

INQUEST INTO THE DEATH OF

L I S A S H O R E

SUBMISSIONS/CHARGE BY THE CORONER

TAKEN FEBRUARY 10, 2000

BEFORE DR. JAMES CAIRNS, DEPUTY CHIEF CORONER

CORONER'S COURT, TORONTO

A P P E A R A N C E S:

Counsel for the Coroner	MARGARET BROWNE, MS.
Counsel for the Shore Family	FRANK K. GOMBERG, ESQ.
Counsel for the Hospital for Sick Children, et al	PATRICK HAWKINS, ESQ. RENEE A. KOPP, MS.
Counsel for Drs. Schily, Catre and Wright	ANNE POSNO, MS.
Counsel for Corometric	VAN KRKACHOVSKI, ESQ.

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1 end, however long it takes. You're not going
2 to be rushed about this. You'll have lots of
3 time. Thank you again on behalf of everybody
4 in the inquest. I'd like to thank the
5 lawyers for their submissions and their
6 suggestions, and of course, Constable
7 Culleton, without whom I could not operate.

8 THE CORONER: Thank you, Ms. Browne.

9
10 CHARGE BY THE CORONER:

11 It remains but for me to give you my final
12 address and before I do so, I have to remind
13 you that all the summations by the lawyers
14 and by myself are but summations. You are
15 not bound to accept the summation of any of
16 the lawyers and you're not bound to accept my
17 summation. You're the jury, I'm not the
18 jury. Summations also are not evidence.
19 People may, in their summations, have
20 interpreted evidence the way they want, but
21 that's not evidence, the evidence is only
22 what you heard from witnesses when they were
23 on the witness stand, and those are the only
24 ones that you can accept. You can accept or
25 reject all or part of any of the Counsel's

1 interpretation of the evidence in their
2 summation. That's up to you, but it's your
3 decision, if it's not taken.

4 And quite often, since I am presiding
5 over the inquest or the Coroner presiding
6 over the inquest goes last, there is a
7 feeling that the jury feel like since I've
8 been presiding they must accept what I say
9 with more weight than anyone else, and I want
10 to stress that my summation, apart from where
11 I will clarify to you what you can and cannot
12 do, anything I say is -- give no more weight
13 than you think it deserves. The fact that
14 I'm sitting at a slightly higher level in the
15 court than anyone else is not of relevance to
16 anything I say.

17 We started this inquest, as you know,
18 last November, it got off the rails pretty
19 quickly and this inquest has been a rather
20 unusual inquest. I mentioned at the
21 beginning of the inquest that an inquest in
22 Ontario was a public inquiry that served
23 three primary functions; for the public
24 ascertainment of facts relating to deaths;
25 for a means for focusing community attention

1 on and initiating a community response to
2 prevent deaths. In other words, that's the
3 recommendations; and a means of satisfying
4 the community of the circumstances
5 surrounding the death of no one of its
6 members will be overlooked, concealed or
7 ignored.

8 With particular regard to number three,
9 that no death will be overlooked, concealed
10 or ignored, I think it is fair to say that
11 when this inquest started, one could not
12 clearly say that all the facts or all the
13 evidence or anyone who had something that
14 could add, shed light on what happened to
15 Lisa was known. Part of that became a
16 bombshell within the first few days when all
17 of a sudden theories were being brought forth
18 as to why monitors didn't go off and we had
19 to adjourn the inquest. I did indicate at
20 that time that this inquest would be rather
21 unusual in comparison to many other inquests
22 in that it would, in effect, be an
23 investigation of the death.

24 Now, you've heard much about that,
25 you've heard much with regard to why that

1 happened. There have been some good
2 recommendations put forth that in a proper
3 situation, a lot of that should have been
4 done earlier. Some of that certainly is the
5 initial investigation done by the Coroner's
6 office and the communication with the
7 hospital and the family. There have been
8 recommendations aimed at straightening that
9 out. I would certainly support those
10 recommendations. I also have it within my
11 power, with or without that recommendation,
12 to take that in hand and will do so.

