

INQUEST INTO THE DEATH OF

L I S A S H O R E

SUBMISSIONS

TAKEN FEBRUARY 9, 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.
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1 SUBMISSIONS BY MR. HAWKINS:

2 Thank you, Dr. Cairns. Good
3 afternoon, ladies and gentlemen of the jury.

4 As you know, I represent the Hospital for
5 Sick Children and its nursing staff. What
6 I'd like to talk to you about this afternoon
7 is some of the evidence you've heard, the
8 verdict and the recommendations you are
9 considering. I don't intend to review all of
10 the evidence, but some of the important
11 points. I will also try to respond to some
12 of the remarks made by Counsel earlier.

13 I want to begin by repeating what's
14 been said in virtually all of the evidence,
15 in particular by the nurses that I represent,
16 and by Dr. Jean Reeder when she testified
17 yesterday. Different things and different
18 people combining, of human errors and system
19 errors, and to fix the problem, we do have to
20 look at all of those issues. What I'm
21 suggesting and what I'd like to go through in
22 a moment, is that if we are to learn from the
23 death, and if we are to ensure that this
24 doesn't happen again, we cannot focus on

1 particular people or particular nurses. The
2 focus has to be on the whole system, the
3 broader picture, everything and everybody
4 that was involved in the care provided to
5 Lisa, and that is what I and my clients have
6 been trying to talk about and have been
7 trying to demonstrate.

8 The hospital has apologized to the Shore
9 Family, and I repeat that on behalf of myself
10 and on behalf of the hospital. What we're
11 here to do, and what we're trying to do is
12 improve what is acknowledged to be an
13 imperfect system and try to prevent things
14 from happening again.

15 What I and my clients, however,
16 have been saying throughout the inquest is
17 that while there were nursing errors and
18 while there are significant nursing errors,
19 that is not all that this is about.
20 Absolutely, nursing errors and nursing issues
21 need to be considered, and nobody is in any
22 sense trying to back away from that. But to
23 not look at the whole system, and to not look
24 at quite critically, the conduct of everybody

1 and everything involved in the care provided
2 to Lisa, is to forget the purpose of this
3 process, which is to try to improve things
4 and to try to ensure that it does not happen
5 again.

6 Jennifer Stinson, when she
7 testified, talked about a snowball effect.
8 Different things and different people
9 combining, of human errors and system errors,
10 and to fix the problem, we do have to look at
11 all of those issues. What I'm suggesting and
12 what I'd like to go through in a moment, is
13 that if we are to learn from the death, and
14 if we are to ensure that this doesn't happen
15 again, we cannot focus on particular people
16 or particular nurses. The focus has to be on
17 the whole system, the broader picture,
18 everything and everybody that was involved in
19 the care provided to Lisa, and that is what I
20 and my clients have been trying to talk about
21 and have been trying to demonstrate.

22 Otherwise, if we do not look at the
23 broader picture and absolutely consider the
24 individual issues and the individual

1 decisions that are involved, but we've got to
2 get beyond that and we've got to look at the
3 whole picture. And that is what the hospital
4 has tried to do, and that is certainly what
5 the nurses are trying to acknowledge.

6 And Ms. Posno is right. I am going
7 to talk about Dr. Schily. But I don't want
8 to talk about Dr. Schily from the perspective
9 of trying to shift responsibility or trying
10 to blame Dr. Schily. It's not about that.
11 The issues relate with Dr. Schily, and I'll
12 get into these in more detail later, are
13 essentially issues of communication.
14 Communication is always a two-way street;
15 information sent and information received.
16 And if you are to fix the system, to fix the
17 communication, you do have to look critically
18 at both ends, at the sender and the receiver,
19 and see whether there are issues, see whether
20 there are things that can be improved.

21 At the outset, I'll highlight
22 again, and I must say this many times, what
23 we're here to do is see if we can prevent
24 similar tragedies. We're not here to point

1 the finger, and we're not here to blame you.

2 That's not the purpose of this process.

3 Unfortunately, we have heard an awful lot
4 about that, and spent an awful lot of time
5 pointing the finger and blaming. We've heard
6 lots of accusations, lots of theatrics by
7 lawyers and other people involved. We've
8 seen attacks on the honesty and integrity of
9 witnesses.

10 I know you're not supposed to read
11 the press, but we've seen a lot of it in
12 there, and a lot of that has been an awful
13 lot more blatant than anything we've heard in
14 here. We hear more of that same blame and
15 pointing the finger in Mr. Gomberg's
16 summation, suggestions of lying, failing to
17 meet standards, disregarding basics of
18 nursing practice, covering up.

19 All of these, in my view, are a
20 distortion of this process, and a distortion
21 of why we're here, and an abuse of the
22 fundamental principle of what an inquest is
23 about, to try to prevent similar tragedies.
24 It's not about pointing a finger; it's not

1 about laying the blame.

2 I haven't heard the various
3 rationales before Mr. Gomberg offered them.
4 He's certainly entitled to state his opinion,
5 and as he states it, I'm not entitled to
6 object as it goes along. What I am entitled
7 to say is that in my view, those rationales
8 and those findings would be a distortion of
9 the process. The purpose is to move forward;
10 the purpose is to try to figure out how we
11 can improve the system. It's not about
12 through rationales and through a verdict to
13 condemn the actions of particular individuals
14 or systems. That is not the purpose of this
15 process.

16 What I want to do is leave blame,
17 try to leave blame, and try to see what we
18 can learn and try to see what we can do to
19 improve the system, and try to see how we can
20 move forward to prevent things like this, to
21 prevent tragedies such as this in the future.

22 And what I'd like to see is if we and you,
23 in particular in your recommendations, can
24 assist us in building a better system, in

1 building a better health care environment at
2 the Hospital for Sick Children and for that
3 matter, more generally, where things like
4 this don't have to happen.

5 Before I turn to the events of the
6 night, I would like to address briefly, the
7 events afterwards. A Coroner's investigation
8 is supposed to be an inquiry into death.
9 We've heard a lot about the inquiry into the
10 inquiry into death, and nobody has denied,
11 nobody has tried to suggest other than the
12 investigation at the hospital got off to a
13 very poor start.

14 This is acknowledged by the
15 hospital, and similarly, from Dr. Cairns'
16 office, it's acknowledged by the Coroner's
17 office that there were errors made, that
18 there were miscommunications, that there were
19 misunderstandings, that there was confusion.

20 And what we have to do from that is learn
21 from our mistakes and try to move forward and
22 try to improve things.

23 The confusion starts that morning
24 on the ward. Nobody there had ever been

1 involved in a Coroner's case before. We've
2 heard this was one Coroner's case in 11
3 years. Nobody knew the procedures, and
4 unfortunately everybody was assuming that
5 somebody else was doing it, or somebody else
6 was handling it. Absolutely, that shouldn't
7 happen. Absolutely, that led to confusion
8 and miscommunication and it was months before
9 the investigation got on track. The wrong
10 assumptions were made. As Dr. Reeder said,
11 that is too long and that has to be fixed,
12 and that has to be dealt with.

13 We also have to sort out, and we
14 have to get into a dialogue with the
15 Coroner's office, which has been suggested by
16 Dr. Cairns and Dr. Reeder, to sort out who's
17 responsible for what, and who is to do what.

