

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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REPORTING PLUS
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1 THE CORONER: Good morning, Constable. Good
2 morning, ladies and gentlemen of the jury.
3 Good morning, Ms. Browne. I think the
4 understanding was that we are ready for
5 summations by all Counsel. It's also my
6 understanding that Mr. Krkachovski is going
7 to go first with his summation to the jury.

8 MR. GOMBERG: Dr. Cairns, can I just get my
9 clients? They were doing some printing, and
10 she seems to be outside, so ...

11 THE CORONER: I'll get the Constable to do
12 it.

13 MR. GOMBERG: Thanks, Dr. Cairns, I
14 apologize.

15 THE CORONER: All right, Mr. Krkachovski,
16 you're free.

17

18 SUBMISSIONS BY MR. KRKACHOVSKI:

19 Good morning, ladies and gentlemen. I have
20 elected to go first, because I expect to be
21 the shortest of the group, so I thought it
22 made sense to do it that way.

23 As you know, I represent the
24 manufacturer of the Corometric monitor, G.E.

1 Medical, Marquette Medical Systems, and I in
2 fact will be relatively brief in my
3 submissions for a number of reasons. First,
4 I plan to confine my submissions to the
5 monitoring equipment, namely the Corometric
6 monitor and the pulse oximeter. While it's
7 clear from the evidence that the care that
8 Lisa received left a lot to be desired, I
9 have no doubt that Mr. Gomberg will cover
10 that in detail, and I see no need for me to
11 go over that ground as well.

12 The second reason for my brevity
13 is, as Dr. Williams agreed with me, Robin
14 Williams from the Paediatric Review
15 Committee, this inquest isn't about the
16 monitoring equipment. It's about the failure
17 to properly use that equipment, and it's -- I
18 think even Nurse Doerksen acknowledged there
19 is no suggestion that the equipment
20 malfunctioned in any way. And, of course, as
21 we all know, the monitor was not even turned
22 on at the time of Lisa's death, so there is
23 not a heck of a lot of need to talk about the
24 Corometric monitor.

1 And the last reason for my brevity
2 is, to its credit, the hospital is in the
3 process, as you heard yesterday, of
4 implementing virtually all of the
5 recommendations that I would have made to
6 you, and what I'm referring to is the -- it's
7 marked as Exhibit 68. You'll have it in the
8 jury room, the electronic monitoring
9 guidelines.

10 So that I only have one
11 recommendation that I would make to you,
12 which is that these guidelines be implemented
13 because they effectively set out, and I'm not
14 going to go through them in any way, but
15 they effectively set out what I would propose
16 be implemented with respect to monitoring
17 equipment.

18 Let me talk about the Corometric
19 monitor now. As you know, there is a serious
20 issue as to whether Lisa was on a monitor at
21 any time. You've heard the evidence of Nurse
22 Doerksen and Nurse Soriano, and you've heard
23 the evidence of Mrs. Shore.

24 I would suggest to you that on any

1 reasonable interpretation of the evidence,
2 that Lisa was not attached to a monitor that
3 was on and functioning at any time during the
4 course of the night. It seems to me that it
5 makes little sense that a monitor of any kind
6 would sound up to four alarms in 5 or 10
7 minutes, without there being any dialogue
8 whatsoever between the nurse and the child's
9 mother.

10 It seems to me that Mrs. Shore's
11 evidence is far more credible on the point
12 that, had she heard an alarm, she would have
13 been after the nurse before the nurse even
14 got to the room. That of course, didn't
15 happen. Mrs. Shore heard no alarms. There
16 was no dialogue about a monitor, because Lisa
17 was not on a monitor. Had she been on a
18 monitor, common sense dictates that the nurse
19 would give some instruction to the parent
20 about the monitor.

21 If you go to a hospital and your
22 child is attached to a piece of equipment,
23 it's -- if the parent doesn't ask the
24 question, I suggest it's natural for the

1 nurse to explain what the equipment is for,
2 particularly in this case, because the
3 equipment is intended to alarm. One would
4 expect the nurse to say to the parent, "Look,
5 during the night this machine might go off,"
6 and as we heard the beep, it's a very
7 alarming alarm. "Don't be concerned, I'm
8 going to come and deal with it."