13 I do not think that the appropriate time
14 to be finding all these things out is at the
15 inquest because you, as you commented and I
16 couldn't agree with you more, it was, "What
17 bombshell are we going to hear today," so
18 that it did mean that a lot of the evidence
19 was fragmented, we had to stop for a day or
20 two because not only did you not understand
21 it, but nobody else in the courtroom
22 understood it. So in that way, this has been
23 a much more controversial inquest than
24 normal.

25 It has meant in many ways that it took

1 on a much more adversarial situation at many
2 stages throughout the inquest than would be
3 necessary, but in order to try and get all
4 the facts out, I feel that that was
5 necessary. I was quite liberal in allowing
6 Counsel to ask questions because there hadn't
7 been an opportunity for those to be
8 satisfactorily clarified. And in as far as
9 they can be clarified, given that there are
10 some pieces of paper, et cetera, missing,
11 there's nothing we can do about it. I hope
12 you feel that at least insofar as evidence
13 can be presented to you, that that has been
14 done.

15 An inquest, as I told you at the
16 beginning, it not a trial, although if you
17 walked into this inquest on many of the days,
18 you would be very confused to know as to
19 whether you were at a trial or not. There is
20 nothing to prevent questions being asked in
21 order to make sure that the facts are
22 obtained, so that a lot of the hard
23 questionings are there to obtain the facts.
24 The difference between obtaining the facts at
25 an inquest and obtaining the facts at either

1 a criminal trial or a civil trial is what you
2 can do with those facts.

3 And in those other forums, obviously the
4 facts will be used to, in fact, attribute
5 blame one way or the other, be it either that
6 someone is guilty of a criminal offence or
7 that someone is found negligent civilly with
8 regard to their actions. That you cannot, as
9 has been said, you cannot do that so that
10 there's a catch-22 here; you've heard the
11 evidence the way you've heard it, it's been
12 very much like a criminal trial, it's been
13 very much like a civil litigation trial.

14 I have presided over inquests before
15 where, in fact, the inquest, there was, under
16 different circumstances, it clearly, and I'm
17 not referring to this, it clearly was a
18 murder, but for various reasons it could not
19 go to trial, and in those situations, once
20 again, although the facts come out, you could
21 not draw the same conclusions. You cannot,
22 in this case, either, do that.

23 There are other ways and there are other
24 forums for talking about blame and guilt.
25 There is the criminal justice system, which

1 does not apply to this death, there is civil
2 litigation. We have heard there has been
3 civil litigation in this case and there are
4 also disciplinary bodies that can deal with
5 whether someone, in fact, has erred in terms
6 of or to such an extent that they are
7 negligent in regard to their discipline
8 bodies. With regard to physicians, there's
9 the College of Physicians and Surgeons,
10 there's also the College of Nursing, et
11 cetera, so there are other forums that will
12 deal with some of the issues that obviously
13 have concerned you regarding discipline. So
14 that is not your function here, even though
15 the evidence was presented in such a way that
16 at many times, you may want to speak out on
17 that and give some voice on that; the law is
18 absolutely clear that is not the purpose of
19 an inquest. And it's quite rightly not the
20 purpose of an inquest.

21 Many of these other forums where deaths
22 are looked into, you may get at the end of it
23 an innocent or guilty verdict but that's it,
24 you get nothing that will do anything and you
25 may not even get the full facts of the case

1 because the full facts of the case due to the
2 strict rules of evidence may not be allowed
3 in. Here they can be allowed in, so very
4 often at an inquest, you will get a more
5 detailed, factual account of what went on
6 because we do not restrict things in the same
7 manner putting it before you as the jury.

8 If you were sitting at this in a
9 different forum, your answer would be
10 "innocent" or "guilty." You would have no
11 role in saying, okay, now that we know what
12 happened to Lisa, Lisa is dead, we
13 unfortunately cannot bring her back, but her
14 death does not have to go in vain. There are
15 the aspects of the recommendations that you
16 can make that you can go home later feeling
17 that Lisa Shore's memory will live on and it
18 will live on in a very positive manner
19 because of issues that you have found that
20 needed corrected. And that way, it is much
21 more satisfying, and I'm saying to you that
22 your verdict is a much nicer verdict than
23 innocence or guilt because you're doing
24 something positive.