18 And that will be done as soon as this
19 process is over and on an ongoing basis.

20 Mr. Gomberg has, throughout this
21 process, made a number of inflammatory and,
22 in my view, inappropriate remarks about the
23 motivations of people, their honesty, their
24 integrity in investigating the death; that is

1 contrary to the evidence, and all it is, is
2 insinuations and innuendo.

3 Dr. Reingold, the investigating
4 coroner, clearly stated he had no evidence,
5 no suspicion, nothing to suggest it was
6 intentional and anything but inadvertent.
7 And one of the things that I do want to say,
8 and one of the truly unfortunate things, is
9 that this insinuation and this innuendo that
10 there's hiding and that there's covering up
11 is placed on the shoulders of Ruth and
12 Anagaile and the suggestion that there was an
13 intentional attempt on their part to hide
14 things.

15 And quite frankly, that places the
16 focus for those mistakes and those errors in
17 the wrong place. The obligation to
18 investigate rests with the hospital and the
19 Coroner's office, and that's acknowledged by
20 both parties. Ruth and Anagaile testified
21 that they were waiting for somebody to talk
22 to them, and nobody did. They were not
23 hiding, they were waiting, because that's
24 what they thought they should do, and they

1 hadn't been through this process before.

2 When questions were eventually
3 asked, they did answer them. Ruth
4 volunteered her side of the story to Mary
5 that morning, with all its gaps and with all
6 its inconsistencies. She's clearly not
7 trying to hide. If she had been, why offer
8 that sort of explanation? If she's trying to
9 hide, why offer the explanation -- why talk
10 about the patient care summary? Who would
11 have known if she hadn't said anything about
12 it? Of course she's not trying to hide
13 anything. Otherwise, why tell? Why tell
14 that day to Mary? Why tell -- why talk in
15 the witness stand?

16 People have made much, or tried to
17 make much of the inconsistencies of Ruth and
18 Anagaile in telling their version of events
19 in the moments and days following death.
20 Everyone who has testified, who saw and
21 talked to Ruth and Anagaile that morning has
22 testified to the genuine shock, emotional
23 upset and devastation that they were
24 experiencing. Quite frankly, it is too much

1 to expect that they would be coherent, that
2 they would be completely consistent at a time
3 like that. And that's why the obligation to
4 investigate rests elsewhere, rests with other
5 than Ruth and Anagaile.

6 The other issue that we have is
7 that by the time people are asking Ruth and
8 Anagaile questions, it's a full-blown legal
9 process. It's a public process. Lawyers are
10 involved. Lawyers for the family, lawyers
11 for the doctors, and myself for the hospital
12 and nurses. Accusations are being made. It's
13 no longer just questions being asked to try
14 to find out what happened; it's accusations
15 being made, accusations of lying, accusations
16 of incompetence, and accusations of covering
17 up.

18 And certainly by March, very early
19 on in the process when Dr. Cairns is
20 involved, it's a public process. It's in the
21 press. And in that context, it's little
22 wonder that people like Ruth and Anagaile,
23 completely unfamiliar with the process, would
24 go to a lawyer and rely on his advice.

1 And I take full responsibility for
2 my involvement in the investigation and my
3 involvement in the Coroner's process, for the
4 advice that I gave to my clients. That's my
5 job, that's why they rely on me, that's why
6 they retain me, as with all of the other
7 parties who retained Counsel, and rely on
8 that Counsel. It's a legal process that the
9 clients are unfamiliar with. Because it's a
10 legal process, they rely on people such as
11 myself.

12 And so for Ruth and Anagaile, my
13 request is please don't put responsibility
14 for the delayed investigation on their
15 shoulders. That responsibility rests with
16 the hospital, it rests with me, and it rests
17 with the Coroner's office. When they were
18 asked to tell their story, when they were
19 required to do so, which is in the witness
20 box, they did. They testified two and three
21 times. They did their best to answer
22 questions. They acknowledged what they did
23 and what they didn't do. They acknowledged
24 that they had made mistakes. They

1 acknowledged that they had reasons for what
2 they did, that with the benefit of hindsight
3 didn't seem like very good reasons in some
4 cases. It's not an easy thing to do, but
5 they tried to do it, and they're certainly
6 not in their testimony trying to hide or
7 trying to cover up.

8 As far as the hospital is
9 concerned, a lot of insinuations are made
10 that the mistakes were intentional, and that
11 they were trying to hide. As Dr. Reeder
12 testified to yesterday, that is so contrary
13 to the very nature of the people working at
14 the Hospital for Sick Children that the very
15 idea is offensive. That's not what they do;
16 that's not what they try to do. These are
17 people who love children. They love to try
18 to care for children as best they can, and
19 when things happen, want to improve and want
20 to make the system better.

21 And I would highlight again what
22 Dr. Reingold said. He in no way suggested
23 that there was any intention, any advertence,
24 any coverup. And aside from insinuations and

1 innuendo, there really is nothing before you
2 to support that.

3 Each of the errors that were made
4 were corrected by the Hospital for Sick
5 Children without prompting, without the need
6 for further Coroner's warrants. And I think
7 the Kidcom errors, the Kidcom error is a
8 primary example. And look at Exhibit 54
9 when you're back in the jury box, which is
10 the letter to Dr. Cairns setting out the
11 chronology relating to production of the
12 chart. It explains what happened, and how
13 those orders were printed.

14 When the hospital realized that
15 error in January, the orders were provided to
16 the Coroner's office without further
17 prompting, without demand by the Coroner's
18 office for further information. Didn't need
19 to serve a new warrant; it was information
20 that was offered by the Coroner -- by the
21 hospital.

22 And in particular, following that
23 -- and that's in the letter, and that's
24 confirmed by Dr. Cairns, the process was

1 verbally explained by the hospital to Dr.
2 Cairns, and in that respect, until the issue
3 came up in the inquest, there had been no
4 further questions, or no further issues in
5 terms of the production of those Kidcom
6 orders.

7 We learned with hindsight that that
8 information was not known to the family, and
9 that's unfortunately another miscommunication
10 between the hospital and the Coroner's
11 office. And I can fully understand why Mr.
12 Gomberg and why the family raised the
13 questions that they did in the inquest,
14 because they didn't know. They still didn't
15 understand to the time of the inquest, what
16 had gone on.

17 But that was an explanation that
18 was provided a number of months ago to the
19 Coroner's office. It should have been
20 provided to the family, absolutely. And
21 through a miscommunication between the
22 hospital and the Coroner's office, it was
23 not.

24 And certainly in that respect, and

1 as has been covered in some of the dealings
2 with Dr. Reingold, the hospital understood
3 that the Coroner's office would be liaising
4 with the family. And as I discussed with Dr.
5 Reingold and when I was questioning him about
6 the letter that the hospital wrote in
7 response to the family's questions, he said
8 he would be communicating that to the family.

9 When it became apparent that he had not, I
10 obtained his permission and we provided it
11 directly, or I provided my copy to the
12 family.

13 Unfortunately, there was a
14 misunderstanding and a miscommunication
15 between the hospital and the Coroner's office
16 as to responsibilities and as to who was
17 doing what. And I come back to something I
18 said earlier that everybody was assuming
19 somebody else was doing it. That's not how
20 an investigation should work, but that's far
21 from insinuations and allegations of coverup.

22 Mr. Gomberg commented at length a
23 few moments ago about the hospital's response
24 to the Coroner's office. It's not something

1 that has been referred to in any great detail
2 at the inquest, and I think that's very
3 significant. I'd urge you to read the
4 letter, read the questions and read the
5 response.

