in terms of--well, no, I'm just asking  
 9 about whether or not Dr. Reza was ever  
 10 actually, you know, introduced to the idea and  
 11 if so, if he understood the potential  
 12 significance of the change in protocols over  
 13 time.  
 14 DR. MACDONALD:  
 15 A. We certainly had identified the issue of  
 16 different protocols used at Mount Sinai and a  
 17 lab here and that that might interject a  
 18 difference in and of itself into the change in  
 19 results, but we didn't take it any further  
 20 than that and it certainly wasn't part of the  
 21 database.  
 22 COFFEY, Q.C.:  
 23 Q. Okay.  
 24 DR. MACDONALD:  
 25 A. So, our results, as we've said, you have your

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1 original ER/PR, there is no protocol around  
 2 that. You have to retest ER/PR and there is  
 3 no protocol around that. So, it's basically a  
 4 flat file saying here's what you had and  
 5 here's what you got.  
 6 THE COMMISSIONER:  
 7 Q. I'm not sure your original question was  
 8 answered, Mr. Coffey and I'm not sure the  
 9 witness understood you original question.  
 10 COFFEY, Q.C.:  
 11 Q. So, in terms of--if you were to be told, okay,  
 12 that this would indicate, that for that  
 13 surgical number, see that surgical number  
 14 right here?  
 15 DR. ALAGHEHBANDAN:  
 16 A. I can see that, yes.  
 17 COFFEY, Q.C.:  
 18 Q. And that's the pathologist?  
 19 DR. ALAGHEHBANDAN:  
 20 A. That's right.  
 21 COFFEY, Q.C.:  
 22 Q. And that's the technician.  
 23 DR. ALAGHEHBANDAN:  
 24 A. That's correct.  
 25 COFFEY, Q.C.:

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1 Q. That on that particular day -  
 2 DR. ALAGHEHBANDAN:  
 3 A. That test was -  
 4 COFFEY, Q.C.:  
 5 Q. - that surgical number, those two, an ER and a  
 6 PR slide were produced.  
 7 DR. ALAGHEHBANDAN:  
 8 A. Um-hm.  
 9 COFFEY, Q.C.:  
 10 Q. Would that have been of any use--if that was  
 11 available just unmasked to you, you were able  
 12 to tell from the computerized database that  
 13 using that surgical number, you can search the  
 14 database, search it using that surgical number  
 15 and identify what particular day it was done,  
 16 by what technologist -  
 17 DR. ALAGHEHBANDAN:  
 18 A. So, let's look at the surgical number here.  
 19 The surgical number is from 1998. It's says  
 20 Central. If I am at Centre and I'm looking at  
 21 Meditech in Central, if I have access to  
 22 Meditech in Central, I can put that number  
 23 into Meditech and I can pull out the pathology  
 24 report. However, if I'm in St. John's and St.  
 25 John's Meditech is not connected to Central

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

10 COFFEY, Q.C.:  
 11 Q. Um-hm.

12 DR. ALAGHEHBANDAN:  
 13 A. So, when I'm looking at this, this is a  
 14 surgical number from Central. If I'm here or  
 15 somewhere else, except Central, I won't be  
 16 able to pull it out.

17 DR. MACDONALD:  
 18 A. If we had those fields, we could further  
 19 analysis, obviously, on associations. For  
 20 example, doctors, technicians, to look to see  
 21 if something, if there's a trend, in results.

22 COFFEY, Q.C.:  
 23 Q. Um-hm.

24 DR. MACDONALD:  
 25 A. So, I mean, if that's what the question was,

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

3 THE COMMISSIONER:  
 4 Q. Well, what about something as simple as  
 5 identifying whether or not you have all the  
 6 patients identified? If you have a DAKO  
 7 system or two DAKO systems and you have a DAKO  
 8 machine, whatever they're called, which  
 9 provides, within it, a record of every test  
 10 done by that machine and that record includes  
 11 a number through which I assume you can  
 12 identify the patient, why could that machine  
 13 not make you aware of whether or not you  
 14 actually got every patient, up to the point  
 15 that they stopped using the DAKO?

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

25 THE COMMISSIONER:

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1 Q. Um-hm.

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

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

20 DR. ALAGHEHBANDAN:  
 21 A. That's useful -

22 DR. MACDONALD:  
 23 A. That would be very -

24 DR. ALAGHEHBANDAN:  
 25 A. That's valuable.

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1 COFFEY, Q.C.:  
 2 Q. In terms of that -

3 DR. ALAGHEHBANDAN:  
 4 A. It is.

5 COFFEY, Q.C.:  
 6 Q. Because you wouldn't be running around,  
 7 amongst other things, looking at handwritten  
 8 lists.

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

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

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1 to be breast or whatever, but -  
 2 DR. ALAGHEHBANDAN:  
 3 A. If the surgical number indicates where that  
 4 specimen is coming from, then that would be  
 5 quite valuable.  
 6 THE COMMISSIONER:  
 7 Q. Um-hm.  
 8 DR. ALAGHEHBANDAN:  
 9 A. In this case it indicates that it's coming  
 10 from Central (CNH).  
 11 THE COMMISSIONER:  
 12 Q. Yes.  
 13 DR. ALAGHEHBANDAN:  
 14 A. If that doesn't indicate where it is coming  
 15 from, then you have a surgical number, could  
 16 come from Anywhere.  
 17 THE COMMISSIONER:  
 18 Q. Okay, all right, I understand. Wherever you  
 19 find a convenient spot, Mr. Coffey, we'll  
 20 break.  
 21 COFFEY, Q.C.:  
 22 Q. Exhibit P-3550. This, Mr. MacDonald, is an e-  
 23 mail from yourself to Mr. Thompson of October  
 24 15, 2008 indicated that "a 'manual' search is  
 25 a robust approach given it applies all hard

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

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

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1  
 2 CERTIFICATE  
 3 I, Judy Moss, hereby certify that the foregoing is  
 4 a true and correct transcript in the matter of the  
 5 Commission of Inquiry on Hormone Receptor Testing,  
 6 heard on the 23rd day of October, A.D., 2008 before  
 7 the Honourable Justice Margaret A. Cameron,  
 8 Commissioner, at the Commission of Inquiry, St.  
 9 John's, Newfoundland and Labrador and was  
 10 transcribed by me to the best of my ability by  
 11 means of a sound apparatus.  
 12 Dated at St. John's, Newfoundland and Labrador  
 13 this 23rd day of October, A.D., 2008  
 14 Judy Moss

Inquiry on Hormone Receptor Testing

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