25 I indicated to you at the beginning that

1 when all the evidence was in, that you would
2 have to then make a decision and you would
3 have to include in your decision who Lisa
4 was, when she died, where she died, her
5 medical cause of death and the by what means,
6 and I'd like to deal with those briefly at
7 this time. I'm repeating, but it's my
8 obligation to do so.

9 Obviously we know that it's Lisa Shore
10 that died, we know that she died on the 22nd
11 of October and in terms of the time of her
12 death, you can either put the official time
13 when her death was pronounced, which was, I
14 think, at 7:50 or, if you wish, I have no
15 objection if you put that she died sometime
16 between 6:00 a.m. and 7:15. I think the
17 evidence will not take you any further than
18 that. We know she died at the Hospital for
19 Sick Kids.

20 Her cause of death, that is the medical
21 cause of death, is one of the questions that
22 has to be answered and you will have to base
23 your medical cause of death on the evidence
24 that you've heard. And who did you hear,
25 what evidence did you hear with regard to the

1 cause of death? You heard Dr. Smith
2 testifying on behalf of Dr. Taylor saying
3 that at the autopsy, they could not find any
4 anatomical cause of death; they could not
5 find any disease process or any congenital
6 abnormality or any injuries to Lisa that
7 would explain her death. So therefore the
8 pathologist at the end of that autopsy says I
9 don't know what the cause of death is. That
10 does not mean that the pathologist is
11 therefore saying that there will never be a
12 cause of death, just within the confines of
13 that expertise, there's no cause of death.
14 It is ruling out, as far as they could find,
15 natural causes of death.

16 With regard to the toxicologist, the
17 toxicologist, Dr. Mayer, was able to indicate
18 the different drug levels and was able to
19 indicate that the drug levels that were found
20 from his background were in and of themselves
21 not a cause of death, so he did not directly
22 have a cause of death, although if you will
23 remember, he indicated that he did not feel
24 he could properly interpret those because he
25 was not a doctor and was not a clinical

1 pharmacologist, so he would prefer to just
2 say individually those drugs did not cause
3 death.

4 The Pediatric Review Committee reviewed
5 the death, as well, and from within their
6 expertise, they themselves did not come up
7 with a cause of death, but in their report,
8 they did indicate that some of those
9 questions would be addressed by a toxicology
10 expert opinion which concluded, "I do,
11 however, think it is likely the death was
12 caused by a cardiac conduction disturbance,
13 which may have resulted from a complex
14 interaction among the therapeutic drugs in
15 the patient."

16 And originally it was also included that
17 there may have been an concurrent viral
18 infection, myocarditis, that was subsequently
19 ruled out. So the Pediatric Review
20 Committee, in their expertise, the committee
21 did not have a cause of death but they did
22 not say that therefore there was no cause of
23 death, they were suggesting that it should be
24 relied basically on Dr. MacLeod's evidence.

25 And Dr. MacLeod's evidence, to get to

1 the cause of death or to get to his opinion
2 about the cause of death, really did take
3 until December of this year, so even from the
4 time this inquest started in November, he was
5 still changing his opinion on things and you
6 heard his evidence that he feels, I'm quoting
7 from his report, he believes, "The cause of
8 death in this case will not be made
9 definitively." In other words, not beyond a
10 reasonable doubt on the basis of pharmacology
11 or toxicology analysis.

12 He does, however, think it's likely that
13 the death was caused by a cardiac arrhythmia
14 or a cardiac conduction which may have
15 resulted from a complex interaction among the
16 therapeutic drugs, and particularly with
17 regard to morphine and gabapentin. And on
18 the witness stand, my personal feeling is
19 that he said he felt that was the probable
20 cause of death.