6 All of the people, all of the facts
7 that are reflected in that letter, they
8 relate to the evidence, they relate the
9 versions of events offered by various people
10 who've been witnesses at this inquest. Dr.
11 Schily, Nurses Doerksen and Soriano, Nurse
12 Douglas, Pauline Matthews, Dr. Catre; all of
13 these people, the facts that they have to
14 offer, the factual background, that's what's
15 written up in the letter.

16 Each and every one of these people
17 testified, with the exception of a couple of
18 questions to Nurse Doerksen, the letter came
19 up with nobody. A couple of questions to Dr.
20 Wright. It wasn't addressed, the facts of
21 the letter weren't addressed with anybody,
22 with any of the witnesses to say this is
23 wrong, that's wrong. All we have is a global
24 allegation that it's a sham, or a global

1 allegation that it's misleading. What I
2 would suggest you do is read the letter, read
3 the questions, and read the answers. If you
4 compare the questions to the answers, you'll
5 find, I believe, that it is accurate and it
6 is complete. It is an honest attempt at
7 answering the family's questions.

8 And also remember what Dr. Reingold
9 has talked about and what Dr. Cairns has
10 talked about. Prior to that, there was a
11 meeting with Dr. Reingold and he talked about
12 his recollections of that meeting, and he
13 confirmed that everything he was told in the
14 meeting was substantially confirmed in the
15 letter, and he took no issue with the honesty
16 and integrity of the people who were involved
17 in that process.

18 Dr. Cairns has confirmed that there
19 was an ongoing dialogue thereafter between
20 the hospital and the Coroner's office to try
21 to sort out various issues. Lawyers are
22 involved at that time, Mr. Gomberg and
23 myself, and we're involved at various points
24 in that process. There is no suggestion in

1 any of that that there's a sham, that there's
2 a coverup, anything of the sort.

3 Having talked about investigation,
4 I'd like to turn to some of the issues raised
5 in the case, and I want to address three
6 issues, and three more -- three global
7 issues, in the context of which I'll try to
8 address some of the facts. I think the three
9 main issues are communication, the monitoring
10 of the patient on 5A, and the presence of the
11 Corometric monitor.

12 What I want to do is try to address
13 those issues from the perspective of how can
14 we improve things? How can we make things
15 better? What can we learn? In some cases
16 that we've heard, we've got irreconcilable
17 differences, differences of evidence, or
18 there is a conflict that cannot be sorted
19 out. And what I think we need to do is try
20 to understand those differences in evidence,
21 and see if there's a way that we can improve
22 things so that it doesn't happen again.

23 I think that there were two main
24 times that communication adversely impacted

1 on Lisa's care. And those two times are
2 first, the information transfer from the
3 Emergency Department to 5A, and then the
4 discussion between Dr. Schily and Dr.
5 Soriano (sic) at 4:05 in the morning.

6 MR. GOMBERG: Nurse Soriano.

7
8 BY MR. HAWKINS:

9 Nurse Soriano. I apologize. And
10 on those issues, I know you have, and I guess
11 three weeks ago you had an opportunity to
12 read the transcripts of Dr. Schily and Nurse
13 Soriano -- Dr. Schily and Nurse Matthews, who
14 deal with the first issue of communication.
15 I would urge you to review those transcripts
16 carefully. Ms. Posno has talked -- has
17 referred to excerpts. I would encourage you
18 to read the transcripts, and those two in
19 particular in their entirety, because I think
20 they're very instructive.

21 The first issue is information
22 transfer from the Emergency Department to 5A.
23 We've heard testimony that the message
24 received on 5A was that the main issues were

1 managing Lisa's pain, allowing her to sleep,
2 and that the Pain Service would see her in
3 the morning.

4 I absolutely agree, that's the
5 wrong message. But that's the message that
6 was received. And that message impacts on
7 the care received later in the night. Then
8 what we need to do is try to look at that and
9 try to look at how we can improve the
10 message. We've heard from everybody who's
11 testified that this type of case was unique,
12 was very rare. People had little or no
13 experience dealing with the situation, and I
14 would suggest that in that type of case, in
15 that type of situation, the need for close
16 and detailed communication is even more
17 important.

18 Pauline Matthews testified she
19 didn't know Lisa's history. She didn't know
20 anything about chronic pain or reflex
21 sympathetic dystrophy. She's therefore not
22 in a position to communicate that type of
23 information to 5A. She also stated on more
24 than one occasion that she didn't receive

1 specific instructions for monitoring the
2 patient in the Emergency Department. I
3 accept that Dr. Schily's letter to his lawyer
4 says he gave verbal instructions. Nurse
5 Matthews' testimony, and I'd encourage you to
6 read it, is that she didn't receive those
7 instructions. That was her evidence.

8 I think in these circumstances
9 where there is little knowledge about Lisa's
10 condition and what's going on, I think it is
11 reasonable to expect, and this is what Dr.
12 Williams said, it is reasonable to expect a
13 physician to make a note of his examination.

14 Absolutely, we have his orders, but that's
15 not the point. The point is a note or a
16 communication of his history of the patient,
17 his assessment, his examination, and what he
18 feels are the issues, something to document
19 that interaction, or to communicate that
20 interaction that he's had with the patient.

21 And that is a progress note or a
22 consultation note. It's the type of
23 information that he put the next day in his
24 letter to his lawyer. That's the type of

1 information that, in my view, and in the view
2 of a number of people who testified, should
3 be communicated somehow to the receiving
4 nurses, either in writing or verbally.

5 Dr. Williams agreed that it's
6 reasonable in these circumstances for there
7 to be a progress note. Jennifer Stinson said
8 that especially in unique circumstances, you
9 got to be careful about your communications,
10 either verbally or in writing. Ms. Posno
11 even quoted Dr. Schily who says that he
12 believes in writing things down, and my
13 suggestion is that a note by Dr. Schily,
14 findings, assessment, examination, may have
15 helped.

16 And that's certainly something that
17 as a reminder, it's not an extra step, it's a
18 reasonable expectation as a reminder to
19 nurses and physicians to carefully note
20 (inaudible). I think that is a good thing to
21 do, and a reasonable way to try to move
22 forward.

23 And in particular, we've heard lots
24 of criticisms of nurses for making incomplete

1 notes. The same standard, the same
2 expectations have to apply to physicians and
3 others involved in patient care, particularly
4 when there are no notes, and particularly
5 when you're dealing with a unique and unusual
6 situation.

7 The second communication issue is
8 at 4:00, or 4:05, and that's the conversation
9 between Dr. Schily and Nurse Soriano. And I
10 stress again that communication is a two-way
11 street. It's information sent and it's
12 information received. And it's some
13 combination of the information given and the
14 questions asked. And in this case, we know
15 from Dr. Schily's evidence as to that
16 conversation, there was a misunderstanding of
17 what was going on.

18 Dr. Schily's letter to the CMPA,
19 the note that's recorded in the pain chart of
20 the meeting with Dr. Desparmet, Dr. Schily's
21 evidence, all talk of him thinking that it
22 was a present situation of decreased
23 respirations. Dr. Schily got the message
24 that the respirations were down now, not that

1 they'd been down some time in the past, and
2 that is a fundamental problem. Somewhere in
3 the communication, that's been missed. We
4 know that's not the case, but that's what Dr.
5 Schily thought.

