INQUEST INTO THE DEATH OF

L I S A   S H O R E

RESUMED EVIDENCE OF MARY DOUGLAS

TAKEN FEBRUARY 3, 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.

REPORTING PLUS
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1 THE CORONER: Good morning, ladies and
2 gentlemen. Once again, I seem to be
3 eternally apologozing to you for delays. The
4 delays are trying to resolve issues that will
5 be of help to you, so I apologize again. It
6 was necessary to start late.
7 I would like to put on the record at
8 this time there was some evidence yesterday
9 regarding the Kidcom system and regarding the
10 auditing ability, particularly of who -- not
11 who would look at the printout or who would
12 look at the chart, but who would print
13 anything from the chart. And if you will
14 remember, the evidence by Nurse Doerksen is
15 that, in fact, shortly after the deaths, she
16 did print out a copy of the suspended orders
17 and Counsel, I think, quite rightly, are
18 saying who else printed out parts of this
19 chart.
20 The evidence given by the expert from
21 Sick Kids was that any audit of printouts is
22 kept on a tape for a six-month period and
23 after that six-month period, that tape is
24 then recycled and it is no longer in the

1 permanent record of the computer.
2 I was requested if I could contact the
3 company who actually make Kidcom and could
4 get some confirmation of whether that, in
5 fact, was accurate or inacurrate. There will
6 be a fax coming later today which I will
7 enter as an exhibit, but at this time, I have
8 spoken with a representative from the company
9 this morning and it has been indicated to me
10 that that audit trail with regard to
11 printouts from a chart does go onto a tape,
12 that that tape, in different institutions,
13 they make a decision how long that tape will
14 be kept, be it three months, six months,
15 whatever; that a six-month retention is an
16 average retention span from the different
17 clients that they have and that once that
18 tape has been recycled, then there will be no
19 way of auditing that information, basically
20 confirming that the evidence given by the
21 computer person from Sick Kids yesterday
22 morning is correct as far as the technology
23 of the Kidcom system that had been used at
24 the Hospital for Sick Kids. But I will --
25 I've asked can they actually fax me that with

1 their signature so that I can put it in, so
2 that you're assured of that.
3 I think, Mr. Gomberg, that was one of
4 the questions that you quite rightly had and
5 I certainly -- I'm mentioning it now because
6 it's going to follow up later today.
7 MR. GOMBERG: No, I'm satisfied with that
8 answer.
9 THE CORONER: I think there was a recall
10 of ---
11 MS. BROWNE: Ms. Mary Douglas.
12 THE CORONER: --- Mary Douglas.
13 MS. BROWNE: I think the jury wished to ask
14 her some questions. Ms. Douglas?
15 THE CORONER: Ms. Douglas was sworn in on a
16 previous occasion, so does not need to be
17 resworn. Ms. Douglas, it was particularly
18 the request of the jury that you be recalled.
19 They had some questions that they had to ask
20 of you, so I will turn it over at this time
21 to the jury. There may also be some
22 questions from other Counsel that will
23 clarify up some issues that you may have
24 knowledge of but were not asked the first
25 time 'round. We'll see what happens with

1 that as we go along.

2

3 CROSS-EXAMINATION BY THE JURY:

4 BY JUROR #4:

5 Q. Yes, I have a few questions. I'm not
6 sure if you're aware of the fact that no member of the
7 jury is involved in any medical profession.

8 A. I'm aware of that, yes.

9 Q. So that testimony that we hear and when
10 we hear it gets to be confusing. And some of our
11 questions may seem to be out of line, so this is why we
12 have Dr. Cairns as our preceptor. So please bear with
13 me if some of the questions are out of line. Being a
14 Nurse Educator, could you just recap what your role or
15 what your functions are?

16 A. Sure. My role, really, is two-fold.
17 The most distinct part of the role is the orientation
18 phase of new staff. That's particularly been a busy
19 part of my role in the last few years because of the
20 number of nurses that we're hiring into the hospital,
21 and that involves a variety of things.

22 Education of the new nurses as they
23 arrive into the hospital through classes, through
24 informal and formal conversations with them, as well as
25 organizing their orientation, getting a variety of

1 experts from the hospital to teach them a variety of
2 different things according to their needs. I have a
3 pre-set program that is established that is directed
4 towards -- my particular role is that I direct their
5 learning towards the specialties that they will be
6 dealing with in the areas that they will be working.
7 There's also a hospital "general
8 orientation," we call it, and that deals -- and that's
9 dealt with through our central education department
10 where the nurses are provided classes that are more
11 common to nurses across the hospital as opposed to
12 directly to the unit that they happen to be working on.
13 So the general orientation is seven in-class days and
14 then the unit-specific orientation is, at this point,
15 three and a half in-class days, as well as that then I
16 arrange the preceptor, the preceptorship relationship.
17 My personal philosophy is that I select
18 one preceptor to be with the one new nurse who has
19 arrived, and that that is an established relationship
20 that is mantained for, as Annagaile testified, I
21 believe it's 20 shifts at the time. We also flex that
22 orientation so that if a nurse needed more than 20
23 shifts to feel comfortable on the unit, then we allow
24 that to be expanded, or if a nurse is feeling very
25 comfortable and is feeling as though he or she can take

1 on their role on the floor, then they can actually have
2 less shifts than 20 and that's a decision that is made
3 with myself, the preceptor and the nurse at around the
4 time of the 20 shifts.
5 The other part of my job is ongoing
6 education for the rest of the staff, and that really is
7 a difficult part to define because that can be anything
8 from giving advice around how to write a resume or how
9 to update their resume or what classes and things like
10 that should I be looking into to actually -- a need
11 coming up on the unit such as, you know, we're really
12 struggling understanding this, can we have some
13 information on that or can we have some classes on that
14 or do you have any articles on that or there's a new
15 procedure that we're doing next week, Mary, you know,
16 you need to get some stuff pulled together for the
17 staff. So really that's the part of my job that's hard
18 to define, because every day it's a surprise, whatever
19 happens to come through on my pager, my voicemail, then
20 I try to meet those needs.
21 Q. Do you know who the preceptor was for
22 Nurse Soriano?
23 A. Yes, I do.
24 Q. And who was that?
25 A. Her name was Laurie Zeleney (ph.)

1 Q. Because Nurse Soriano couldn't recall.
2 A. Yes, I actually looked it up just the
3 other day, because I was wondering myself. I couldn't
4 remember, it had been a while ago.
5 Q. At the time you arrived on the floor,
6 which I'm recalling would be about 7:30 in the
7 morning ---
8 A. I arrived to work, according to my
9 notes, I arrived to work at 7:35 and I shortly
10 thereafter heard the stat call overhead, so it would
11 have been around 7:40 probably that I arrived to the
12 unit.
13 Q. And at that time or shortly thereafter,
14 Nurse Doerksen took you into a room?
15 A. That's correct.
16 Q. Once you realized what had gone on or
17 what was happening ---
18 A. Mm-hmm.
19 Q. --- how were you emotionally?
20 A. Well, as a professional and I've been in
21 nursing and pediatric nursing for a number of years, my
22 typical response is I keep my lid on during the event
23 and then tend to break down afterwards, and so I had my
24 moments after I got back to my office that morning
25 where I was also very distressed. At the time, I

1 really feel like I tried to -- I felt as though I was
2 trying to support those around me, so I was more
3 concerned about the situation around me rather than
4 myself but certainly it had an impact on me at the
5 time, but I was feeling as though I was appropriate at
6 the time as a professional.
7 Q. Now after you spoke to Nurse Doerksen,
8 she had mentioned the fact that she had turned off the
9 apnea meter?
10 A. That's correct.
11 Q. Was there anyone in the room at that
12 time that may have heard Ruth say that you turned it
13 off?
14 A. I believe that she and I were alone when
15 she said that, because it was -- it was either before
16 or after that that the other group of nurses came in.
17 I believe the nurses came in and Ruth told me there
18 after that the apnea had been turned off. I'd have to
19 refer to my notes to see the order, but the note that I
20 wrote up would probably be the most accurate account of
21 that. As I understand it, as I remember it, I believe
22 we were alone at that time.
23 Q. Because if anyone had have been in the
24 room and overhead this conversation ---
25 A. Mm-hmm.

1 Q. --- they had an opportunity to bring
2 this matter up to anyone?
3 A. Mm-hmm.
4 Q. That would have been a major concern.
5 A. If they had -- I'm not sure I understand
6 your question.
7 Q. Could anyone have approached anyone
8 possibly investigating the nurses to, in fact, inform
9 them that they overhead that the monitor had been
10 turned off?
11 A. Well, I certainly could have gone
12 forward and told other people about it. I had no
13 reason. Ruth was completely honest with me at the
14 time. She certainly didn't try to hide it from me at
15 the time and myself or anyone else, I know -- I'll just
16 speak for myself, I certainly assumed that since she
17 had been so blatantly honest with me about what had had
18 happened that night that she would continue to be
19 honest with anyone else that asked her, so I didn't
20 forward that information and I assume had anyone else
21 heard that information, they would assume the same
22 things, that, you know, she just said what happened,
23 she clearly wasn't trying to hide it and so she would
24 have gone forward from that point and did go forward
25 from that point and was up front with what happened

1 that night.
2 Q. Were you concerned about the fact that
3 she turned it off?
4 A. I was -- I must admit, when she said
5 that, I was surprised. At the time, I was -- I really
6 wanted to ask her why because obviously that was going
7 through my mind, as well. I didn't ask her why
8 because, again, my role at that point was this was an
9 extremely distressed person who needed a lot of support
10 and didn't need to be pushed into a corner about why or
11 why not and what, and I knew that would come later at a
12 more appropriate time, and so I allowed her to just
13 tell me what happened and I was going to support her at
14 that time.
15 Q. You then went into Lisa's room to
16 confirm that the Corometric monitor was, in fact, off.
17 Was this your duty?
18 A. No, no. When she was discussing the
19 issue of, you know, I turned the apnea off and what the
20 limits were set at, she was so distressed -- I guess in
21 my mind I was thinking maybe she doesn't even believe
22 herself that that's what she did, because she kept
23 saying the monitor was on and this is how I set it.
24 And I thought, you know, I probably need to confirm for
25 her sanity at that point that indeed, yeah, you did set

1 the limits to that and that is exactly how it was left
2 and I think at that point, too, I needed to confirm for
3 myself that what she was saying was indeed, you know,
4 accurate, because she was so upset and I don't think I
5 -- you know, I just -- I think it's fortunate that I
6 did go in and look and I did pick up the monitor and
7 look and it was exactly as she had said it was. And I
8 went back in and reassured her, yes, Ruth, that is
9 exactly how you set it, you know, you're right, you did
10 set it that way, that is exactly how it is.
11 It didn't solve the problem of why the
12 alarm didn't go off and, you know, that's what her
13 distress was over, why didn't that thing go off.
14 Q. Now we've heard testimony that the
15 monitor was not in the room or couldn't be found in the
16 room.
17 A. Right.
18 Q. Did you remove the monitor?
19 A. No, I did not.
20 Q. Do you know who did?
21 A. No, I don't.
22 Q. We've heard from Dr. Wright regarding
23 possibly a team investigating the nurses or discussing
24 what had happened with the nurses. Is there such a
25 team that would, in fact, question the nurses as to

1 what basically happened that night?
2 A. Unfortunately, I wasn't here for all of
3 Dr. Wright's testimony yesterday, so I'm not sure what
4 you're referring to, but if you could give me some
5 context of that.
6 THE CORONER: To some extent, the jury --
7 this witness is not here to answer what other
8 witnesses have testified to. We need to
9 confine your questions about her direct role
10 or her role as an educator as opposed to on
11 the witness stand and asking her things about
12 what other witnesses such as Dr. Wright have
13 talked about.
14 JUROR #4: Maybe I can reword it in such a
15 way ---
16 THE CORONER: That's fine.
17
18 BY JUROR #4:
19 Q. Is there an investigating team set up at
20 the hospital to investigate instances such as this?
21 A. No, there isn't. I mean, there's --
22 nurses know in a -- generally nurses know about
23 coroner's inquests. The details of something such as
24 this has been just as new to me as to every other nurse
25 in this situation. My understanding that morning is

1 that the nurses knew not to touch anything on the body
2 and to leave the room as it was until the coroner came.
3 And thereafter as the direction I would have taken is
4 that you rely on the coroner once they come to give you
5 further direction. In terms of an investigating team,
6 unless I'm thinking of something completely different,
7 I'm not aware of anything to that extent, no.
8 Q. All right. The name Bill
9 Kruetzweiser ---
10 A. Yes.
11 Q. --- would he have discussed this
12 situation with the nurses?
13 A. I am not sure if he discussed that with
14 the nurses at all.
15 Q. So we can assume that you weren't
16 involved with any discussions or questioning of anybody
17 with the nurses at all?
18 A. No, I was not.
19 Q. You had an opportunity or did you go
20 over the flow sheet and the information that was sent
21 up from the emergency room with anyone?
22 A. No. I believe the first time I saw the
23 chart was well after the event. Again, that morning my
24 concern was the nurses and my focus was the nurses. I
25 don't think I ever saw that chart that morning at all.