21 In terms of when you decide on the cause
22 of death, you will make that decision on the
23 balance of probability. It's not as the
24 criminal code, where it has to be beyond a
25 reasonable doubt. I don't think Dr. MacLeod

1 was able to say beyond a reasonable doubt
2 this was the cause of death. It will be up
3 to you to decide whether you feel on the
4 balance of probability. We know that Lisa is
5 dead; unfortunately, that is the saddest fact
6 about the inquest, and therefore we're not
7 talking in a vacuum. We have someone that's
8 dead, we have ruled out other things and
9 there must be a cause and therefore if there
10 is a likely cause, if this was a theoretical
11 discussion, could this cause death and we
12 weren't talking about the death, it would be
13 more academic, but we do have the death and
14 therefore I don't think it is a big jump
15 under those circumstances to say given
16 everything else has been ruled out and given
17 the expertise of Dr. MacLeod, and I think it
18 is important in terms of Dr. MacLeod is
19 suggesting that he feels there is a probable
20 cause of death here, you have heard no other
21 evidence from any other witness that is
22 contradicting that.

23 It would be my anticipation if there was
24 other good experts out there who had
25 something very, very different to say about

1 that, that the resources of the various
2 Counsel that have been at this inquest would
3 have been able to and could have called
4 witnesses to that effect. So I think it is
5 significant that that has not been
6 contradicted.

7 But you will, on the cause of death,
8 have to decide whether on the balance of
9 probabilities you accept Dr. MacLeod's
10 opinion or not. If you cannot accept his
11 opinion on the balance of probabilities, then
12 you would be left with that the cause of
13 death is undetermined, it's unknown. And
14 that's your decision. It's on the weight of
15 the evidence you've heard that you will
16 decide on whether you can say one or other of
17 those things.

18 Following from that, you have to go and
19 answer the "by what means." And once again,
20 the by what means is on the balance of
21 probability. Let's deal, first of all, if
22 you decide that the cause of death is
23 undetermined, logically the by what means is
24 also undetermined. One flows from the other;
25 if you don't know what the cause of death is,

1 you cannot make any comment on the by what
2 means.

3 Since the only two options, really, open
4 to you in the cause of death are undetermined
5 or as a result of a cardiac conduction
6 disturbance as the result of a drug
7 interaction, if you decide it's that, then
8 that would -- it cannot be natural causes.
9 It is not a natural disease, it is
10 medications that the girl was on that have
11 somehow caused her death. You have heard
12 that none of the medications in and of
13 themselves would have caused the death,
14 you've heard no evidence that the amount of
15 medications given were inappropriate or were
16 grossly in error or were somehow drawn up
17 wrong so instead of getting the dose of
18 morphine that was ordered, she got twenty
19 times that, all the medications that were
20 given were in appropriate order.

21 We've also heard that, in fact, this
22 interaction between gabapentin and morphine,
23 the first paper, the first time that this
24 were the issue or potentially being an issue
25 came up was when Dr. MacLeod found a research

1 paper, and I stress it's only a research
2 paper, in December, so therefore one would
3 not have anticipated that someone on morphine
4 and gabapentin, given the levels that were
5 found at autopsy, would not have anticipated
6 that there was a cause of death. So in that
7 respect, this death is certainly unexpected,
8 it's an unexpected reaction from these drugs.

9 You would have to determine, therefore,
10 if the death is an accident, if the death is
11 a suicide, which we don't need to go into at
12 all, or if the death is a homicide. I have
13 to redefine for you again an accident is
14 defined as, "An occurrence, incident or event
15 that happens without foresight or
16 expectation." In terms of the fact that this
17 is the first time that is has been reported
18 to the best of Dr. MacLeod's knowledge that
19 death may occur from an interaction of these
20 drugs, I would have to say that no one was
21 aware that the potential interaction of these
22 drugs would cause death and in that
23 situation, it would clearly be not improper
24 if you decided to call it an accident.

25 In terms of whether you decide it's a

1 homicide, you have to use the Oxford English
2 Dictionary and it's, "The action of a human
3 being killing another human being." Or if
4 you use the Webster Dictionary, it is defined
5 as, "The killing of one human being by
6 another." I think you will have to think
7 long and hard as to did any action of a human
8 being kill Lisa? There certainly were things
9 that were not done that some of the expert
10 witnesses, both Dr. MacLeod and Dr. Williams,
11 in particular, said if they were done, may
12 have prevented her death, but there's a big
13 difference between that and actually being
14 the direct cause of the death.