6 And with that information and if we
7 take what Dr. Schily thought, we have to
8 listen to what Dr. Williams said and what
9 others said. He's dealing with a present
10 situation, or thinks he's dealing with a
11 present situation. It's even more important
12 to ask detailed questions. It's even more
13 important to make sure we get the information
14 out. He thinks he's dealing with a present
15 situation, not a past situation. We've got
16 to improve and work on that communication.

17 I don't raise that in any to pass
18 judgment on Dr. Schily. That's not what it's
19 about. I raise it as an issue to say we've
20 got to look carefully at both sides of
21 communication, we've got to look carefully
22 and recognize that there was a fundamental
23 miscommunication here that very adversely
24 impacted, or very adversely affected the

1 care. We've got to look at both
2 professionals, the sender and the receiver,
3 and see how we can improve that
4 communication.

5 The issue isn't about what's
6 mandatory to ask or not. The issue is about
7 how do we improve communication. The issue
8 is good communication and trying to encourage
9 professionals to better interact with each
10 other.

11 I'm not really sure how to address
12 that communication issue in recommendations,
13 except to say that people should be
14 encouraged to give and ask for complete
15 information. Every situation is unique,
16 every phone call is different. I don't think
17 you can write down a set of steps to follow
18 in a phone call, except to encourage people
19 to give and to ask for complete information.

20 The second of the three issues that
21 I wanted to address was the monitoring on
22 unit 5A. And, again, to reiterate and to
23 state again is to acknowledge that there were
24 judgment errors made. Nobody is trying to

1 back away from or in any way diminish the
2 significance of the errors that were made.
3 They've agreed to those errors, and they're
4 not trying to avoid it.

5 As Dr. Reeder said, and as other
6 people testified to, particularly Dr.
7 Williams, and I want to talk about her
8 evidence, these were honest, human mistakes.

9 We all make mistakes in every day of our
10 lives. We're all human, and what we try to
11 do is learn from our mistakes and improve for
12 the future. There is no suggestion by
13 anybody, by any witness, except the
14 insinuations, that this is anything more than
15 honest, human mistakes, but a lot of
16 insinuations to the contrary. Listen to the
17 evidence and keep the evidence in mind --
18 honest, human mistakes. Nurses are human
19 beings. Nurses make mistakes. And I think
20 the evidence of Dr. Williams is particularly
21 instructive.

22 I want to refer to an exchange that
23 I made careful note of between her and Mr.
24 Gomberg. Mr. Gomberg asked her if it was

1 about nurses ignoring the prompts. Dr.
2 Williams' response was "I don't like that
3 word. 'Ignoring' suggests they're choosing
4 not to do something." Mr. Gomberg backed
5 away from that. The next question in their
6 agreement was okay, what it's about, is about
7 signs not impacting or signs not being picked
8 up. That was the exchange with Dr. Williams
9 who was called by Mr. Gomberg, I believe a
10 few moments ago, "the conscience of the
11 inquest."

12 I'm very surprised, given that
13 exchange, that he comes back in closing to
14 suggest, "ignored, wilfully disregarded,
15 blatant errors" and all of the things that he
16 suggested. He's cross-examining Dr.
17 Williams, the conscience of the inquest, and
18 he backs away from that suggestion, and he
19 accepts and Dr. Williams accepts honest,
20 human mistakes.

21 "Not impacting" is far, far
22 different from "ignoring." And I repeat
23 again, and I'll keep coming back to this,
24 nothing to suggest in any of the evidence

1 beyond the insinuations, beyond the
2 innuendoes, that this is anything more than
3 honest, human mistakes.

4 And what Dr. Williams did, as well,
5 which I think is important to acknowledge, is
6 that the nurses did some things right. Their
7 analysis of the Flow Sheet requires a
8 recognition that they're not ignoring Lisa.
9 They were concerned enough, they cared enough
10 to go in that room 11 times between 1:45 and
11 6:00 a.m. Absolutely, signs were missed,
12 things weren't done that probably should have
13 been done.

14 Let's recognize that they did some
15 things, and they did some things right, and
16 that they were trying, honestly trying, to
17 care for Lisa that night. They were thinking
18 about it. Maybe they didn't pick up on the
19 signs, but they were thinking about it. They
20 were paying close enough attention to go into
21 her room 11 times over the course of the
22 night.

23 And what we need to do is see how
24 we can improve that, see how we can work on

1 our systems, work on our people, work on our
2 education, work on our plans to improve that
3 and move forward, to try to make things
4 better for the future.

5 And let's forget any notion as was
6 abandoned in the cross-examination of Dr.
7 Williams, of ignoring or forgetting about
8 her, or being wilfully blind, of disregarding
9 and things like that. That's not the
10 evidence, and that's not what you've heard.
11 In this context, you've heard an awful lot
12 and from basically every witness about
13 clinical judgment. It's not something that I
14 don't think can be precisely defined. I'm
15 not sure that you can see a textbook
16 definition of what is clinical judgment.

17 I thought Jennifer Stinson
18 described it best when she said, "Every
19 profession is an art and science and
20 literally everything that a nurse does is
21 about clinical judgment. Clinical judgment
22 is about prioritizing and deciding to go into
23 this patient's room, or that patient's room
24 first. It's prioritizing how often you see

1 the patients and what you do when you get in
2 there. Clinical judgment has to be applied
3 to virtually every situation in patient
4 care."

5 And what we should be trying to do
6 through this process, through your
7 recommendations, is trying to improve
8 clinical judgments. It's not about
9 eliminating clinical judgments, it can't be
10 about making nursing or medicine about
11 following a cookbook, or following a point by
12 point process. Every step in a
13 professional's life, be it a nurse, a doctor
14 or any other professional, involves the
15 exercise and has to involve the exercise of
16 clinical judgment.

17 The issue before us should be about
18 trying to improve clinical judgments, trying
19 to make the environment, make clinical
20 judgments better. It's not about making it
21 harder or easier to make a clinical judgment,
22 but about trying to make them better. And I
23 know that you are concerned about clinical
24 judgments, and where I would suggest the

1 answer is in trying to improve clinical
2 judgments in some of the areas that we talked
3 about -- that we've talked about, and that's
4 where I would urge you to make
5 recommendations, is in areas of education, to
6 improve the knowledge base of professionals.

7 In policies as appropriate, to serve as a
8 guide to the exercise of professional
9 judgment; in ensuring that we have
10 appropriate resources, both people resources
11 and equipment resources; and in developing
12 systems for the evaluation of clinical
13 judgments.

14 I think that's what Dr. Reeder was
15 trying to testify to yesterday, and trying to
16 explain. And I think that's where the answer
17 lies. Because if we try to prevent nurses
18 from exercising clinical judgment, I think
19 patient care will be compromised. Nurses do
20 a lot in patient care, and all that they do
21 involves clinical judgment. The notion that
22 nurses do not, or that health care
23 professionals or any professional does not
24 exercise judgment, I think is an outdated

1 notion.

2 And if there is no need for nurses
3 who exercise clinical judgment, why do we
4 have nurses? Why do we need skilled
5 professionals providing care? Because we
6 want them to think about it, and we want them
7 to exercise their judgment. And what we need
8 to try to do is work on systems and work on
9 people to improve the judgments that are
10 made.

11 The last and one of the main issues
12 and certainly the focus of this inquest has
13 been the presence of the Corometric monitor.

14 And there are, in this area, some
15 irreconcilable differences. There are issues
16 of credibility and allegations of honesty and
17 integrity of witnesses.