1 It was probably many weeks later before I actually saw
2 the flow sheet or the emergency records or any other
3 part of the chart.
4 Q. Well, would anyone have been concerned
5 as to look at that and discuss it with the nurses
6 involved?
7 A. Again, at the time, when a child dies,
8 it's a very difficult time for everybody and usually in
9 the immediate -- after the immediate day or so
10 afterwards, you're trying to pick yourself up and pull
11 yourself together. We know that the chart is always
12 available to look at when we need to and therefore
13 there's no sort of urgency at the time to look at
14 something like that.
15 Certainly there is always ample
16 opportunity afterwards and certainly the nurses were
17 available and the -- myself, we were all available to
18 be spoken to at any time and that's what our role would
19 be in that situation, is you know where we work, you
20 know our number kind of thing and you can give us a
21 call if you want to talk to us.
22 Q. And in this particular case, there was
23 such a major incident, that wouldn't you want to get at
24 that report as soon as you could or someone to prevent
25 anything else happening, maybe at the same time or the

1 same day?

2 A. And that's exactly why a coroner comes

3 in and deals with the situation of unexpected

4 unexplained deaths, to see what's gone on here. We all

5 the time were assuming that it was morphine, that's all

6 of us assumed that at the time and we were, you know,

7 just as interested as everybody else to hear the

8 toxicology results.

9 So I think that that was what was on

10 everyone's mind at that time and as you say, that this

11 has become such an incident, it certainly has become an

12 incident in this inquest. At the time it was -- we

13 didn't know what had happened, we didn't -- there was a

14 lot of things we didn't know and we were waiting for --

15 to find out from the coroner what had happened or from

16 the autopsy.

17 Q. But would the records have indicated a

18 possible problem themselves?

19 A. Do you mean looking at the flow sheet,

20 would that have indicated to me there was a problem?

21 Q. That a problem did happen?

22 A. No. I mean, the flow sheet to me is --

23 and I've testified earlier there was a couple of blood

24 pressures that were missing and that.

25 Q. There were a few other vital signs

1 missing.

2 A. I mean, according to the policy, the

3 couple of blood pressures were missing, the pulse rates

4 were taken appropriately and there were extra pulse

5 rates taken and certainly we've talked infinitum about

6 pain scales and sedation scales, but when you look at

7 the flow sheet themselves, the child certainly had a

8 mild respiratory depression at one point in the night,

9 but stabilized as the night went on. It's not as

10 though she went in one direction downward, which would

11 have indicated a lot more distress to myself, to the

12 nurses, to anyone involved, and that's the part that's

13 confusing for us, even now, is to see that the child's

14 respiratory rate came up and stabilizied, but her heart

15 rate was elevated and everything was thinking pain and

16 settled down. And to look at that flow sheet of any

17 child in the hospital right now, to look at her heart

18 rate and respiratory rate at 5:00 and 6:00 and just to

19 know that an hour later this child was dead is

20 extremely distressing, because we just ...

21 Q. Well, that's what I'm trying to get at.

22 In other words, it's distressing, if it's painful,

23 wouldn't you think somebody would act immediately and

24 say what happened?

25 A. And exactly, that's the coroner's role

1 is to -- that's my understanding, is that's the
2 coroner's role is to investigate what has happened.
3 Q. But in meantime, now, the nurses are
4 still on the floor.
5 A. In that immediate few hours. I mean,
6 it's -- our role in that position is to leave things as
7 they are and to wait for the coroner to come in. And
8 that's hard to explain, I know, when you're not in the
9 health profession, you know, going back and analyzing
10 and hashing and things like that at the time probably
11 seems very curious to you.
12 To us as health professionals where we
13 have to deal with emergencies every day or very ill
14 children every day, that this is not -- it's extremely
15 distressing and extremely tragic, but to actually go
16 back at that moment and rehash and pull that out and
17 pick it apart, that wouldn't probably occur to any
18 nurse that I can think of. You're trying to get
19 through that moment, that day, that 24 hours and make
20 sure you're okay and then leave it up to those around
21 you to direct you and ensure, you know, let's go back
22 and look at this or answer questions that are asked of
23 you.
24 Q. Can you tell me if there's any
25 disciplinary protocol in place at the hospital?

1 A. Yes, there is.
2 Q. When such an incident occurs and ---
3 MR. HAWKINS: Well, I don't think that's an
4 appropriate subject for this process.
5 THE CORONER: I agree.
6 MR. GOMBERG: I'm not so sure about that.
7 I'm not so sure about that. I think that the
8 juror is entitled to ask that question. It
9 has nothing to do with civil liability, it
10 has nothing to do with criminal liability, it
11 has to do with exactly what we're here for.
12 I think it's a perfectly proper question.
13 THE CORONER: Mr. Hawkins?
14 MR. HAWKINS: This process is about
15 inquiring into the facts and circumstances of
16 Lisa's death. Disciplinary protocols are not
17 relevant to the facts and circumstances of
18 Lisa's death and to that investigation, and I
19 think I might be speaking out of turn, but I
20 think you were in the process of objecting to
21 the question or cutting off the question as I
22 was about to do it, so ...
23 THE CORONER: If there is a generic
24 question, "Does the hospital have a system
25 for discipline," not referring to this case,

1 I do not mind that question being asked. I
2 do not -- would not allow a question to be
3 asked what was the disciplinary process or
4 was a disciplinary process, did it take place
5 in this because that answer may well, in my
6 opinion, start to get into a finding of fault
7 and into areas where we shouldn't go, but the
8 general question, do you have an objection to
9 a general question, Mr. Hawkins?
10 MR. HAWKINS: No, I do not.
11 THE CORONER: Mr. Gomberg, will that satisfy
12 you, the general question?
13 MR. GOMBERG: Well, it depends how far the
14 general question goes. In terms of
15 discipline and how discipline fits into
16 education, and this lady is an educator, if
17 those questions are asked and I'm sure the
18 juror is going to ask them, then it goes as
19 far as you're prepared to permit it to go.
20 It doesn't go far enough as far as I'm
21 concerned, but I'm mindful of your ruling.
22 If the juror doesn't ask those questions, I'm
23 going on the record right now saying that I
24 fully intend to ask them.
25 THE CORONER: I will allow a general

1 question, I will not allow any question about
2 discipline with regard to the death of Lisa
3 Shore. Sorry, members of the jury, do you
4 want to ask a general question?
5 JUROR #4: I'm not sure how I would even
6 approach it.
7 THE CORONER: If you like, you can leave it.
8 I think Mr. Gomberg may ask the question.
9 MR. GOMBERG: You have my commitment to deal
10 with it, sir.
11 MR. HAWKINS: Well, when it comes Mr.
12 Gomberg's turn to ask questions, we can deal
13 with that issue.
14 THE CORONER: That's fine.
15 JUROR #4: Am I permitted to give my
16 thoughts as to what I figure happened that
17 night?
18 THE CORONER: No, you're entitled to ask
19 questions. In terms of your conclusion about
20 what happened that night, it has to be
21 confined to your verdict and you can give
22 those conclusions in answering the verdict
23 and indirectly through the recommendations
24 that you'll be making.
25 MR. KRKACHOVSKI: It would be appropriate, I

1 think, Mr. Coroner, for the juror, if this is
2 what he's thinking of, to put a hypothetical
3 to Ms. Douglas, or any witness, for that
4 matter.
5 THE CORONER: I have no problem with that.
6
7 BY JUROR #4:
8 Q. I guess if a patient is sent up to an
9 orthopedic ward from the emergency ward for the first
10 time and she's in pain, just pain, now the nurses on 5A
11 are accustomed to working with patients with broken
12 limbs, I assume, and various other ...
13 Now understanding the fact that she's
14 sent up, somebody might question the fact as to why
15 this person is being sent up, she has a pain in her
16 leg. They take her in, assuming that, gee, put her
17 into a room, give her an aspirin and she'll be gone
18 tomorrow without realizing how critical that patient
19 is, that no care was, in fact, given or very little
20 care was given to that patient.
21 A. I'm trying to pick apart your question a
22 bit, because it's sort of opened up a few areas that I
23 think I can comment on. One area is that when Lisa
24 came in, she was a child with chronic pain who lived
25 with pain every day and who functioned quite well in

1 between times of pain. She's a child that came in and
2 in any nurse's mind, would not be considered critical;
3 in fact, you know, she may have been the healthiest
4 child on the floor that night when she came in and
5 that's, you know, another part of it is that this is a
6 child just with pain in her leg, as you said. Her
7 status, as you described, as being critical is one that
8 I don't agree with. That's one where, you know, in
9 hindsight we look back and say this ---
10 Q. No, no, I didn't say it was critical,
11 she has a pain in her leg.
12 A. Right.
13 Q. We'll put her into a room.
14 A. Right.
15 Q. And basically forget her.
16 A. Well, I would disagree that they forgot
17 her. Certainly they did extensive checks on her with
18 her respiratory status because of the morphine and, you
19 know, their assessment of her was that she hit a point
20 when she had mild respiratory depression that was dealt
21 with appropriately. The physician was informed and
22 then she stabilized and improved through the night.
23 She had no more morphine in her system at that time,
24 according to the nurses, it had been given many hours
25 before and I'm sure that's what was going through their

1 mind. The intent of Lisa coming to the floor was to
2 allow her to sleep the night so that they could start
3 an epidural in the morning.
4 Q. So regardless of why she was sent up,
5 she would still get as much care as what any of the
6 other patients would have had that night?
7 A. Oh, no. The care for every patient is
8 individualized according to their diagnosis, their
9 status, their medications, their treatments. Every
10 child that has an intravenous is checked hourly just to
11 see that the intravenous is -- that the site is okay
12 and it's functioning and dripping correctly. Some
13 children need one nurse in the room at all times for
14 constant nursing observation because of their status.
15 Some children, just depending on their recovery stage,
16 their stability at the time, it varies with every
17 patient and a nurse uses a great deal of judgment to do
18 that, to decide how often to go in, what kinds of other
19 monitoring needs to be done and things like that. I'm
20 not sure if I'm answering your question.
21 Q. Might it have been possible that the
22 nurses decided that she didn't require as much
23 attention?
24 A. I'm not sure that that -- I'm not sure I
25 can answer that on their behalf. I think that the flow

1 sheet is indicative of how often they went in and how
2 closely they watched her and yes, there were some vital
3 signs missing, the two blood pressures, the one that
4 they, as I testified earlier, they kept an extremely
5 close eye on her respiratory status, which is the
6 primary concern in a child receiving morphine.
7 Q. I just have a couple of more questions.
8 THE CORONER: Certainly.
9
10 BY JUROR #4:
11 Q. The testimony that we've heard by the
12 nurses telling us what was done, what we find wasn't
13 done ---
14 A. Mm-hmm.
15 Q. --- filling in flow sheets with parts of
16 what should have been filled in, we've heard of
17 instances supposedly where people have lied to one
18 another, improper forms being made or errors being made
19 in certain documents. And I'm not sure, Dr., if I'm
20 allowed to ask this but to me this sounds like a
21 coverup.
22 A. I mean, I ---
23 Q. We've been given a smokescreen.
24 A. Mm-hmm.
25 Q. Now, I'm not asking you to answer it,

1 but my thought is ---

2 THE CORONER: I don't think this witness, in

3 her capacity, is able to answer that

4 question.