15 You have heard the other Counsel give
16 you their various reasons. I am not going
17 to, it's not my position, I'm just giving you
18 the -- what you have to decide. It's you to
19 decide whether, in fact, you think this is an
20 accident, undetermined or a homicide. But
21 consider it seriously, consider all the
22 evidence, consider the definitions before you
23 come to a conclusion. And that conclusion
24 has to be based on the balance of
25 probability.

1 JUROR #1: Could you repeat the conclusion
2 of "accident," sir?

3 THE CORONER: An accident is defined in the
4 Oxford English Dictionary as "An occurrence,
5 incident or event that happens without
6 foresight or expectation."

7 And in terms of if you accepted the
8 cause of death is an interaction between
9 these two drugs, it's an interaction between
10 these two drugs that certainly, from the
11 evidence presented at this inquest, no one
12 was aware of previously. If there had been
13 warnings all over the medical literature that
14 these two drugs should never be used in
15 combination, then you may well say if someone
16 dies of that combination, that obviously
17 there was an expectation or there were was
18 some foresight that that might happen. The
19 situation here, I suggest to you, but it's up
20 to you, clearly indicates that that did not
21 -- that was not the case.

22 And the fact that the cause of the death
23 or a possible cause of death took from -- I
24 got involved in the case in March. Earlier
25 to that, I think part of the reason that this

1 early investigation went off the rails and it
2 did was that there was an assumption that
3 this girl had died of a morphine overdose and
4 there was lots of work went into and effort
5 went into ensuring what dose of morphine she
6 got by an examination of the PCA pump which,
7 as you know, and early on that was a major
8 part of the investigation, it turned out to
9 be in error, that she got exactly the amount
10 she was given and the toxicology came back
11 with the -- showing that it wasn't morphine.

12 The problem is that while awaiting the
13 results of that, nothing else was done
14 because even if that had come back with
15 morphine, the questions that are now being
16 asked, well, if it was morphine, what was
17 being done in terms of monitoring to prevent
18 it? All that investigation, which should
19 have taken place early on, did not take place
20 early on. But in terms of the cause of death
21 when we got it in March, it went to the
22 Pediatric Review Committee, it went to
23 various places and there wasn't a cause of
24 death until Dr. MacLeod came up with an
25 explanation that he felt was plausible in

1 December. So there are other situations
2 where we deal with death where it's obvious,
3 we can say that drug and that drug, there are
4 warnings all over the place, they should not
5 be used together. So in that situation, it
6 might be entirely different concerning
7 whether this was an accident or not an
8 accident. So does that help you with your
9 definition of "accident"?

10 JUROR #1: Yes.

11 THE CORONER: In terms of recommendations,
12 they really are, in most inquests, they are
13 the most important thing because the facts in
14 a lot of inquests are clearly known, they're
15 clearly known to all the Counsel in the room
16 and they are presented in a more orderly
17 fashion to you, the members of the jury.

18 This inquest, I feel, was extremely
19 important to try and bring out the facts.
20 The first time that many of the people
21 involved surrounding this death had been
22 interviewed, had said anything about the
23 death, was on this witness stand, so that
24 without this inquest, that would never have
25 been done and I think that certainly Mr. and

1 Mrs. Shore deserve to hear from everyone who
2 was involved with Lisa's care, what, in fact,
3 they did or didn't do and hear it in a public
4 forum in an inquest under oath. And I hope
5 they are satisfied that as far as possible
6 they have now heard from all of those
7 witnesses.

8 So that aspect of the inquest, it was
9 extremely important and it was extremely
10 revealing and, in fact, I think many of your
11 recommendations will probably only be made as
12 a result of hearing things that came out on
13 the witness stand.

14 In regard to your recommendations, I'm
15 not going to go over them. I couldn't agree
16 more with all Counsel. Some of you were
17 asking, all of you were asking extremely good
18 questions. It's obvious from the questions
19 that you understand exactly what this is all
20 about. I testify many times at murder trials
21 and I will be looking at a jury like
22 yourselves and I genuinely will have no idea
23 of whether the jury understand a single thing
24 I'm saying.