18 Now, what I want to try to do, is
19 not focus on the differences, but I'd like to
20 talk about the areas of agreement. And
21 surprisingly -- and this is one of the
22 reasons I spent a fair bit of time
23 questioning Mrs. Shore -- there is really
24 only one issue on which Mrs. Shore and the

1 nurses disagree, and that's the hooking up
2 and the alarms of the monitor. I think on
3 everything else, ultimately, there is no
4 disagreement between the nurses and Mrs.
5 Shore.

6 And the reason I'm somewhat
7 surprised by this is in Mr. Gomberg's
8 questioning of Nurses Doerksen and Soriano, I
9 took the questioning and the suggestions made
10 as a suggestion that there was no agreement,
11 as a suggestion that all of these
12 interactions at the beginning of the night
13 that Ruth and Anagaile had talked about,
14 didn't happen. But as we go through the
15 questioning with Mrs. Shore, things that seem
16 to be suggested in earlier questioning hadn't
17 happened, there actually was agreement on
18 some of those issues.

19 And ultimately, most of what the
20 nurses talked about in terms of the initial
21 interactions between Lisa, Mrs. Shore, and
22 the nurses, what was in agreement and we do
23 have a fair bit of agreement on what actually
24 happened in those initial moments, 1:45,

1 2:00, what's going on there. Mrs. Shore
2 agreed that Lisa assisted in some manner in
3 getting from stretcher to bed. There is
4 disagreement about how awake she was, but
5 there was agreement that she assisted in some
6 manner.

7 There was agreement that the nurses
8 changed Lisa and undressed her before she
9 went to sleep. Mrs. Shore agreed that it was
10 possible, if unlikely, that the nurses were
11 right in saying that she helped a bit in that
12 process, and she wasn't prepared to swear
13 that she didn't. Agreed that there was a
14 statement about pillows, and particular
15 pillows from home. They've agreed that there
16 were statements about blankets that couldn't
17 go on Lisa's leg. And she's agreed that
18 somebody got bed linens for her. She thought
19 it was Anagaile, but agreed that it could
20 have been Ruth. But I think the most
21 significant of these discussions is about the
22 medications. You know in the hospital chart
23 that Ruth has recorded on page 34 the precise
24 dosage of the medications that Lisa was on.

1 Mrs. Shore has confirmed that those doses
2 were accurate.

3 Ruth has also indicated that she
4 was aware of the amitriptyline having been
5 given in the Emergency Department. The
6 precise doses of the medication and the fact
7 that amitriptyline was given is not recorded
8 anywhere else. So Ruth had that information,
9 it's noted in the chart, it had to come from
10 Mrs. Shore. And, again, that's an area
11 where, ultimately, we're not in disagreement.

12 The other significant thing is that Mrs.
13 Shore agrees that on the opening of the
14 night, the nurses were doing their usual
15 nursing routines.

16 She can't say that she really
17 observed what was going on, and she won't
18 disagree if the nurses say they put patches
19 on the chest and leads onto the patches. She
20 wasn't focused on that, and she'll agree that
21 it's possible that those things got on at
22 that time.

23 Mrs. Shore agrees that she fell
24 asleep, and did not wake up until 7:15. She

1 is not disagreeing that the nurses came in
2 ten or eleven times after, or ten times after
3 that 1:45 note. She agreed that it was
4 likely they came in and she didn't wake up.

5 Then we have uncontradicted and
6 essentially uncross-examined evidence of two
7 people who were involved in the arrest. Dr.
8 Catre, you have his transcript, and again,
9 it's something that I'd urge you to read. He
10 talked about stickers and electrodes being on
11 Lisa's chest with leads connected to those
12 electrodes. He said that two or three times.

13 He confirmed that the monitor was there and
14 in one question by Ms. Browne, he confirmed
15 that it was plugged in but not on.

16 So he's confirmed at the moment of
17 the arrest, the monitor in the room is hooked
18 up to Lisa. It's not turned on, but there's
19 a monitor in the room hooked up to Lisa. And
20 this is, again, confirmed by Nurse Matthews
21 who arrives a few minutes into the arrest.
22 Her evidence about the monitor and the
23 patches is again unchallenged, and there is
24 no evidence to the contrary.

1 And then we have various witnesses
2 after the arrest. Nurse Douglas, Sian
3 Phillibert, Marta, who all talk about the
4 monitor being in the room. Nurse Douglas
5 confirms the settings, as indicated by Nurse
6 Doerksen. No evidence is offered to
7 contradict this. No evidence is offered to
8 suggest this didn't happen. We have innuendo
9 and suspicion and allegations, but no
10 evidence to suggest it didn't happen.

11 And it's important, I think, as
12 well, to listen very carefully to what Dr.
13 Reingold said. He's testifying 15 or 16
14 months later, with no notes and only his
15 memory to go on, and he very carefully did
16 not say there was no monitor in the room. He
17 said, "My attention is not drawn to it, but I
18 didn't look at the room closely, and I can't
19 say if it's there or not." He's not denying
20 the evidence of other people that it was
21 there, and that it was in the room.

22 Absolutely, the monitor should have
23 been saved and tested, and I wish it was. It
24 wasn't, and that was one of the mistakes, and

1 I think the first mistake made in the
2 investigation.

3 When Stephan Bauer testified as to
4 the steps taken to try to find that monitor
5 in the immediate aftermath in the day
6 following, that should not have happened.
7 That should have been kept and saved that day
8 and tested. But afterwards, the hospital
9 undertook significant effort, as testified to
10 by Mr. Bauer, to try to find it and sort it
11 out. I wish we had the monitor, but make no
12 mistake, it was there. We've got the
13 evidence that is uncontradicted and
14 unexplained as to the presence of that
15 monitor.

16 The only theory we have that it was
17 never there, cannot address any of this
18 evidence, and cannot address what the people
19 are talking about. There is no attempt to
20 challenge that evidence. Again, the only
21 suggestion -- allegation and innuendo without
22 evidence.

23 And I find it surprising that
24 basically, the second last day of evidence,

1 the suggestion is finally made to Nurse
2 Phillibert and Nurse Doerksen. The
3 suggestion is that Ruth found the patient
4 dead, brought in a monitor and hooked it up,
5 and further it's suggested to Nurse
6 Phillibert that she's participating in this
7 whole thing, that they both ignored a
8 patient.

9 I find that suggestion absurd,
10 demeaning, and offensive. It's contrary to
11 everything the nurses, and Ruth Doerksen in
12 particular, stand for. These are people who
13 love children, who care for children, who
14 have done that for many years. It's
15 offensive and demeaning to make the
16 suggestion that they would do something like
17 that on nothing but innuendo on the second
18 last day of evidence in the entire case.

19 And timing-wise, the theory that
20 Mr. Gomberg would put together makes
21 absolutely no sense. We've got doctors
22 rounding at the time that he's suggesting,
23 we've got new nurses arriving on shift. The
24 conspiracy that Mr. Gomberg would paint

1 involves almost every witness you've heard in
2 the witness stand, from the orthopaedic team,
3 to all of the nurses who arrived, who were
4 all in and around the floor at that time. To
5 suggest that that would go on, the idea that
6 she could do it is impossible. The idea that
7 she would do anything other than press the
8 bell and call the code is absurd, and to
9 suggest that she involved these others is
10 patently ridiculous.