5

6 BY JUROR #4:

7 Q. I do have one other comment. I realize

8 Sick Children's Hospital is well known and unblemished,

9 basically, and I hope that this situation is just an

10 isolated case and it covers the whole iceberg and not

11 just the tip.

12 A. I assure you this has been unlike

13 anything I've ever experienced in my career. If that

14 gives you any assurance or reassurance, it's been

15 extremely distressing for all of us and unusual, never

16 seen it before, unheard of, distressing, extremely

17 tragic, extremely unfortunate. I wish we could all

18 roll back the hands of time and fix something to

19 prevent this.

20 THE CORONER: Any other jury members? Yes.

21

22 BY JUROR #2:

23 Q. I'd like to go back to the education, to

24 speak of the education. First of all, if I could just

25 ask, just to be refreshed, you, yourself ---

1 MS. BROWNE: Could I interrupt you to ask
2 you to raise your voice a little?
3 JUROR #2: Sorry.
4 MS. BROWNE: It's hard to hear you.
5 JUROR #2: Sorry.
6
7 BY JUROR #2:
8 Q. You, yourself, you were a nurse at one
9 point?
10 A. Yes, that's correct.
11 Q. And then you went on. And if you don't
12 mind me asking how you reached the level of being a
13 Nurse Educator?
14 A. Well, a long pathway there. I've given
15 in my resume, I guess you would have a copy of that,
16 wouldn't you?
17 Q. Yes.
18 A. I certainly started out as a staff nurse
19 on the transplant unit for a few years, went over to
20 Africa and ran a clinic for a year, came back to Sick
21 Kids, worked again as a staff nurse. My education, I
22 guess, opportunity came up on the second trip to Africa
23 for three years where I taught in the School of Nursing
24 and that's where I -- my interest in education began.
25 When I returned back, I got my Bachelor of Science

1 degree and began to realize the impact I could have and
2 the gifts that I had in teaching, so my interest in
3 education grew during my Bachelor's degree, when I was
4 doing that in '94 to '96.
5 An opportunity came up to be an educator
6 in '96 when someone else was on maternity leave, so I
7 did that for eight months and then from there, just
8 sort of grew into the role and I'm currenty in a Master
9 of Nursing degree at the University of Toronto, which
10 is actually a requirement of the position of Nurse
11 Educator currently. At the time I got it, it wasn't.
12 Q. Okay. Just so I can be familiar. I was
13 going to ask you how you update your knowledge, but you
14 say you're working on your Master's degree now.
15 A. Yes, I am. And tons of reading. I have
16 a pile of reading on my desk every day that you do try
17 to work through and anything that is sort of brought
18 across my table, I feel is my responsibility to follow
19 that up to -- look it up to follow it up, to go talk to
20 someone else who may know if I don't know, because I
21 think if nothing else, we've appreciated how complex
22 nursing is, how complex medicine is and one person
23 can't be expected to know everything, so you just have
24 to know who to ask if you don't know yourself and
25 that's how I've approached it.

1 Q. The hospital itself, do they set forth
2 for you any guidelines of your education as Nurse
3 Educator, once you were hired and you were in place,
4 did they then guide you in taking further courses or
5 did they accept it as complete at that point?
6 A. Part of our professional development
7 system as nurses in the hospital and as nurse educators
8 is an expectation of life-long learning and that can
9 come about in many things, either formal education or
10 informal education conferences, workshops, your own
11 personal reading, your own personal pursuits of
12 education and as I say, that can come formally or
13 informally. Right now the formal part of it is
14 consuming me quite a bit, but certainly there is a lot
15 of informal, as well. In our yearly reviews, we are
16 expected to grow in a variety of areas and that being
17 one of them.
18 Q. You've touched on two areas that I was
19 going to ask about. With the nurses -- well, if I
20 could back up, first. On ward 5, you are the nurse
21 educator, so you look at all the nurses ---
22 A. Mm-hmm.
23 Q. --- and you look at the qualifications
24 and their daily requirements, what they're dealing with
25 and make sure that they are the right person for the

1 right job. But do you act as a guidance counsellor, in
2 fact, and advise them of different courses they should
3 be taking? Like you were saying that you set up
4 orientation of new staff and that you co-ordinate the
5 experts to come in so that you have the right people
6 discussing, for example, dealing with pain and whatnot.
7 A. Some of the classes I teach myself and
8 some I bring other experts in.
9 Q. Do you review nurses who have been on
10 staff for two or three years and decide that they need
11 further courses or ...
12 A. Every nurse, as a professional, our
13 College of Nurses is our regulatory body and has
14 expectations of us as professionals to maintain quality
15 assurance and every year, every nurse in the province
16 of Ontario is required to complete a quality assurance
17 portfolio, I believe they call it. The requirements of
18 the college are actually met at the Hospital for Sick
19 Children by our internal hospital yearly performance
20 management system and so every nurse is to be held
21 accountable for his or her own practice, his or her own
22 knowledge-base, his or her own skills that they feel
23 that they need. As an educator, at times issues are
24 brought to me. Many times, though, nurses come to me
25 and say I need more information on, so we rely heavily

1 on them to identify their own needs.
2 Q. Mm-hmm.
3 A. We also have mechanisms through the
4 yearly reviews to see if certain people need to focus
5 on a certain area or they are struggling in certain
6 areas.
7 Q. Okay. And I guess that leads me to
8 another area of, in essence, a job description where
9 you would look at what you would see as the overall
10 requirements for the position, to be able to fulfill
11 the position properly. Do you have input in that?
12 A. As an educator, I am actively involved
13 in the hiring process, if that's what you are meaning.
14 The hospital standards for hiring a registered nurse
15 as a discipline is that it's a preferred degree
16 program, but there are a number of nurses in the
17 hospital that have their diplomas, myself included. I
18 was hired as a diploma and got my degree later, and so
19 a number of nurses in the hospital are pursuing their
20 degrees actively. There actually is a job description
21 for registered nurses in the hospital that might be of
22 assistance for the jury to see at some point if you're
23 interested. For me to describe it would be tough,
24 because it's fairly broad.
25 Q. Okay, now, I'm going to direct this a

1 little bit back to the event we're dealing with,
2 insofar as with Nurse Soriano, and I hope I'm asking
3 the right question. With Nurse Soriano, she was saying
4 that she had completed her nursing degree and then was
5 brought onto ward 5 and I asked her if there was a set
6 course requirement or an upgrade that she could take to
7 make herself a little more familiar with the
8 medications being dealt with and the expertise level.
9 In testimony from Ms. Stinson, they were saying that
10 ward 5 was considered sort of the ultimate area of
11 expertise in dealing with children on PCA pumps.
12 A. That's correct.
13 Q. And I was just asking Nurse Soriano
14 basically where does she fit into that, having just
15 been a new graduate. Did you provide her with any
16 courses that you would recommend, a special orientation
17 that would make her -- would help to lift her level of
18 expertise in that area when she started?
19 A. Yes, yes. As I stated, there's the
20 general orientation which is seven days, and at the
21 time of Anagaile's orientation, part of the information
22 on pain in children was taught in the general
23 orientation, but in addition, because she was on 5AB, I
24 arranged through the three days that I had, the three
25 and half days that I had with them for the pain

1 service, to come and actually do classes on epidurals
2 and on PCA morphine infusions, so that was an addition
3 that some nurses in the hospital may not be exposed to,
4 so she was provided with that education at that time.
5 Q. In that education, would you deal with
6 drug interaction, potential dangers and warning signs,
7 would that have been part of your orientation?
8 A. Specifically what you're asking, my
9 answer would be no, but generally I think it's
10 important for you to understand that when nurses go
11 through their university or college, whatever, to learn
12 how to become a nurse or learn their profession, a
13 great deal of that is learning about drugs and the fact
14 that they do interact and a variety of things like
15 that.
16 But to get into the actual specifics of
17 the types of drugs that Lisa was in, especially for a
18 ward like 5A, 5AB which is an active surgical unit, you
19 often have healthy kids that break their legs and
20 aren't on a variety of other drugs, or you have things
21 like antibiotics that they're on or things like that.
22 The mixture that Lisa was on and
23 certainly with Dr. MacLeod being here saying that, you
24 know, even he had to search long and hard to see that
25 this was a potential possible maybe interaction that

1 happened, although he couldn't even say with certainty,
2 that is not something that a nurse on the floor would
3 ever be ...
4 Q. But taking that a little further, do you
5 deal with that in the abstract that you, in your
6 orientation, do you deal with that, that potentially
7 something like that could present itself and ---
8 A. I think that that's a fair question to
9 say and I guess the only answer I can say to that is
10 every nurse is always aware of, as a base of
11 understanding, that when patients are on drugs, there's
12 always the potential that they can interact.
13 Q. Would a nurse with less than a year's
14 experience necessarily fall back on that knowledge, in
15 your opinion?
16 A. We have very high expectations of
17 nurses. There's tons to learn.
18 Q. Yes.
19 A. And certainly we always have an
20 expectation of nurses that if they don't know, they
21 would seek out that information.
22 Q. Okay, which leads me a little further
23 down this path. You, yourself, you were saying that
24 you are a mentor, a peer mentor to your group. When
25 you were on the stand the last time, you were

1 describing yourself as a peer mentor, that if there's
2 any problems or they need guidance or information, that
3 your door is open and the nurses are welcome to come in
4 and I guess you're the ultimate preceptor.
5 A. Well, I have good preceptors and I rely
6 heavily on them, but certainly I'm available to the
7 nurses as well.
8 Q. You were saying that you select
9 candidates for the preceptor role.
10 A. That's correct.
11 Q. Do you have a mandate that you set for
12 what you're looking for in a preceptor?
13 A. Personally, I have my own opinions about
14 how I choose preceptors. We look at least a years'
15 experience, and again that sounds minimal to probably a
16 group of you sitting there, a years' experience doesn't
17 sound like a lot. Usually when a nurse has been around
18 full-time for about a year, I'll approach them to say
19 are you interested in something like this and if they
20 say I'm not ready, then I kind of leave them, because
21 usually a nurse will know when they start to feel
22 comfortable.
23 I usually tell new nurses coming in it
24 takes a good year before you feel comfortable on a unit
25 because in a hospital like Sick Kids, you see new