25 The very fortunate thing in an inquest

1 is that the jury do get to ask questions and
2 it certainly is of great assistance to me
3 from your questions, I will be able to see if
4 you understand the issues that are at hand.
5 In fact, sometimes I think you understood the
6 issues at hand much better than Counsel and
7 myself, so I don't think I need to talk to
8 you at all about what recommendations you
9 should or should not make. I think you are
10 in a much better position and you are
11 entirely neutral, you come to this process as
12 five members of the community. It's up to
13 this court to be able to explain complex
14 medical things and complex Kidcom things to
15 your satisfaction. Hopefully in as far as it
16 was possible, that has been done.

17 With regard to your recommendations, I
18 must stress that considering your
19 recommendations, they must be reasonable and
20 they must be practical. Your recommendations
21 are not law, they are recommendations that
22 are going to be forwarded and they're going
23 to be forwarded directly to the Hospital for
24 Sick Kids in this case, but they may have
25 implications for many other hospitals who

1 would be very interested in seeing what you
2 recommend in terms of the various issues of
3 monitoring and computer systems, et cetera.
4 So if they're not reasonable and practical,
5 what my experience has been, an institution
6 or whoever receives them, if they find that
7 some of the recommendations are off in left
8 field, they will be inclined, if there's even
9 one of them way off in left field, they'll be
10 inclined to disregard the jury as not knowing
11 what they're talking about and I think that
12 is terrible when that happens, so I would
13 suggest you spend lots of time to make sure
14 that you're not only -- are they
15 recommendations, but they are reasonable and
16 practical.

17 And the only one that I would comment on
18 as Ms. Browne has commented on that I think
19 you should seriously consider before adopting
20 is that you're going to basically close down
21 a unit and suspend people from work while an
22 investigation is going on. I think with a
23 proper interaction, and I can guarantee you
24 there will be one between the Coroner's
25 Office and Sick Kids, I do not think it is

1 necessary that people cannot continue with
2 their work while that's going on. There are
3 many deaths occur in the intensive care unit;
4 because of the type of work there is at Sick
5 Kids, there's many deaths occur in the
6 operating room and it really would just -- it
7 would be a danger to other people's health.
8 I think what is important is that the proper
9 investigation is done.

10 So make sure your recommendations are
11 reasonable and practical. It is more
12 important, in my opinion, that you come up
13 with a number of recommendations that are
14 very good; the quality of your
15 recommendation, in my opinion, is better than
16 the quantity. You do not have to come up
17 with two hundred recommendations, I would
18 prefer you to come up with good sound ones
19 that relate to the issues.

20 Your verdict in terms of the cause of
21 death and in terms of the by what means must
22 be based on the evidence you've heard here.
23 Likewise, all of your recommendations must be
24 based on evidence that's heard here. You
25 cannot, even though you may have all sorts of

1 theories yourself, you cannot make a
2 recommendation that you think is a good
3 recommendation but it was not discussed by a
4 witness on the witness stand, so you have to
5 confine your recommendations. They have to
6 arise out of the evidence that you heard
7 here.

8 You may, if you wish, give an
9 explanation or a reason why you want to make
10 that recommendation. If you decide to do
11 that, I caution you to be extremely careful
12 in the words that you use. The explanation
13 would be to assist the person to whom the
14 recommendations are directed to understand
15 why you made that recommendation. It can be
16 very easy in that process to add words that
17 would be inappropriate and would make it not
18 a proper verdict, that would inadvertently be
19 a conclusion in law or placing blame. And it
20 is not -- it should not be necessary to do
21 so, so if you've got any concern about the
22 explanation in any way indicating that
23 someone is at fault or blame or substandard
24 or falls below the normal level other than
25 just human error, be extremely careful

1 because I will have to send you back and tell
2 you to take that out of your verdict,
3 otherwise when your verdict comes, I may not
4 be able to accept it and if I accept an
5 improper verdict, it may well go to
6 Divisional Court for a ruling on whether your
7 verdict stands.

8 I think you've spent far too much time
9 and effort, I think Lisa's life and Lisa's
10 death is worth too much for us at this stage
11 to be involved in any more legal arguments
12 and hassling over wording, so be very careful
13 so that your verdict will be a true verdict,
14 so that your verdict will have excellent
15 recommendations that nobody can argue about
16 in the legal context, and so that the
17 Hospital for Sick Kids will be able to
18 clearly see why you're making them and do
19 something about them.