11 What is irreconcilable, and the
12 only irreconcilable difference in the
13 evidence is Mrs. Shore, on the one hand, Ruth
14 and Anagaile on the other hand, on hooking up
15 the monitor and the alarms that occurred at
16 roughly 2:00. This is one of the big
17 mysteries in the case, and there is a direct
18 contradiction in the evidence. But unless we
19 get into the absurd, there is no explanation
20 for the monitor being there at 7:15 and
21 onward.

22 None of the witnesses, none of the
23 evidence as to what happened can be
24 contradicted and is contradicted, and it's

1 not challenged, and it's not, no suggestions
2 were put to Nurse Douglas that this wasn't
3 the case, to Dr. Catre, to all of these
4 people afterwards, that somehow they were all
5 participating in some great coverup.

6 Having reviewed some of the
7 evidence, what I'd like to do now is turn to
8 the verdict that you have to consider. And
9 essentially, there are two parts. There are
10 five questions that you have to answer, and
11 there are the recommendations that you are
12 considering. For both, you were cautioned by
13 Dr. Cairns at the outset, and I fully expect
14 you'll be cautioned again, to render your
15 verdict based on the evidence.

16 The evidence is the answers by
17 witnesses in the witness stand. The evidence
18 in particular is not the questions or the
19 lawyers' suggestions. The evidence is the
20 answers, the answers that you've heard. And
21 in particular when you're dealing with
22 complex medical and nursing issues, I think
23 it's very important to rely on answers given
24 in the witness stand.

1 You've indicated and it was stated
2 earlier that you do not have a medical or
3 nursing background. Particularly in areas
4 that involve those issues, I think it's
5 especially important to listen to what the
6 witnesses say, and pay close attention to the
7 answers, not the questions, but the answers,
8 because it's very difficult for a lay person
9 such as myself or yourself without that
10 assistance to come to conclusions, to come to
11 recommendations on medical and nursing issues
12 and to come to conclusions on proper and
13 appropriate practices, and how we improve
14 those.

15 The brief example I'd like to
16 address, which is one of the issues raised by
17 Mr. Gomberg in his closing, is the settings
18 of heart monitors. Mr. Gomberg has suggested
19 to various nurses that setting a high heart
20 rate alarm at 160 to 180 is way too high.
21 The nurses that he asked said no, that's an
22 appropriate setting.

23 He asked the question of Dr.
24 MacLeod and Dr. Wright. They both testified

1 that I would want to know about a heart rate
2 before it gets to 160 or 180, but
3 particularly Dr. Wright said setting those
4 alarms is a bit beyond my area; I'm not the
5 one to talk to about it. And there's a clear
6 difference, and there was an exchange when
7 Dr. Wright was on the stand, about the
8 difference between wanting to know about a
9 heart rate and wanting to be alarmed about a
10 heart rate.

11 We have a monitor that's designed
12 for high heart rate settings of 120 to 240.
13 Obviously, there has to be a reason for
14 settings in that range, and a reason to have
15 those, and in some circumstances, I assume
16 that each of those settings would be
17 appropriate, but it's beyond my expertise,
18 and beyond, with respect, your expertise,
19 your expertise without the evidence to
20 suggest those are inappropriate settings.

21 And I think very significantly the
22 experts on the Paediatric Review Committee,
23 and you have that report, they have before
24 them, in the form of the hospital's, or Mr.

1 Gomberg's letter and the hospital's response,
2 they have before them that information about
3 the alarm settings. They did not make a
4 recommendation that 160 or 180 was too high.

5 It's not in their report. Dr. Williams
6 wasn't asked to testify about that.

7 If the issue of alarm settings or
8 similar issues concern you, I would suggest
9 that the appropriate thing to do is a
10 recommendation that that be looked at, that
11 it be studied, that it be considered. To
12 suggest by way of recommendation that a
13 setting is way too high without the evidence
14 would be going too far or would be going
15 beyond what you've heard and beyond the
16 expertise that you have.

17 And so while the question is
18 clearly raised, the answers don't justify the
19 conclusion that 160 to 180 is too high.
20 Because if that was to be the conclusion,
21 we'd need to hear more evidence on the issue.

22 It's something, and if there are other
23 issues that concern you, that's an
24 appropriate area to say, look into it; not

1 this is wrong, but look into it.

2 And that, with that in mind, we
3 come to answering the question, the cause of
4 death. You've heard on this subject from
5 four experts: Darryl Mayer, the
6 Toxicologist; Charles Smith, the Pathologist;
7 Stewart MacLeod, the Pharmacologist/
8 Toxicologist; and the Paediatric Review
9 Committee.

10 And the choice that you have from
11 the evidence that you've heard is between
12 undetermined and a drug interaction. And my
13 suggestion to you is that on the weight of
14 the evidence, the appropriate answer is
15 undetermined. I think it's an unfortunate
16 answer and it's an unsatisfactory answer
17 because we want to know. We want to come to
18 a conclusion, better to have an answer. But
19 on the weight of the evidence before you, I
20 think the answer is unfortunately,
21 undetermined.

22 We start with the evidence of
23 Darryl Mayer, who is the Toxicologist hired
24 by the Coroner's office. He said on an

1 individual basis, none of these levels is
2 toxic or beyond therapeutic for any of the
3 drugs that were in Lisa's system. And he
4 also said that he was not aware of published
5 information on interactions between these
6 drugs in those concentrations.

7 Charles Smith was the Pathology
8 expert. He reviewed completely and did some
9 further testing on the original pathology
10 report. He also had access to the toxicology
11 report of Darryl Mayer, and also to the
12 report of Stewart MacLeod. In his expert
13 opinion, the answer was undetermined. He
14 thought there was insufficient evidence to
15 conclude that there was a drug interaction,
16 or something else. And that left him
17 concluding that the answer was undetermined.

18 The evidence that we have to point to a
19 drug interaction is in the form of Stuart
20 MacLeod's report and Stuart MacLeod's
21 evidence. In his report, which you have as
22 Exhibit 31, he says it may be related to a
23 drug interaction, or that there is a strong
24 possibility of a drug interaction. He's not

1 sure, but he thinks that there is
2 insufficient evidence for him to come to a
3 firm conclusion.

4 When he testified, he talked about
5 two things, and he mixed up his language a
6 bit. Sometimes he said words like "may
7 have", "might have", "possibility". Other
8 times he said "probability of a drug
9 interaction". If you listen to his evidence
10 as you review his notes, he has said both
11 things, and I don't think his evidence is
12 clear on the issue.

13 What changed between his report and
14 his testimony is he discovered one study in
15 rats to suggest an interaction between
16 gabapentin and morphine. He acknowledged
17 that this was only one study, with a limited
18 number of rats. He acknowledged that rats,
19 rat studies do not necessarily translate into
20 human reactions. He acknowledged the still
21 essentially experimental nature of gabapentin
22 as a treatment for chronic pain, and in
23 particular that we do not yet know why
24 gabapentin works on chronic pain. It does

1 work, but that's one of the things we haven't
2 quite figured out yet.

3 And one passage in particular from
4 Ms. Browne's examination of Dr. MacLeod, I
5 think, is particularly instructive. When he
6 was talking about the paper and what that
7 gave him, he said that the paper is the
8 beginnings of an explanation for a possible
9 interaction that may have affected Lisa.
10 Those were his words, "The beginnings of an
11 explanation for a possible interaction that
12 may have affected Lisa." While some of his
13 testimony became more definitive than that, I
14 think we have to look to his words, and look
15 to the evidence that he said.