1 things every, every day, and it really does take at
2 least a year before you start to see things over and
3 over again.
4 Q. Again, I'm going to bring this back a
5 little bit. Do you test the preceptors in any way on
6 their knowledge?
7 A. No, there's no tests.
8 Q. And just to bring this back, if I could,
9 again, if Nurse Soriano, when we were discussing her --
10 when she was discussing Kidcom, her testimony in the
11 end clearly indicated by her understanding, she was to
12 have doctor's permission to activate emergency room
13 orders and I believe that's her understanding at this
14 point.
15 A. Mm-hmm.
16 Q. And how do you view that as a preceptor
17 having this kind of information to pass on? Isn't that
18 a bit dangerous?
19 A. I think I can shed some light on that,
20 because -- and I don't want to bring more confusion to
21 this, because Kidcom is a complex system and I don't
22 want to try to take you into an area of Kidcom that is
23 unnecessary for you to understand. You were correct,
24 that Anagaile's understanding of a suspended order from
25 emergency needs to be corrected. She was unclear about

1 that. I think, though, that it's important for you to
2 understand that there are cases where suspended orders
3 do require ---
4 Q. Yes, I understand that.
5 A. --- a doctor's permission to activate
6 those.
7 Q. Yes.
8 A. And so ---
9 Q. However, as in everything, there are
10 different tiers and levels.
11 A. Right.
12 Q. And I think to be a preceptor, it's
13 probably best to understand all the different tiers and
14 levels before you can become what is perceived as an
15 authority.
16 A. I agree, and that, certainly that
17 knowledge base needs to be -- or that understanding for
18 Anagaile needs to be made clear.
19 Q. Okay, which takes me to -- if we could
20 leave Anagaile behind -- future preceptors.
21 A. Mm-hmm.
22 Q. How you would identify their knowledge
23 and competency?
24 A. Right. We deal with nurses every day
25 and we learn to know how they are as nurses, who they

1 are as nurses. If there are any problems, they are
2 identified and dealt with and if there are no problems
3 identified, then we have confidence in our staff as
4 professionals. If there is a misunderstanding on
5 Anagaile's part, it was on the side of caution. I'd
6 rather know I called the doctor to check a suspended
7 order and if that's incorrect information, I agree with
8 you completely, it needs to be straightened up.
9 There are many resources to check in
10 instances like that if you're not sure where you could
11 call and find out and she, you know, clearly that
12 didn't happen that night. But certainly there are so
13 many things to learn. My expectation of preceptors is
14 not that they know everything, but they know who to ask
15 if they aren't sure.
16 Q. Did they understand that?
17 A. Absolutely they do with me, yes.
18 Q. So if I can move on, now, if I could
19 move on to -- well, it's not really moving on quite
20 yet, with nursing staff, clearly we've seen evidence
21 here that perhaps some nursing staff have areas that
22 even though they've been working for a standard period
23 of time, there are areas that may be of concern. Do
24 you identify these areas of concern and identify need
25 for retraining? Is that a role of yours or is that a

1 role of anyone's?

2 A. If myself or anyone in the hospital

3 identified an area of concern or need, that would be

4 brought to the manager and dealt with through the

5 manager and through the Chief of Nursing, if there were

6 other issues to be dealt with.

7 Q. The manager, is he a nursing person, is

8 he a medical person or is that an administrative

9 person?

10 A. The manager of 5AB is not a nurse.

11 Q. It's administrative?

12 A. It's an administrator.

13 Q. So is there a policy on, like, I mean,

14 how would you identify, if something's hidden deep in

15 records and files, how would you identify any problems?

16 Do you do audits of any type?

17 A. There are audits that are actually done

18 on 5AB.

19 Q. What type of audits?

20 A. I believe -- I'm not on 5AB anymore, so

21 I'm not familiar ---

22 Q. You're 5A now, aren't you?

23 A. I'm on 5C now.

24 Q. 5C.

25 A. Which is a different thing.

1 Q. Okay.

2 A. I believe that their system currently is
3 that their clinical nurse specialist and their nurse
4 educator, and/or they do rounds around the unit and I
5 believe this has been implemented ---

6 Q. Since the incident.

7 A. I think it has been, I can't be one
8 hundred percent certain about that, but I think it has
9 been implemented since this incident, but I don't want
10 to hold myself to that. It's a little fuzzy to me.

11 THE CORONER: There may be another witness
12 we can clarify that point for you.

13 THE WITNESS: They currently go -- they have
14 a sheet, an audit sheet that they do. They
15 pick up flow sheets and charts and they go
16 through and check for certain, you know, has
17 this been done, has that been done.

18

19 BY JUROR #2:

20 Q. Was that in place before the incident?

21 A. You see, that's what I'm not clear on.

22 Q. When you were on 5AB, did you see any of
23 that happen?

24 A. Well, when I was on 5AB, if it was
25 happening, it would have been the clinical nurse

1 specialist doing it, not myself.
2 Q. Right.
3 A. Because I personally was not involved in
4 it, although I certainly know that those discussions
5 happened at some point and started, I just can't recall
6 if that happened before this incident or after it.
7 Q. Okay. If I may, I'd like to move on to
8 staffing.
9 A. Mm-hmm.
10 Q. For the unit 5AB, there's two shifts,
11 right, 12-hour shifts?
12 A. That's correct.
13 Q. And just so I can clarify, because
14 someone else mentioned the shifts, the nighttime shift,
15 unless -- there's a capacity of 24 beds ---
16 A. That's right.
17 Q. --- and if it reaches more than five
18 patients per nurse, then another nurse will be brought
19 in.
20 A. Generally speaking, we know how many
21 patients we're going to have on the floor prior to the
22 shift. We have a schedule where there's a certain
23 number of nurses automatically scheduled to work on a
24 day shift or a night shift. As that evening
25 approaches, that afternoon approaches and we look at

1 the number of patients that are there and the number of
2 nurses that would be required, we don't do assignments
3 strictly on the number of patients.
4 Q. Right.
5 A. There are, as I said earlier, there are
6 cases when one nurse, one patient.
7 Q. Right.
8 A. Those kinds of situations. So the nurse
9 in charge in the daytime, the person we call the
10 "Resource Person" in the daytime, would look at the
11 patients and therefore they have a general familiarity
12 with those patients and they would decide, based on
13 their judgment, how many nurses are required that
14 night.
15 Q. Okay.
16 A. Obviously we experience admissions in
17 the night and things like that. If it got to the point
18 where the capacity was beyond the nurses, in other
19 words, you know, we have lots of empty beds but we
20 don't have nurses, the nurses can say I'm sorry, you
21 know, we aren't able to take that child. So it's not
22 as though they're obligated to just put a person in a
23 bed ---
24 Q. Right.
25 A. --- and cope. They also have a

1 responsibility as professionals to say this is too much
2 and we need another nurse.
3 Q. Now, generally speaking, at night time,
4 there's not doctors on the floor unless they're called
5 in?
6 A. That's correct.
7 Q. But whereas during the daytime, you
8 might have doctors on the floor on and off?
9 A. On a surgical unit, usually the doctors
10 are there first thing in the morning to do rounds and
11 then at the very end of the day to do rounds again.
12 During the day, surgeons are in surgery and there is
13 always somebody to page or to call who is on call for
14 that day, but usually you won't see a number of
15 physicians around.
16 Q. At night, is there an information clerk
17 available on staff?
18 A. I believe that the information clerk is
19 now working until 11:00 p.m., and I don't believe
20 there's one from 11:00 p.m. until 8:00 a.m., but again,
21 that's -- I'm not sure about that. Every ward has
22 different system in place for their information, their
23 schedules and such, and I'm not sure what that
24 situation was at the time of Lisa's death. I'm not
25 even certain what it is now.

1 Q. Okay. The policy for breaks, is there a
2 policy that says that in a 12-hour shift you must take
3 your break, or is that at the discretion of the nurses
4 that we've been hearing?
5 A. Certainly the nurses are entitled to a
6 break on each shift. Obviously there are many
7 circumstances when nurses can't get breaks or can't get
8 a long enough break or ---
9 Q. Do you know that that happens on a
10 regular basis or is that an isolated ---
11 A. On a regular basis, that would be ---
12 Q. Or is it more isolated?
13 A. It does happen, it does happen. I think
14 every nurse in Canada can give stories of times when
15 they haven't had breaks.
16 Q. Okay. Well, sorry, my fellow juror was
17 just saying there's the dinner break, or what it may be
18 called, the dinner break, would be an hour and a half.
19 Is that the only break there is?
20 A. Well, on daytime usually what happens is
21 they'll try to do a lunch break and then a dinner
22 break, so they sort of divide it up throughout the day
23 or they'll have a coffee break and a lunch break or
24 something like that. On nights, usually what nurses
25 try to do is combine those together so they can go

1 and ---

2 Q. Snooze.

3 A. --- either have a power nap or whatever,

4 go and eat chocolate or something, whatever they need

5 to do to, you know ---

6 Q. Perk themselves up.

7 A. --- to perk themselves up.

8 Q. Okay, I just want to check that I've

9 covered everything I need. Another question, of

10 course, to bring it back to the incident is Ruth

11 Doerksen, when she came out, you said that she took one

12 look and saw you and came running out and together you

13 ran into the conference room where she opened up to

14 you. At that time, was that as a peer mentor or was

15 that as a friend?

16 A. As a mentor.

17 Q. Okay, so you feel that Ruth's procedure

18 as a mentor when she was -- sorry, that does remind me

19 of another -- the Nurse Educator for 5AB, would that be

20 the person now who would be responsible for orienting

21 staff to the protocol and policy of the coroner's

22 investigation? Who is responisible for that?

23 A. If that were to be a recommendation that

24 you would make, currently I don't believe we have a

25 class that is given to every staff as they come into

1 their own and say this is what you need to know about a
2 coroner's inquest. If it were to happen, it would
3 probably be more appropriate to do it on a general
4 level or on across the hospital level rather than a
5 unit-specific level. The other thing to keep in
6 mind ---
7 Q. But with your new staff, I mean, there's
8 constantly new staff, so ---
9 A. Yes.
10 Q. --- you would be dealing with that.
11 A. Yeah, you would have to ---
12 Q. But is there a person, I guess my
13 question also is two-part: is there a person who in
14 the event of a coroner's inquest or a sudden death
15 where it would be expected there would be a coroner's
16 inquest, is there a person whose role is to co-ordinate
17 and oversee what's happened or is it basically a free-
18 for-all of whoever can remember do what, does it?
19 A. I wouldn't describe it as a free-for-
20 all. I -- a place in the hospital where they deal with
21 more deaths is intensive care unit. If I were involved
22 in something like this and had not been exposed to this
23 inquest, and obviously I've learned a lot, as well, in
24 this, my instinct would be to call intensive care unit
25 where they do deal with a lot of deaths. There always

1 is somebody in the hospital who has knowledge of it and
2 as I say, if you don't know, you need to know who to
3 call. There is always people to call to ask.
4 Nurses in general, as I say, know
5 coroner's inquests, you don't touch anything, wait
6 until the coroner comes. And from that perspective,
7 irregardless of somebody in the hospital saying they're
8 in charge of the situation or not, they would rely on
9 the coroner to say what do I do now, tell me what you
10 want me to do.
11 Q. Okay. Sorry, I do have other questions.
12 There's been an awful lot of talk about clinical
13 judgment.
14 A. Yes.
15 Q. And we've heard many different
16 interpretations of clinical judgment and I guess what I
17 want to ask you is how you would define it, first of
18 all, if you don't mind?
19 A. How I would define clinical judgment.
20 Clinical judgment is the nurse, the professional nurse
21 using his or her knowledge, skill and judgment to come
22 up with a decision, keeping in mind the entire set of
23 circumstances surrounding him or her.
24 Q. Is this is something that is taught in
25 nursing school?