20 You will have, during your
21 deliberations, all the exhibits that have
22 been introduced during the inquest. Your
23 verdict does not have to be unanimous, a
24 majority decision is all that is required, so
25 basically there are five of you in the jury.

1 I would discuss it all among you. If you
2 have differences, as long as three of you
3 agree on it, then that can be accepted.

4 I suggest that when you go over your
5 verdict, do it in draft form, look over it
6 again until you're satisfied. There will be
7 no rush, we will not be sequestering you.
8 The sequestering of a jury I think at times
9 means that you don't necessarily consider
10 that you're here to look at the verdict, it's
11 more if I don't get this finished by 10:00
12 tonight, I'm not going to see my family for
13 four days.

14 I have been told by the Coroner's
15 Constable that the phenomenal fee that we pay
16 you for sitting on a jury has now got to the
17 next stage because you have been sitting for
18 a number of days, so in terms of willing to
19 spend as many days as you wish on this, this
20 is not a problem. I would anticipate that
21 you can deliberate on your own hours, 10:00
22 to 4:00 or 9:30 to 4:30, whatever you feel is
23 convenient, there will be no rush on you to
24 come back. We will not have you sequestered,
25 you can go home at night. Obviously you

1 cannot discuss the evidence with anyone other
2 than among yourselves in the jury room.

3 If you have a problem that needs
4 clarification, then at any times during your
5 deliberation, you can let the Constable know
6 and we can, if necessary, reconvene the
7 inquest and bring back a witness if you feel
8 it's necessary. My own feeling on it is from
9 listening to you, that I don't think that
10 that's likely, but that option is open to
11 you.

12 I will state that when you have finished
13 your verdict, it is my responsibility and
14 that of Ms. Browne as my legal counsel to see
15 your verdict, not in any way to change your
16 verdict, but to make sure it is a legal
17 verdict so that when you have the final draft
18 of your verdict ready, all Counsel are aware
19 that it will be reviewed by Ms. Browne and
20 myself, that we will not be saying we don't
21 like this recommendation or we don't like
22 your conclusion, providing it does fall
23 within the law, then whether I like it or not
24 is not up to me, it's your verdict. It's
25 only my responsibility to make sure it is a

1 proper verdict.

2 All Counsel have agreed and know that
3 that's my responsibility and have no
4 difficulty with counsel or myself seeing the
5 verdict before it's read out in public. If
6 at that time there is something in the
7 verdict that would make it an improper
8 verdict, then that will be passed back to you
9 and it most likely, if it occurs at all,
10 would be in the way of a certain word being
11 used that has to be changed without in any
12 way tampering with the actual meaning of your
13 verdict at all, so I don't feel that you need
14 to be overly concerned about that.

15 I don't think I have anything else that
16 I need to add at this time, other than to
17 thank you for the last 18 days of your
18 attention. It is very difficult to come in
19 here, blind, to a complex medical matter and
20 complex computer matters. I think you have
21 caught on to them extremely well. I am
22 entirely satisfied that you will be able to
23 go and render a true verdict and you will
24 render a verdict that unfortunately cannot
25 bring Lisa back, but that it will be a

1 lasting memory to Lisa's life that her death
2 was not in vain and by your verdict, you will
3 prevent some other parents like Mr. and Mrs.
4 Shore having to have to go through the agony
5 that they have gone through for the last 18
6 months, you have it in your power to do that
7 and I look forward to seeing a verdict that
8 will fulfil those.

9 So I thank you for your attention and I
10 will now ask the Constable to take charge of
11 the jury until they have reached a verdict.

12
13
14
15 --- ADJOURNED.

16
17
18 THIS IS TO CERTIFY that the foregoing
19 is a true and accurate transcription
20 of my recordings and notes, to the
21 best of my skill and ability.

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28 Barbara A. Pollard
29 Certified Court Reporter

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31
32 Photostatic copies of this transcript are not certified and

1 have not been paid for unless they bear the original
2 signature of Barbara Pollard, and accordingly are in direct
3 violation of Ontario Regulation 587/91, Courts of Justice
4 Act, January 1, 1990.