16 Finally, we have the opinion of the
17 Paediatric Review Committee. You have their
18 conclusion as stated in their report, and I
19 want to read that to you. The conclusion of
20 the committee which was presented by Dr.
21 Williams was:

22 "... The Review Committee did not
23 feel there was sufficient evidence to
24 determine the cause of death. A number

1 of theories were discussed and explored,
2 including some complex drug interaction
3 as yet undescribed. But no cause was
4 confirmed from the evidence
5 reviewed ..."

6 The Committee, in coming to its
7 conclusion, had Dr. MacLeod's report, they
8 had his opinion and his thoughts, and that
9 was the conclusion that the Coroner's
10 committee came to. No cause of death
11 confirmed on the evidence reviewed.

12 MacLeod, Dr. MacLeod testified
13 after the Paediatric Review Committee report
14 was finalized, but significantly, the
15 Paediatric Review Committee did not re-meet
16 to revise its report. The report that Dr.
17 MacLeod, Dr. R -- I'm getting my doctors
18 mixed up -- the report that Dr. Williams came
19 to present was the report that said "no cause
20 of death confirmed on the information on the
21 evidence available." I think that's because
22 of the way that Dr. MacLeod testified. "What
23 we may have is the beginnings of an
24 explanation for a possible interaction that

1 may have affected Lisa."

2 Unfortunately, I don't think that
3 brings us to the answer, and I don't think
4 that brings us to a firm conclusion. I think
5 the recommendation that flows from that is as
6 suggested by Mr. Gomberg. Further research,
7 particularly in the areas of gabapentin as a
8 medication for chronic pain, figure out why
9 it works and study that. And also in the
10 area of figuring out whether there are, in
11 fact, interactions. And study that
12 carefully, and study that closely, 'cause as
13 Dr. MacLeod testified, this is a combination,
14 this is a medication that is now being used
15 in lots of people for chronic pain. We need
16 to figure out precisely what we're dealing
17 with.

18 Before leaving this topic, I think
19 two issues do need to be addressed and you
20 have my submissions, and my views on the
21 cause of death. Mr. Gomberg and Ms. Posno
22 have offered two different views in terms of
23 the precise mechanism of death. Ms. Posno
24 said "respiratory arrest possibly related to

1 adverse drug reaction". One aspect of that
2 respiratory arrest is not established on the
3 evidence. If we accept Dr. MacLeod's theory,
4 his evidence is "a cardiac conduction
5 disturbance related to drug interaction."
6 Not respiratory arrest, but cardiac
7 conduction disturbance.

8 And I think on that point, Mr.
9 Gomberg's submissions, again, if you accept
10 Dr. MacLeod, is that a drug interaction
11 leading to respiratory and cardiac arrest is
12 a closer description. But again, that
13 requires accepting Dr. MacLeod's theory,
14 which in my submission, his evidence on that
15 issue is unclear, and the weight of the
16 evidence goes the other way.

17 And in particular, if we look at
18 the Paediatric Review Committee in terms of
19 the precipitating event, or the mechanism of
20 death, what the committee says is:

21 "... The committee noted that the
22 clinical history suggested a respiratory
23 depression leading to cardiac arrest,
24 or cardiac arrest secondary to

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arrythmia ..."

The committee could not sort out whether it's respiratory or cardiac as the initiating event, and so, again, in my submission, I don't think, unfortunately, we can come to a conclusion on that issue.

Timing of the arrest was addressed very briefly, and answering the question as to time hasn't really been addressed in the evidence as to when Lisa arrested. We haven't heard much. Certainly none of the experts were asked any questions about the precise timing of the arrest. At the outset, Dr. Cairns in his opening said date and time were not an issue. Unfortunately, I don't think we can get much more precise than some time prior to 7:15, and I don't think we can pin it down on the evidence that you've heard, much more than that.

The other question that you're required to answer is the "by what means" question. And you've heard, and it was stated at the outset and other Counsel have referred to it, that there are five possible

1 answers: suicide, homicide, natural causes,
2 accident, or undetermined. And there are
3 only five answers. I will talk in a moment
4 about homicide and Mr. Gomberg's suggestion,
5 but Mr. Gomberg suggested homicide due to a
6 variety of other things. That can't be the
7 answer to the question. The answer based on
8 the Act and the Coroner's office is one of
9 those five words, or natural causes is two
10 words.

11 As I prepared my remarks last night
12 and this morning, I said right at the outset,
13 you can rule out suicide and homicide as
14 issues because there is no suggestion of
15 that. That was my second remark, but based
16 on Mr. Gomberg's submissions I do have to go
17 further and talk about those. The Coroner
18 will give you the definitions and explain the
19 meaning of the words, and he will go through
20 it, as I believe Ms. Browne will.

21 I would like to go briefly through
22 it and give you my interpretation.

23 "Homicide" as defined is the action of
24 killing, the action of a human being killing

1 another, or the killing of one human being by
2 another. By definition, homicide is an
3 action, a positive step. It is not inaction,
4 it is not omission, it is not failure to act.
5 The dictionary definition is an action,
6 somebody taking a positive step.

7 Whatever is stated about this case,
8 and whatever Mr. Gomberg wants to state about
9 this case, there is no evidence whatsoever on
10 anything before you of a positive act taken
11 by anybody in this case that resulted in
12 Lisa's death. It goes far beyond any of the
13 evidence to suggest that this in any way fits
14 with the definition of homicide.

15 Trying to date it back to the act
16 of administering morphine, in my view, far
17 stretches and takes the definition of
18 homicide well beyond the plain and ordinary
19 meaning of those words, which is an act, an
20 act causing death. And there is absolutely
21 no suggestion, no evidence of any act. There
22 are errors, there are errors of omission,
23 people failing to do things. That is a far,
24 far cry from suggesting that there is a

1 positive act resulting in death. And that's
2 the definition of homicide.

3 I think the two answers, or where
4 the answer lies is either accidental or
5 undetermined. And to some extent, that
6 depends back on your determination of the how
7 question. What is the medical cause of
8 death, and can we conclude that there is a
9 medical cause of death. The definition of
10 "accident," again, is an occurrence or
11 incident or event that happens without
12 foresight or expectation.

13 And certainly no one has suggested
14 anything to the contrary but that this event
15 was unexpected and unforeseen. None of the
16 treating professionals in any way
17 anticipated, expected, foresaw something like
18 this happening. Even if we accept that it's
19 a drug reaction, we have to realize that it
20 took the Coroner's office and the Coroner's
21 experts some 15 or 16 months to come up with
22 a possible explanation for a drug reaction.

23 And it's not surprising, and it's
24 not difficult to see why the treating

1 professionals did not foresee, did not
2 expect, did not anticipate. And so on that
3 level, if we accept drug interaction, I think
4 the answer, and I'd agree with Ms. Posno, is
5 accidental.

6 However, if we accept that the
7 answer is undetermined on the cause of death,
8 the answer that we may be left with, for the
9 "by what means" is equally undetermined.
10 Because if we do not know the precise
11 sequence of events, the precise medical
12 events that lead to death, I'm not sure that
13 we can answer the question "by what means" on
14 anything other than undetermined.

15 And so, my view, depending on your
16 interpretation or your decision on the cause
17 of death, is that the answer is somewhere
18 between accident and undetermined.

19 Unfortunately, some of the fundamental
20 answers to the questions are unknown, and I'm
21 not sure that I can suggest which of the two
22 answers it is, but it is certainly not
23 homicide, as suggested by Mr. Gomberg.