1 A. Clinical judgment?
2 Q. Yes.
3 A. It's something that's talked about. Can
4 you teach it?
5 Q. Is it addressed? Is it addressed in
6 school?
7 A. It's a common phrase or concept in
8 nursing school among nurses across the world, I would
9 argue. If it were able to be taught, I would love to
10 know how to, because it's something that you develop
11 over time with experience, with exposure and with
12 common sense. You know, you develop clinical judgment
13 over time and certainly learn a lot of it as a student
14 in the four years or three years in school, you learn
15 a lot of that. As time goes on, you learn more and
16 more and more. We have a concept in nursing, a person
17 called Patricia Benner (ph.) who has a concept called
18 "From Novice to Expert" which describes how the nurse
19 progresses from being just starting out to an expert
20 nurse and there's five stages in between.
21 And there's descriptions of those, each
22 of those individuals and those five stages and how they
23 learn and how they develop judgment and things like
24 that, and this is an example where we had perhaps a
25 novice and perhaps an expert, and you can see how they

1 are thinking differently and I can see from listening
2 to their testimony even how they answer, answering in
3 terms of where their mindset was, where their clinical
4 judgment was at the time, that's extremely difficult
5 for you as jurors, I'm sure, to grasp and I don't blame
6 you for that at all, it is difficult.
7 Q. Well, it is something we do want to
8 address, so I guess my next question is I'm assuming
9 you don't discuss it in your orientation meetings with
10 the nurses. Is that correct, that you don't deal with
11 it?
12 A. No, we don't discuss it.
13 Q. When you have the new nurses coming in,
14 do you deal with that issue?
15 A. Clinical judgment?
16 Q. Yes.
17 A. Yes, we do.
18 Q. And how do you deal with that? What do
19 you advise them?
20 A. In a variety of ways. Rely a lot on
21 preceptors to ---
22 Q. Beyond that stage.
23 A. Beyond preceptors?
24 Q. Mm-hmm.
25 A. In the class itself, I talk -- in

1 classes, I mean, I teach a variety of them. You can
2 talk about this is the rule, this is the regulation,
3 this is the policy. Then you need to say, okay, how
4 did we get to this point? Why do you think that we do
5 this? Why do you think that -- I'm trying to think of
6 a good example. I'm not coming up with a good example
7 right now on the spot. Why does a heart rate go up
8 when a temperature goes up? What's going on there?
9 And my way of approaching it is to get
10 them thinking around -- I can give them a series of
11 facts about this is what this disease is and this is
12 what this means and this is this pump. I'd rather have
13 them think about, you know, why is it we got to this
14 point or how did we get to this point or what would you
15 do at this point, and so a lot of it is that kind of
16 interaction or discussion, which continues on the floor
17 probably more effectively on the floor as there
18 (inaudible).
19 Q. However, I guess we see incidents of
20 clinical judgment being applied to decisions such as
21 accessing orders.
22 A. Mm-hmm.
23 Q. How big is this broad range?
24 A. I think that the not accessing orders in
25 this case, I wouldn't describe as a lack of clinical

1 judgment, I would describe it as human error.
2 Q. And still on the subject of clinical
3 judgment, at what point, you were discussing the five
4 stages, which can be applied to any area of working if
5 you've been there ---
6 A. Sure, exactly.
7 Q. --- something along (inaudible) at a
8 certain point you do each level of expertise. At what
9 point, and again, this is in connection with Nurse
10 Soriano, at what point do you really feel that clinical
11 judgment is an acceptable standard?
12 A. An acceptable standard?
13 Q. Yes. Would you say three months or five
14 months?
15 A. I don't know that I know how to answer
16 that. I think that that's -- we use -- I used my
17 clinical judgment to just, you know, it's a -- that's a
18 difficult question to answer.
19 Q. I mean, when you look at the lifeline of
20 a working career as a nurse ---
21 A. Right.
22 Q. --- and you look at five months, does it
23 fit?
24 A. Again, in the orientation phase of three
25 months, we have a decision -- we have a point at any

1 time in that three months to decide this isn't working
2 or you need more. And in Anagaile's case, she was
3 functioning efficiently and fine and very well, and so
4 certainly in my opinion, in the opinion of our
5 preceptor at the time, she was perfectly fine to be on
6 the floor working as a full-time nurse, certainly under
7 the direction of those around her. And she knows in
8 one of the lectures I gave them as they go out at their
9 three-month stage in our three-month review with them
10 is you still need to ask questions, you know who your
11 resources are and, you know, if you need anything else,
12 then you need to come back and seek that out.
13 Q. Okay. One last question, I promise it's
14 the last one, is you are a Nursing Educator?
15 A. Yes.
16 Q. Is there a "Doctor Educator?"
17 A. I don't -- I don't know. I don't know.
18 Q. Just curious. That's it, thank you.
19
20 BY JUROR #3:
21 Q. Ms. Douglas, when a nurse comes into a
22 patient's room and checks the patient, when does she
23 record that on the flow chart?
24 A. Generally speaking, they either take the
25 flow sheet in with them to the room and do it

1 immediately or if they leave it in the slot outside the
2 door, they'll do it as they walk out the door and jot
3 it down before they leave the door.
4 Q. In this particular case, she didn't want
5 to wake up the patient and the mother, so both were
6 sleeping.
7 A. Mm-hmm.
8 Q. So then the light was off. She wouldn't
9 turn on the light, so where would she write down her
10 findings after she saw the patient at 5:00 and 6:00 in
11 the morning?
12 A. There's always a light on in the hallway
13 of the hospital and the door of the room is a window,
14 so sufficient light gets in that you can easily see and
15 record things inside, or the nurse could have just
16 stepped out in the hallway and jotted it down at that
17 point in time. That's why nurses often jot down things
18 like vital -- and I think one of the two nurses
19 testified that they jotted down the vital signs on
20 their worksheet and then put them into the computer
21 later, so often that's what happens. If you don't
22 bring the flow sheet in, you jot it down on your little
23 work sheet and then you transfer it over either to the
24 computer or to the flow sheet as soon as you come out
25 of the room.

1 Q. In your statement, you have indicated in
2 here, "I sat with Ruth while she charted the incident."
3 A. That's correct.
4 Q. What chart you were talking about? (sic)
5 A. The added nursing note in the progress
6 notes, the one that was done at 9:00 in the morning.
7 Q. You testified this morning that you
8 helped the new nurses in writing their resume.
9 A. Well, one of the many things that I do
10 is if nurses are needing assistance in updating their
11 resume, then I can help them with that, I guess.
12 Q. Yes. Did you help Ms. Doerksen write
13 her testimony?
14 A. Her testimony? Absolutely not, no.
15 Q. Thank you.
16
17 BY JUROR #1:
18 Q. I really don't have very many questions,
19 I don't really have any except what has come out of
20 this. We have clinical judgment and we have good
21 clinical judgment, don't we? But we also have poor
22 clinical judgment. How do we address poor clinical
23 judgment?
24 A. Are you talking as a hospital how do we,
25 the Hospital for Sick Children, how do we address poor

1 clinical judgment?
2 Q. Yes, okay, let me restrict it to your
3 hospital.
4 A. Well, I guess it's our hospital or any,
5 is that if there is a situation where a nurse is
6 performing poorly or showing any indications that there
7 are problems, the hospital as a whole is obliged to
8 follow that up in whatever mechanism they have in that
9 hospital. Disciplinary type of actions at Sick Kids
10 are usually dealt with through the manager and then --
11 and in some cases, through the Chief of Nursing.
12 Q. Disciplinary measures dealt with through
13 the manager, is that the administrative manager, Mr.
14 Kreutzweiser?
15 A. And, again, because Mr. Kreutzweiser is
16 not a registered nurse, then that would be in close
17 consultation or in whatever -- in agreement with the
18 Chief of Nursing.
19 Q. So there's a general policy on
20 disciplinary measures?
21 A. Yeah. I'm not sure that there's a
22 policy, but certainly there is an expectation and
23 understanding by the management staff. It's their
24 responsibility.
25 Q. So there are consequences to errors?

1 A. Yes, yes.
2 Q. We spoke -- I don't know if you and I
3 spoke about that. I seem to keep coming back to this
4 heart rate of 134 for some reason. I think we spoke
5 about it earlier.
6 A. I think we did.
7 Q. And I think you said the last time you
8 were on the witness stand that that was acceptable,
9 given all these circumstances and all that you now
10 know.
11 A. It's a mild tachycardia, yes.
12 Q. Having heard the evidence that you've
13 heard and having heard physician witnesses that dispute
14 that ---
15 A. Mm-hmm.
16 Q. --- do you still agree that 134 at 4:15
17 that morning was acceptable and not an alarm?
18 A. I do.
19 Q. Would you still agree with that?
20 A. Absolutely, and I have seen children in
21 their sleep have heart rates that go up for a variety
22 of reasons, fever, pain, and they do settle down and in
23 my experience as a pediatric nurse, that is nothing --
24 that is something that I've seen before and it is
25 something to -- when we look in hindsight, we obviously

1 have a lot of different explanations.
2 Q. Well, we can -- sorry.
3 A. It's all right. We obviously have a lot
4 of explanations. For in foresight, it is mildly
5 elevated heart rate.
6 Q. But one can learn from hindsight.
7 A. Absolutely, that's why we're here.
8 Q. But have we learned from hindsight that
9 this is unacceptable or acceptable? From your
10 perspective, it's still acceptable, is that what you're
11 saying?
12 A. Well, in hindsight, it would have been
13 nice to have done some -- a blood pressure in
14 association with those things to discover more. In
15 hindsight, there's a lot of things, I think, we wish,
16 as I say, we wish we could turn back the hands of time,
17 but to see that heart rate, in other children, I've
18 seen a number of times and it is -- it's not been an
19 issue and ---
20 Q. But it is an issue here, I believe. I
21 believe it's an issue here.
22 A. It's an issue in that we're looking in
23 hindsight. If it had kept going up or if it had
24 dropped suddenly, it would have been an issue.
25 Q. But if this occurs again and nurse

1 educators and nurses accept this as an acceptable
2 standard under similar circumstances, guessing that the
3 child might be in pain, even though that youngster is
4 very drowsy and hasn't been awakened to be asked if
5 they're in pain, if we accept that as a standard and
6 that is taught, couldn't this occur again?
7 A. I guess what I need to say ---
8 Q. Because we do have the benefit, now, of
9 hindsight.
10 A. Absolutely. Again, I think in this case
11 the added addition of a blood pressure would have been
12 valuable. The other thing is that the role of the
13 nurse in that situation is to let the physician know,
14 because the physician's scope of practice is much
15 broader than the nurse's scope of practice and it would
16 be the nurse's responsibility to inform the physician
17 of what was going on.
18 Q. I guess the physician was informed,
19 though, wasn't he?
20 A. That's correct.
21 Q. Wasn't he told that the vital signs were
22 in the normal range, so how could he have known that?
23 A. I believe Nurse Soriano testified that
24 she read to him what the heart rate and the -- what the
25 respiratory rate was and that the heart rate was in the

1 120's and 130's, so he wasn't ---
2 THE CORONER: I don't think this witness can
3 help you. I think we've had both the doctor
4 and the nurse and I think it's a fair summary
5 that their testimonies are at significant
6 loggerheads. One is saying he said one
7 thing, one is saying he said the other, so
8 it's ---
9 JUROR #1: I'm clear on that now.
10
11 BY JUROR #1:
12 Q. The other thing that I just wanted
13 to say is when Dr. Wright came in and called the
14 coroner ---
15 A. Mm-hmm.
16 Q. --- after that all kinds of assumptions
17 were drawn. Is it reasonable to draw assumptions when
18 a child, a healthy child, lost her life, is it
19 reasonable to draw any assumptions but rather not to
20 take all precautions? I mean, this one assumes that
21 the room will be covered, there was no one in that room
22 when Dr. Wright came and you yourself say you assume,
23 that you trust these nurses, you expect them to tell
24 you the truth, so therefore you assume.
25 A. Mm-hmm.

1 Q. Why should we be assuming anything at
2 that point of crisis? I mean, if there was a monitor
3 in the room, someone (inaudible) it out, so the chain
4 of command and responsibility -- I mean, you yourself
5 assumed that Nurse Doerksen was being candid and honest
6 with you.
7 A. And I believe that to this day.
8 Q. And did Nurse Doerksen tell you she did
9 not use doctor's orders?
10 A. I don't believe she was aware of them at
11 that point. I mean, I don't want to make light of
12 this, I think that we've all -- we all, myself
13 included ---
14 Q. We've gone over it and over it and over
15 it.
16 A. --- will approach things, you know,
17 differently in the future. Because of this, we've
18 learned a lot and you're right, there are assumptions
19 that are made in the course of a day in a hospital. If
20 a case like this were to happen again, I think myself
21 and a lot of people within this courtroom who have
22 heard anything will react (inaudible).
23 Q. And also I wanted to comment on the fact
24 that to date, Ms. Soriano does not understand the
25 Kidcom system clearly enough to access the doctor's

1 orders that night, and to operate on the doctor's
2 orders rather than her clinical judgment, yet she has
3 been working, employed with the hospital 18 months, I
4 believe, although I haven't heard the full CV, is Nurse
5 Soriano still employed at your hospital?
6 A. Yes, she is.
7 Q. Yes. So she's worked 18 months and she
8 was there from August '98 when she became the full-
9 fledged oriented nurse.
10 A. Mm-hmm.
11 Q. And if we take it to one year hence,
12 that was an additional year and somehow in the check
13 (sic) you said that the employees were reviewed. It
14 has not surfaced that Ms. Soriano was ignorant of the
15 -- that's not a good word, I can't think of the ---
16 A. Unaware?
17 Q. That she was less informed as I, a lay
18 person, as to how that Kidcom worked that night, how
19 she should have accessed those doctor's orders for that
20 little girl. And it hasn't surfaced in her review and
21 so she's had one employee review.
22 A. Mm-hmm.
23 Q. And continued working an additional six
24 months and, I mean, we heard it here, folks. She did
25 not understand.

1 A. Well, again, I think that ---
2 Q. That's very disturbing.
3 A. I think it's important for you to
4 understand that she knew how to activate suspended
5 orders, but her understanding was she needed to get the
6 doctor's approval to do so, and that's extra
7 communication on her part, rather than I just don't
8 bother and there are many other circumstances
9 (inaudible) orders where you do require a doctor's --
10 you must contact a doctor to find that out. And I
11 agree with you ---
12 Q. It's written on the form, even this
13 moment, it's written on the form.
14 A. I'm sorry, what's written on the form?
15 Q. On the emergency form that a nurse can
16 -- not that form -- that a nurse can access emergency
17 orders when they are suspended.
18 A. Mm-hmm.
19 Q. And that was put to Miss Soriano and
20 Miss Soriano still disputed that, on the written
21 information, so that's concern.
22 A. Again, because I think what she was
23 thinking was the other suspended orders where you do
24 require a doctor's permission to activate and you're
25 right, that is a misunderstanding for her. She needs

1 to have that clarified.
2 Q. I guess we could go round and round and
3 round on this, Miss Douglas, couldn't we?
4 A. Yes.
5 Q. Those are my questions.
6 THE CORONER: I think there may be one or
7 two Counsel who had questions of
8 clarification, not with regard so much to the
9 jury, but some issues that were going to be
10 additional comments with regard particularly
11 to the timing of Dr. Reingold's arrival. And
12 I don't -- I'm looking at Counsel in general,
13 because I don't know who wants to start.
14 MR. GOMBERG: I thought we dealt with that,
15 quite frankly, but ---
16 MR. HAWKINS: I understood that this was an
17 opportunity for the jury to ask questions for
18 clarification, not for Counsel to go around,
19 I guess, for the third time ---
20 THE CORONER: That's correct.
21 MR. HAWKINS: --- with Ms. Douglas on those
22 issues, but there was an issue with respect
23 to the timing of Dr. Reingold's arrival and
24 whether the nurses, Doerksen and Soriano,
25 were there or not, which I believe Ms.

1 Douglas can clarify.
2 THE CORONER: I was under that impression
3 that there may be some clarification of that
4 from this witness and that question obviously
5 wasn't asked of this witness the first time
6 around because it at that time did not seem
7 to be an issue or something that needed to be
8 clarified.
9 MR. GOMBERG: I don't have a problem.
10 MR. KRKACHOVSKI: I have a few questions,
11 Mr. Coroner ---
12 MR. GOMBERG: So do I.
13 MR. KRKACHOVSKI: --- regarding the patient
14 care summary, that I be permitted to put to
15 Ms. Douglas simply because we didn't have it
16 when she testified the first time. Sorry, I
17 should be clear, the patient care summary
18 that was the mock-up that was intended to
19 reproduce what would have printed up at 6:15
20 or 6:30 the morning that Lisa died.
21 THE CORONER: I think that's fair. Now, who
22 wants to start.
23 MR. GOMBERG: Well, I thought that the
24 discussion that we had earlier that we were
25 permitted to ask questions dealing with the

1 issue of the 6:15 printout and, as well, I
2 have some questions which arise from the
3 questions that the jurors have asked, so I'm
4 happy to wait, but I do have some questions.
5 I undertook to ask a question about
6 discipline, that's an area that came up
7 today, and I intend to ask about that, if I
8 may.
9 THE CORONER: Well, let's leave that one
10 towards the end. Can we ask the other more
11 straightforward questions first?
12 MR. HAWKINS: Just on that issue, we've
13 dealt with this before, but Ms. Douglas was
14 brought back to clarify and answer questions
15 for the jury, which she's done. All of the
16 issues that were addressed by the jury have
17 already been through by Counsel and I recall
18 the sequence with Ms. Douglas, Counsel has
19 gone through twice, so she's been questioned
20 by each Counsel two times.
21 I think if there are new issues relating
22 to the patient care summary, relating to the
23 timing of the coroner's arrival, that's
24 satisfactory, but to suggest that Counsel now
25 have another opportunity to go through for

1 the third time after the juror's questions, I
2 don't think that's the way the process works.
3 And I certainly had no intention of going
4 through any of those issues a third time with
5 Ms. Douglas.
6 THE CORONER: No, I don't intend to let
7 Counsel go through a third time, either, with
8 those issues.
9 JUROR #1: Mr. Coroner, may I say something?
10 THE CORONER: Please.
11 JUROR #1: Or would it be inappropriate or
12 irregular?
13 THE CORONER: I don't know until you tell
14 me.
15 MR. HAWKINS: I would suggest this is Dr.
16 Cairns' decision, but ...
17 JUROR #1: As a group here, it's been of a
18 concern to us all along this particular
19 question, and we have waited and waited and
20 waited, thinking that something may come to
21 us that we would understand the answer to our
22 question, consequences, and so on and so
23 forth. If I'm not supposed to say that ---
24 THE CORONER: No, you will ---
25 JUROR #1: So therefore it's important to

1 all of us and I think that's a concern to all
2 of you, that we learn something more about
3 that, so I just wanted to add that. I
4 suppose had we been more prudent, we might
5 have asked each witness, but we were certain
6 that something might surface of its own, or
7 wonder if we might have an opportunity, Mr.
8 Hawkins, with another witness that we have
9 yet seen to ask that question? Could that
10 be ...
11 MR. HAWKINS: If I might respond and Dr.
12 Cairns has indicated on a couple of occasions
13 and I think it's quite clear that -- and it
14 will be said by all Counsel at the end of the
15 process, that the coroner's process is not
16 about blame, it's not about fault finding.
17 We've heard an awful lot of evidence that
18 starts to got that way, but that's not what
19 the process is about and in my respectful
20 submission, questions like you are suggesting
21 are inappropriate for this process.
22 THE CORONER: Perhaps I can help the jury
23 somewhat, and this does happen on many
24 juries. An inquest as we stated at the
25 beginning was to ascertain the facts to make

1 sure that the death isn't overlooked and to
2 make recommendations at preventing deaths in
3 the future. And it was indicated by me at
4 the beginning that you have certain questions
5 you must answer. Lisa Shore's name is not in
6 contention, where she died and when she died
7 is not. You will have to, based on the
8 evidence you hear, decide among yourselves
9 what her cause of death was and you will have
10 to decide, having heard all the issues, as to
11 whether you think she died of natural causes,
12 whether she died accidentally, the five
13 things, suicide, homocide, or you cannot
14 determine. So those are things you have to
15 answer.
16 Having answered those, you are entitled
17 to make recommendations from the evidence
18 you've heard about things you think may help
19 to prevent this in the future, but in both
20 answering the five questions and in making
21 your recommendations, you may make no finding
22 of fault or no conclusions in law.
23 JUROR #1: We're very clear on that, sir.
24 We are clear on that aspect.
25 THE CORONER: So in terms of what

1 particularly happened or didn't happen to
2 individuals regarding this death falls into
3 the category of potential finding of fault
4 and therefore we cannot get into those. The
5 reason that so much evidence with regard to
6 some of this issue has arisen in this inquest
7 is because it is necessary to go into a lot
8 of that evidence to give you the full facts
9 about the death. And if this was a different
10 forum, you would certainly, having got the
11 full facts in a different forum, would be
12 asked to consider those facts to come to
13 certain conclusions.
14 What is very confusing at times in an
15 inquest is that you will be given facts which
16 you cannot come to a conclusion because that
17 is the way that the inquests are set up. In
18 many other inquests, the amount of facts that
19 you've been given, and I think it has been
20 essential that you get -- that you had
21 witnesses do this so that you get the full
22 facts.
23 In many other cases, the full facts
24 would not be controversial and we wouldn't
25 have gone into so much detail and I agree

1 with you that the debate about who is saying
2 what and who is this and who may be telling
3 the truth or may not be telling the truth are
4 important for you to hear so that you have
5 the full facts, but you will be restricted in
6 your -- both your verdict and your
7 recommendations in terms of how you use that,
8 and I've talked to inquest juries following
9 inquests of this nature in the past, that is
10 frustrating, but there is no one on trial.
11 As the strict laws of evidence do not
12 apply, therefore I allowed much more things
13 to go in in evidence here than would be
14 allowed in in a civil trial or in a
15 disciplinary hearing or in a criminal trial,
16 because that is allowed at an inquest and it
17 is appropriate for it to be allowed at an
18 inquest, because an inquest is there to get
19 facts. Then, unfortunately, also comes with
20 that since the normal protection that would
21 otherwise disallow questions from being asked
22 is not there, there has to be a restriction
23 on what you can do, having heard those facts.
24 JUROR #1: Thank you. May I just add one
25 little thing? We did hear something

1 yesterday that could have possibly been used
2 as a deterrent with regard to the Kidcom,
3 with names or the identification, the access
4 number of people who go into the Kidcom
5 either to read it, to print out or whatever,
6 and if certain systems aren't in place, I
7 mean, or certain systems are in place, I
8 believe they could be a helpful deterrent and
9 so that's kind of what I'm thinking of, sir,
10 consequences as deterrents.
11 THE CORONER: You will be allowed to address
12 those in your recommendations ---
13 JUROR #1: Thank you.
14 THE CORONER: --- without any problem. Mr.
15 Krkachovski?
16 MR. KRKACHOVSKI: Thank you, Mr. Coroner.
17
18 RE-EXAMINATION BY MR. KRKACHOVSKI:
19 Q. Ms. Douglas, I just have a few quetions
20 regarding the patient care summary there. As we
21 learned yesterday, it prints out each morning sometime
22 between 6:15 and 6:30 on the floor, and my under-
23 standing is that that happens automatically, no one
24 activates anything to have that done?
25 A. That's correct.