24 Finally, I would like to address

1 the subject of recommendations. And I've
2 addressed this before in the context of some
3 of the recommendations you might want to
4 consider in relation to specific issues. I
5 want to talk briefly about the
6 recommendations globally. And the Hospital
7 for Sick Children and its staff have tried
8 honestly and intently to learn from Lisa's
9 death. You've heard about many steps that
10 have been taken, many steps that are ongoing,
11 and that's its own attempt to try to prevent
12 a similar tragedy in the future.

13 The inquest has brought up other
14 issues and other steps, and that's why we do
15 hold a process like this, because in any
16 process that minutely examines all of the
17 details and all of the circumstances, we
18 learn things. And as Dr. Reeder testified,
19 the hospital will be taking further steps in
20 respect of the suggestions, the issues, the
21 comments that have been made through this
22 process.

23 Mr. Gomberg has suggested that in
24 making your recommendations, you draft

1 rationales that tie it to specific
2 individuals, to Nurse Doerksen, Nurse Soriano
3 Nurse Douglas, particular individuals who we
4 want to blame, who we want to punish, who we
5 want to condemn for things that they did.

6 And in my view, that is not in any
7 way the purpose of the recommendations. The
8 recommendations are not to punish, they're
9 not to blame; they're to try to improve.
10 They're trying to work at the system, help
11 the system, give the system the benefit of
12 your input, of your thoughts to try to
13 improve it.

14 And to use the recommendations as
15 Mr. Gomberg would have it, to blame and to
16 punish, is inappropriate, and is not what you
17 should be, in my submission, trying to do
18 with your recommendations, which is to look
19 to the future and try to prevent similar
20 tragedies.

21 I know we've heard an awful lot
22 about blaming and condemning. That is not
23 the purpose of this process. That is not
24 what we're here for. That is not what we're

1 trying to do, and I think it defeats the
2 purpose of your recommendations, which are to
3 improve the system, to tie them to blaming
4 people. That's not the point, that's not the
5 purpose of this process.

6 The Hospital for Sick Children, as
7 an institution, the people, the individuals
8 that work there, welcome any suggestions that
9 you can give them, and will give them very
10 serious consideration. I only ask you in
11 respect of the recommendations, to keep three
12 things in mind.

13 Firstly, if you think something
14 would help, but you're not sure that there is
15 sufficient evidence or adequate evidence to
16 make a specific recommendation, your
17 recommendation should be that the appropriate
18 person or the appropriate authority look at
19 the issue, and consider the issue. Rather
20 than saying "do this, or do that," say "look
21 into it and decide whether that's appropriate
22 or not."

23 The second thing that I ask you to
24 remember in making your recommendations is to

1 make them in recognition of some of the
2 realities that face health care today,
3 particularly, as Dr. Reeder talked about,
4 nursing shortages that we have. And that one
5 of the big issues in health care is
6 attracting people to our health care system,
7 to work as nurses, to work as doctors, to
8 work within the system, and that's how --
9 that's why we have shortages. Recognize and
10 deal with these issues, and don't, by your
11 recommendations, make the process more
12 difficult.

13 And in particular, where your
14 recommendation on something such as trying to
15 improve or change patient ratios, or other
16 systemic changes, I think that has to come
17 with a recognition and a statement in the
18 recommendation that appropriate resources be
19 committed to that area.

20 And in particular nursing ratios is
21 more than simply saying nurse ratios should
22 be better, or should be different. Nursing
23 ratios is about dealing with things like
24 nursing education, nursing schools, programs

1 that are available, recruitment on a global
2 basis. And those are things that we want to
3 recommend in that area that need to be
4 addressed, that need to be commented on.

5 And, finally, the last point that I
6 would make on the recommendations, and this
7 is really my own personal comment from having
8 been through and been involved in this
9 process, and having been involved in the
10 inquest process in the past. Recommendations
11 are about trying to make the system better,
12 and as I commented earlier, it's not about
13 making it more difficult, making it harder to
14 be a professional, to exercise clinical
15 judgment. It's about trying to make it
16 better, and there is -- there is a difference
17 between the two. Add steps, add processes,
18 add things that make it better, not things
19 that simply are -- may make it more difficult
20 to practice, more difficult to be and act as
21 a professional.

22 We have to recognize the context
23 within which all health care professionals
24 work, all of the things that they have to do,

1 and we have to recognize that in making
2 recommendations, we need to do things that
3 will try to help make it better, not things
4 that -- and be very careful not to simply
5 make it harder.

6 I would thank you for your time,
7 your attention throughout the process of the
8 inquest. You have asked many valuable
9 questions. You have prompted, I think, all
10 of the witnesses, particularly those that I
11 represent, to think very hard, to try to
12 reflect on their practices, and to try to
13 move forward and improve what they do. I and
14 my clients thank you, and I look forward, we
15 look forward, to your verdict. Thank you,
16 Dr. Cairns.

17 THE CORONER: Ms. Browne, it's 4:20. I'm
18 wondering, do you wish to give your closing
19 address this afternoon? I, certainly, given
20 the time of the day, will not be in a
21 position to give my closing address this
22 evening. I don't think it's fair to the
23 jury.

24 MS. BROWNE: I was going to say, I don't

1 know whether they can take one more. If they
2 want to ---
3 THE CORONER: So mine is held over until
4 tomorrow, irrespective now. If you wish to
5 go now, I have no objection. I'll leave that
6 decision to you.
7 MS. BROWNE: And the jury. If they want me
8 to go now, I'll go. If not, I'll go tomorrow
9 morning. I won't be as long as these persons
10 have been, these other wonderful lawyers.
11 JUROR #2: Wait till tomorrow.
12 MS. BROWNE: Wait till tomorrow?
13 MR. GOMBERG: Dr. Cairns, can I just offer
14 this? We have the recommendations without
15 the rationales, and those were, I think,
16 agreed upon, that they would be filed by you
17 and that may be of some assistance to the
18 jurors in terms of what they've heard from
19 the lawyers up to now.
20 THE CORONER: Certainly. You may give
21 your ---
22 MR. GOMBERG: So may I pass those out?
23 THE CORONER: --- recommendations to the
24 jury, yes.

1 I know that it was hoped that we
2 would get through all the summations today.
3 Summations are an extremely important part of
4 tying together the inquest, and I don't want
5 to limit people, and people did ask me were
6 they limited to any particular time. The
7 only thing I said was that Mr. Gomberg's was
8 limited to the capacity of his bladder, and
9 -- but given the fact that it is this time,
10 and this is very important for you to
11 understand the recommendations and to
12 understand some of the legal issues that are
13 involved, I think it would, you've expressed
14 your opinion, and it is one that I share,
15 that we should adjourn and have Ms. Browne
16 give her summation first thing in the
17 morning, and following that, I'll give my
18 closing address.

19 And I apologize that there may be
20 one or two Counsel who may be somewhat
21 inconvenienced by that, but we'll recess
22 until 9:30 tomorrow morning.

1 --- ADJOURNED

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5 THIS IS TO CERTIFY that the foregoing
6 is a true and accurate transcription of
7 my recordings and notes, to the best of
8 my skill and ability.

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14 Barbara A. Pollard
15 Certified Court Reporter

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18 Photostatic copies of this transcript are not certified and
19 have not been paid for unless they bear the original
20 signature of Barbara Pollard, and accordingly are in direct
21 violation of Ontario Regulation 587/91, Courts of Justice
22 Act, January 1, 1990.