1 Q. All right. And just so that I'm clear,
2 what is it that someone like Nurse Doerksen is to do
3 with that summary?
4 A. Every morning those reports print up and
5 generally speaking, the nurse who is in charge on
6 nights will try to gather those, staple them together
7 and lay them out on the desk for the nurses coming on
8 on days. It's not sort of a letter of the law to have
9 the nurse on charge on nights to do that. Generally
10 speaking, the first person who arrives on day shift, if
11 he or she sees that it's not done, teamwork, you just
12 gather the papers up and you staple them together and
13 get them ready for your colleagues for days, so there's
14 no written rule that somebody must or has to do it by a
15 certain time or anything like that. Everybody knows
16 that's where you go to get your assignment to that
17 printer. If they're not at the printer, then they're
18 on the desk waiting for you.
19 Q. But I gather whatever she had to do in
20 the way of stapling, collating, et cetera, would have
21 been done before 7:15 when the shift changes? Would
22 that be fair?
23 A. Not necessarily, no. There's been -- I
24 mean, it really depends on how busy the night is. I
25 understand she was busy calling on the phone trying to

1 find another nurse for day shift, so she probably
2 wouldn't have had time to even look at the printouts at
3 that point, and that's not unusual at all, especially
4 in doing rounds, as well, with the physicians.
5 Q. In those circumstances, then, it would
6 be left for the day shift to assemble, collate, staple,
7 et cetera?
8 A. Yeah, or another nurse on nights or
9 whoever happens to see that it's not done and everybody
10 understands it needs to be done, so you gather them
11 together and get them together for the shift.
12 Q. Well, is there an expectation that as
13 between the nurses or among the nurses who are on the
14 night shift, they would accomplish that task for the
15 day shift?
16 A. That's always the goal, and if it
17 doesn't get done and as I say, when the day shift
18 arrives, if they see that it's not done, they would
19 gather them up and do it themselves.
20 Q. And then what does the day shift do with
21 those?
22 A. When you get your patient care
23 summaries, usually you take those with you, pop them in
24 your pocket -- different nurses have different habits,
25 but you get a chance to review those before your shift,

1 read them through and then when you get report from the
2 night staff, you can use those as a reference. You jot
3 notes down on them from report from the nurses, you use
4 those to jot notes down onto during your shift, various
5 nurses use them in different ways.
6 People have different habits. Some
7 people transfer that information onto a worksheet,
8 which is just one piece of paper where they sort of
9 summarize everything from those printouts onto the
10 worksheet. Some people's habits is to use the printout
11 themselves to work from, so it really depends on the
12 nurses themselves.
13 Q. As part of what the night nurses do,
14 would they highlight or summarize or in any way bring
15 to the attention of the day staff whatever might appear
16 on the patient care summary?
17 A. No, that's not their responsibility.
18 They have their own from the night before that they are
19 working from and then it's the person who comes on
20 days, it's their responsibility to read that for that
21 period of time, because they differ from nights to days
22 slightly and it would be the day person's
23 responsibility to read those through to highlight
24 whatever information they think is important to get
25 them through that 12-hour shift and then they get

1 additional information from the night staff in the form
2 of a report, either verbal or taped or written or
3 whatever.
4 Q. Would the night nurse read the patient
5 care summary to ensure it's accuracy?
6 A. No. The night nurse would, if there
7 were changes in the night that needed to be updated,
8 could go into the computer and make those changes which
9 would be reflected on the patient care summary, but
10 it's not their responsibility to read those at all, in
11 any way, shape or form.
12 Q. All right. And do I understand, then,
13 the day shift at some point would simply discard the
14 patient care summary?
15 A. That's correct.
16 Q. Typically after they've reviewed it?
17 A. Oh, I see what you -- they would discard
18 it. Generally, again, every nurse has a different
19 practice. Most nurses hang on to them throughout their
20 12-hour shift and then put them in the confidential bin
21 at the end of their shift. That's the usual practice.
22 There may be some nurses who read them once and
23 discard them right away, but most nurses that I've
24 worked with usually keep them with them throughout the
25 shift to refer to if they need to and then discard them

1 at the end.
2 Q. And I think we've heard this already, I
3 apologize, when does the night nurse -- or does the
4 night staff get their own patient care summary?
5 A. Yes, they do.
6 Q. What time does that happen?
7 A. That happens at 6:15 to 6:30 in the
8 evening.
9 Q. In the evening.
10 A. It prints up and they pick those up and
11 they use those to work the night with.
12 Q. That's all I have, thank you.
13 THE CORONER: Ms. Posno?
14 MS. POSNO: No questions.
15 THE CORONER: Mr. Gomberg?
16
17 RE-EXAMINATION BY MR. GOMBERG:
18 Q. Can I just follow up on that, because
19 that's one of the two areas that I wanted to deal with.
20 As I understand it, in terms of the patient care
21 summary, let's back up to the night before Lisa got
22 there, although I don't know that it matters, those
23 patient care summaries would have been pulled off the
24 computer at 6:15 in the evening by the day nurses, is
25 that right?

1 A. They print off on the printer ---
2 Q. Right.
3 A. --- around 6:15 to 6:30 and they're
4 pulled off when the nurse on days gets to it or when
5 the nurses on nights arrive and they ---
6 Q. All right. But preferrably the plan for
7 the printing at 6:15 at night is for the day nurses to
8 do exactly what the night nurses do for the day nurses
9 at 6:15 in the morning?
10 A. That's always the attempt, yes.
11 Q. All right. So let's, then, move to 6:15
12 in the morning on October 22.
13 A. Mm-hmm.
14 Q. All right? So Lisa is in her room and a
15 nursing care plan or patient care plan -- which is the
16 proper term?
17 A. I believe the computer term is "patient
18 care plan" but nurses usually refer to it as a "nursing
19 care plan."
20 Q. All right, so if I refer to it in either
21 way, I'm not incorrect?
22 A. No.
23 Q. In any event, the patient care plan
24 comes off the computer printer automatically, right?
25 A. That's correct.

1 Q. Right. And as I understand it, Ruth
2 Doerksen, because she's the charge nurse, is
3 responsible for figuring out which day nurse takes care
4 of which patients of the nine patients, namely the five
5 and four ---
6 A. Mm-hmm.
7 Q. --- that Ruth Doerksen and Anagaile
8 Soriano were taking care of the night before?
9 A. That's correct.
10 Q. All right. So it's important that she
11 have these patient care plans to look at so she can
12 figure out the balance of which day nurse is taking
13 care of which of the five and which of the four
14 patients, if you understand my question?
15 A. I undertand your question, but no, we
16 don't utilize those for that purpose at all.
17 Q. All right. Well how does Ruth Doerksen
18 figure out which day nurse is taking care of Lisa ---
19 A. Mm-hmm.
20 Q. That's the question, how does Ruth
21 Doerksen figure out which of the two day nurses whose
22 coming on, is to take care of Lisa?
23 A. The actual assignment for the next day
24 is done by the -- this is very confusing, I understand,
25 the nurse in charge the day before does the assignment

1 for the night shift and for the next day shift.
2 Q. All right.
3 A. The nurse coming on on nights, who is
4 the nurse in charge, can, in the course of the night,
5 if there are changes ---
6 Q. Right.
7 A. --- can make changes to that schedule,
8 so if, for instance, an admission comes in ---
9 Q. Right.
10 A. --- they now have another patient to
11 assign.
12 Q. Right.
13 A. So the nurse would look at the assign-
14 ment as it is there, as it was already pre-prepared and
15 would assess whether that's appropriate, which nurse is
16 appropriate to take the additional patient.
17 Q. Right.
18 A. And that, as a charge nurse, Nurse
19 Doerksen heard or would hear -- have heard a report on
20 each of the patients in the whole ward, so she has a
21 general understanding of the level of acuity of each
22 patient on the floor, and so using her discretion,
23 would decide which nurse is best suited.
24 Q. Okay, I understand that. So let's
25 forget about the assignment of which nurse would have

1 taken over Lisa and let's just talk about what comes
2 out at 6:15. The patient care plan for Lisa comes out
3 at 6:15 and somehow makes its way to the counter,
4 right?
5 A. Yes.
6 Q. Right. Now, that has to be looked at by
7 the day nurse, right?
8 A. Yes.
9 Q. All right. And who was the day
10 nurse ---
11 A. I don't know.
12 Q. --- taking care of Lisa?
13 A. I don't know.
14 Q. Well, I thought evidence came up earlier
15 that that day nurse was already on the floor, that she
16 had arrived already?
17 A. I don't know. I don't recall that.
18 Q. All right.
19 A. She might have, I don't know.
20 Q. Well, my point is that if the day nurse
21 would have looked at the patient care plan ---
22 A. Mm-hmm.
23 Q. --- then the day nurse would have known
24 as well about the Kidcom orders?
25 A. That's correct.

1 Q. And do we know -- how do you know that
2 Ruth Doerksen didn't look at the patient care plan at
3 some time between 6:15 and 7:15 in the morning?
4 A. I don't know that she looked at it at
5 all.
6 Q. Well, she says that she looked at it at
7 9:00.
8 A. Right.
9 Q. There would be no reason for her to look
10 at it at 9:00, would there, because at that point, the
11 day nurse would have taken over from her.
12 A. Well, since Lisa had passed away at the
13 change of shift ---
14 Q. Right.
15 A. --- the nurse on days -- I mean, I heard
16 from her testimony. I wasn't aware of it until then.
17 Ruth must have just looked at it or someone gave it to
18 her, whatever, for whatever reason, I don't know.
19 Q. But wouldn't you agree with me that it
20 was the day nurse's responsibility -- what time does
21 the day nurse come on?
22 A. 7:15.
23 Q. All right, so it would have either been
24 the day nurse's responsibility because Lisa wasn't dead
25 at 7:15, to look at the patient care plan ---

1 A. Mm-hmm.
2 Q. --- at 7:15?
3 A. Mm-hmm.
4 Q. All right. And that therefore the day
5 nurse, if she did what she was supposed to do, would
6 have looked at the patient care plan and would have
7 known about the Kidcom orders that hadn't been
8 implemented at 7:15?
9 A. If she had looked at it at that point,
10 remember she had -- probably had a number of other
11 patients and might have looked at the other ones first.
12 I mean, we could make a big synopsis here, I don't
13 know that that would be of any use.
14 Q. I'm not trying to make a big synopsis,
15 I'm just trying to understand who would have looked at
16 the patient care plan and when it was looked at?
17 A. I don't know.
18 Q. Well, certainly the patient care plan
19 for Lisa Shore ought to have been looked at at around
20 7:15, either by the new nurse, that's the day nurse, or
21 by Ruth Doerksen, right?
22 A. It would have been looked at by the day
23 nurse, had she had access to it at that point, yes.
24 Q. Well, assuming that nobody looked at it
25 until Lisa passed away ---

1 A. Mm-hmm.
2 Q. --- shouldn't it have been retained at
3 that point?
4 A. As I say, it's not a permanent part of
5 the record, it's something that nurses discard every
6 day on their shift in a confidential bin. It wouldn't
7 have occured to anyone to have saved it because the
8 assumption is that everything on the nursing care plan
9 is pulled together from a variety of other parts of the
10 chart. It simply -- the idea of the nursing care and
11 the purpose of it is to pull together all aspects of a
12 child's care onto a couple pieces of paper for the
13 nurse to know what's important for the nurse to care
14 for the patient on their shift.
15 The assumption would be that everything
16 that was on that care plan would have been found
17 somewhere else in the chart and there would have been
18 no occurence to -- I don't think it would have struck
19 anyone, myself included, to keep that because all the
20 information on there, our understanding was that that
21 was also available elsewhere in the chart.
22 Q. Have you asked the day nurse who was to
23 care for Lisa whether she saw the nursing care plan?
24 A. No, I haven't.
25 Q. Did you ever print up the nursing care

1 plan yourself?

2 A. No, I did not.

3 Q. Did Ruth discuss that nursing care plan

4 with you?

5 A. No, she did not.

6 Q. You'd agree with me that it would be

7 important to find out whether the day nurse saw that

8 nursing care plan?

9 A. I don't know if it would be important or

10 not. I don't know.

11 Q. Well, in terms of trying to figure out

12 how one could properly investigate an unexpected death

13 with a child who is in the hospital for a non-life-

14 threatening condition, that's the type of information I

15 suggest to you that people like coroners and jurors

16 would like to have, don't you think?

17 A. Certainly I think you could probably ask

18 the person if you wanted to know. I don't know if she

19 saw it or not.

20 Q. All right. I would have thought, and

21 this is my question, wouldn't it have been something

22 that everybody, all of the nurses working on 5A would

23 have run to grab and preserve, given the shocking

24 nature of what had just happened?

25 A. Well, again as I say, that that's --

1 it's a piece of paper that nurses know to be a summary
2 of many parts of the chart onto their worksheet. It's
3 a piece of paper that every nurse knows the information
4 is also available on other parts of the chart. There
5 would be no reason to have them even remotely think
6 that that was something to be saved, because it's a
7 non-permanent part of the chart.
8 Q. Yeah, I would normally agree with that,
9 except that these orders said -- or these Kidcom orders
10 had the word "suspended" before each and every one of
11 them ---
12 A. Mm-hmm.
13 Q. --- which would be unusual in the
14 context of a child dying while there are orders that
15 are suspended. In fact, my question is, isn't this the
16 only time you know of that happening?
17 A. It's the only time that I've known of
18 that happening. I also was not aware until this
19 inquest that when you -- when a child expires and you
20 print up -- the chart automatically prints up as we saw
21 demonstrated yesterday, that that would not be included
22 as part of the final record.
23 Q. No, but I'm saying is part of the
24 auditing of what gets thrown out when a child dies
25 unexpectedly ---

1 A. Mm-hmm.
2 Q. --- a child is in the hospital for a non
3 life-threatening condition, wouldn't somebody, either
4 Ruth Doerksen or the day nurse, be well-advised to look
5 carefully at that nursing care plan and when that
6 person sees suspended orders written on the patient
7 care plan, that that person would segregate that and
8 hand it to the coroner or hand it to Dr. Wright or hand
9 it to Dr. Reeder and say, hey, we're not throwing this
10 one in the recycling bin because we are going to hang
11 onto this, and if it turns out to be a duplicate or a
12 triplicate or a quadruplicate or a quintuplicate of
13 something that's on the chart, who cares?
14 A. Obviously that didn't occur to anyone.
15 Q. Do you know for a fact that Ruth
16 Doerksen didn't see that between 6:15 and 6:30?
17 A. No, I don't.
18 Q. Those are my questions.
19 THE CORONER: Any further questions of the
20 witness?
21
22 RE-EXAMINATION BY MR. HAWKINS:
23 Q. Ma'am, the one issue that I want to ask
24 you about is the timing of the coroner's arrival. To
25 your recollection, when did Ruth and Anagaile leave

1 that morning?
2 A. What I can say is that I know I was with
3 Ruth while she was recording her added nursing, which
4 is recorded for 9:00 and that probably would have taken
5 us 10 or 15, 20 minutes.
6 Q. At that point, had the coroner arrived?
7 A. No, he had not. After Ruth completed
8 that note, Ruth went out to the desk and I think spoke
9 to some colleagues. I also went out. Ruth left
10 shortly after that and I was spending the time checking
11 on all the other nurses to make sure they were okay and
12 my understanding was that at some point after that --
13 at some point while Ruth and I were back in the room,
14 Anagaile must have left and Ruth left shortly after
15 that. Ruth had gone when I left the floor and when I
16 left the floor, the coroner had not yet arrived.
17 Q. Okay, so just that we're clear on this,
18 while you and Ruth were in still talking in the back
19 room, at some point there Anagaile left?
20 A. That was my understanding, yes.
21 Q. And then you and Ruth came out of the
22 back room and shortly after that, Ruth leaves?
23 A. That's correct.
24 Q. At that point, is the coroner there?
25 A. No, he's not.

1 Q. Then you talked to the other nurses on
2 the floor, so you're still on the floor for a little
3 while after that?
4 A. Yeah, probably another five or ten
5 minutes after that.
6 Q. And at that point, you go back to your
7 office?
8 A. That's correct.
9 Q. And so at that point, Ruth and Anagaile
10 have left?
11 A. They had gone when I went back to my
12 office.
13 Q. And is the coroner there yet?
14 A. No.
15 Q. How do you know that?
16 A. I know that because I -- one of the
17 nurses was standing outside of Lisa's room to watch the
18 room, waiting for the coroner to arrive. The door was
19 closed, and her role was just to stand there and wait
20 to make sure that the room was protected. And I
21 stopped and spoke to her and made some comments about
22 is she okay and that this was awkward for her to be
23 doing this and is she okay, and she said she was. And
24 I proceeded off the unit sometime after that.
25 Q. Thank you.

1 MR. GOMBERG: Mr. Coroner, can I just make
2 this point? My understanding was that you
3 -- I had commited to the juror to ask
4 questions about discipline. My understanding
5 was that you ruled that issue to be not
6 something that anybody could question on,
7 either the jurors or me, and that's why I
8 didn't ask the question, so if I
9 misunderstood you, I do have questions. If I
10 understood you perfectly, then of course I
11 defer to you ruling, but I wanted to be clear
12 that I did have questions that I was prepared
13 to ask about that.
14 THE CORONER: My recollection of what I said
15 is I have no problem with a general question
16 in terms of is there a disciplinary process
17 in existence at the Hospital for Sick Kids.
18 I would restrict in terms of if there is,
19 what was used in this case and what was the
20 result of it.
21 MR. GOMBERG: Then I do have one
22 hypothetical question.
23 THE CORONER: Okay.
24 MR. GOMBERG: The hypothetical question is
25 this: if I'm a nurse on ward 5A and I turn

1 off, say, an apnea alarm on a night when a
2 child dies ---
3 MR. HAWKINS: With all due respect, this
4 does not sound like a hypothetical
5 question ---
6 THE CORONER: It's not a hypothetical
7 question.
8 MR. HAWKINS: --- Mr. Gomberg is asking.
9 MR. GOMBERG: All right. What general
10 discplinary process do you have for nurses
11 who may make errors?
12 THE CORONER: That's a fair question.
13 THE WITNESS: General process for nurses who
14 make errors?
15
16 RE-EXAMINATION BY MR. GOMBERG:
17 Q. Yes.
18 A. It's the manager's responsibility to
19 follow up with any particular errors that occur in the
20 course of a nurse's practice. Serious matters are
21 taken to the Chief of Nursing and are dealt with in
22 that level.
23 Q. Right, and just to be clear, we've heard
24 evidence, I take it, that the managers are not all
25 nurses.

1 A. That's correct.
2 Q. Are any of the managers nurses?
3 A. Yes.
4 Q. All right. What happens if a nurse is
5 on a ward -- and this is a hypothetical question --
6 where there's a manager who isn't a nurse in terms of
7 the disciplinary process?
8 A. I understand your question. In that
9 case, that manager relies certainly more heavily upon
10 the Chief of Nursing for direction or upon someone such
11 as myself or clinical nurse specialist to make
12 decisions around things that are discipline situations
13 that need to be followed up further.
14 Q. All right. And the only other question
15 relates to patient -- I guess there are a number of
16 different kinds of discipline or a number of different
17 kinds of conduct which give rise or may give rise to
18 discipline.
19 A. That's correct.
20 Q. And I really do want to make this
21 hypothetical in this sense: if somebody steals a
22 Corometric monitor from the floor -- it's a bad example
23 -- that gives rise to or may give -- you know, steals
24 pens from the floor, that gives rise to a type of
25 administrative response which is different from

1 discipline which would emanate from clinical
2 situations.
3 A. That's correct.
4 Q. All right. Well, are both types of
5 discipline dealt with by the same process; in other
6 words, the manager and then the head of nursing?
7 A. My understanding would be that it would
8 be. Certainly the manager is the primary responsible
9 person in terms of discpline issues. Whether or not
10 each and every case would go forward to the Chief of
11 Nursing in regard, as you say, to stealing or anything
12 else, I'm not aware.
13 Q. I made that up, it has nothing to do
14 with this case. So if there's a clinical nursing
15 judgment ---
16 A. Mm-hmm.
17 Q. --- issue, all right, that doesn't have
18 to do with monitoring, I mean, I'm not sure, let's say
19 the administration of a drug other than the drugs we're
20 talking about in this case, and somebody administers a
21 dose that's ten times what is supposed to be
22 administered.
23 A. Right.
24 Q. All right? Of valium, somebody gives a
25 patient, you know, 100 milligrams of valium -- that's a

1 bad example, it would probably kill the patient, but
2 does that issue get addressed in the context of
3 discipline or does that issue get addressed in the
4 context of some other way of redressing that problem?
5 A. It probably depends on how the error
6 occurred. You know, if it's intentional versus if it
7 was an accident, things like that, so I think that that
8 depends on the circumstances, depends on the situation.
9 Any errors that do occur, there are processes in the
10 hospital with medication incidents, there are processes
11 in the hospital with other disciplinary issues and all
12 of them are followed up appropriately and the manager
13 has the right and the access of other people in the
14 building to consult if he or she is not sure of what
15 the next step should be.
16 Q. All right, I understand. So in the
17 first case, the manager is the "gatekeeper" ---
18 A. Something like that.
19 Q. --- as to whether or not it goes to Dr.
20 Reeder, who is the head of nursing?
21 A. You might describe it that way, yes.
22 Q. All right. Thank you, those are my
23 questions.
24 THE CORONER: Thank you, the witness may
25 step down. I know that's all the witnesses

1 we have for today. We can excuse the jury
2 for this afternoon. I do want you to make
3 sure that they get a government lunch before
4 they go home. They may live to regret that,
5 also, but it's my understanding that after
6 lunch, in the absence of the jury that we do
7 need to reconvene as there are some motions
8 that Council may wish to put before me at
9 that time. So we will adjourn, if it's
10 convenient for all legal Council, until 2:30,
11 would that be convenient? All right, thank
12 you ladies and gentlemen of the jury, we will
13 recess for your purposes until 9:30 tomorrow
14 morning.
15
16 --- LUNCHEON RECESS
17
18
19
20 THIS IS TO CERTIFY that the foregoing
21 is a true and accurate transcription of
22 my recordings and notes, to the best of
23 my skill and ability.
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27
28
29
30

1 Barbara A. Pollard
2 Certified Court Reporter