9 Again, there was no dialogue. That
10 didn't happen. And I suggest it's simply not
11 credible that Lisa was attached to a monitor,
12 the monitor was turned on, it cycled with the
13 alarm sounding, and then subsequently
14 followed by up to four alarms, and nothing is
15 said in the room. You heard Mrs. Shore's
16 evidence that, for all intents and purposes,
17 she was a stranger in the room. No one
18 seemed to have any dialogue with her
19 whatsoever.

20 We also have the evidence of the
21 two day nurses, Sian Phillibert and Han
22 Nguyen, and I apologize for the
23 pronunciations, that they didn't even leave,
24 you're not supposed to leave the constant

1 care room, even for a code, let alone a
2 Corometric alarm. And yet we have the
3 evidence of Nurse Doerksen, that she left the
4 constant care room when she relieved Maureen,
5 to attend to what I understand to be the last
6 false alarm from this monitor and at the same
7 time, as I understand the evidence, disabling
8 the apnea alarm. Again, I find that
9 inconsistent, where we have two nurses who
10 say "even for a code, we can't leave this
11 room." And yet, Nurse Doerksen, rather than
12 asking Nurse Soriano who is now in charge of
13 Lisa's care, going and looking after the
14 alarm herself. Also, query how she knew what
15 room the alarm was coming from.

16 The lack of documentation, of
17 course, doesn't help the nurses' cause.
18 There is no mention whatsoever of the monitor
19 in Lisa's chart prior to her death. Even
20 something as significant as turning the apnea
21 alarm is not recorded anywhere, despite the
22 fact that obviously, different nurses look
23 after the same patient.

24 Nurse Soriano, if she had checked

1 the chart, would have had no notation that
2 the apnea was not turned on. We don't know
3 what might have been said on the audio tape
4 about the Corometric monitor or the apnea
5 alarm, but we do know that in the absence of
6 any recording, had nothing happened through
7 the night, there was nothing in the chart
8 which would have indicated to the day nurses
9 that this child is attached to a monitor in
10 which an alarm will not sound for
11 respiration, which is the very problem with
12 morphine.

13 The side effect of morphine is
14 respiratory depression. It strikes me that
15 it makes no sense to disable the very alarm
16 which would tip you off that there's a
17 problem, bearing in mind again that she's not
18 on a pulse oximeter. So that on Nurse
19 Doerksen's evidence, there is nothing to
20 indicate that something might go wrong with
21 this child's respiration, even though she was
22 on the morphine.

23 And I think it was Dr. MacLeod who
24 acknowledged that respiration in terms of its

1 onset, may be delayed or even it may continue
2 for a longer period of time than the
3 administration of the medication. So that we
4 have a situation where the very problem that
5 might occur is not being monitored, in the
6 way of equipment.

7 Oddly enough, at least to me, there
8 is mention of other equipment in Lisa's
9 chart, such as the IV and the PCA pump.
10 There is also mention as we saw in another
11 patient's chart, of a recording of a monitor.

12 So that we know that some nurses, at least,
13 do have a practice to make mention of the
14 monitor when they apply it to a child. In
15 this case, there is no such notation
16 whatsoever. So the nurse -- the chart, the
17 documentation, unfortunately for the nurses,
18 doesn't back them up.

19 In terms of the notes that were
20 made after Lisa's death, again I find it
21 puzzling that Nurse Soriano in three pages of
22 notes makes no mention of the monitor
23 whatsoever, even though her express purpose
24 in making the notes is (A), to record as best

1 she could what happened, and (B), to come to
2 terms, or to try to understand why it
3 happened.

4 It strikes me that, putting myself
5 in her place, if a patient is attached to a
6 piece of equipment that doesn't sound an
7 alarm and is ultimately discovered to be
8 turned off when the patient is found dead,
9 one would expect a good deal of anger,
10 resentment, whatever you want to call it,
11 from that nurse. Yet, I didn't see that in
12 the testimony of either Nurse Doerksen or
13 Nurse Soriano. There was no outcry. There
14 was no "Who could have done this?" and "Why
15 was this done?" Coupled by the fact that no
16 one seemed to investigate this in the days or
17 weeks that followed.

18 Again, one would expect -- if I did
19 everything I could to look after a patient,
20 particularly putting that patient on a piece
21 of equipment and somebody, for no good reason
22 it would seem, turned it off, if you pardon
23 the expression, I'd be mad as hell. And we
24 didn't get that.

1 In terms of Nurse Doerksen's
2 actions, conversations, notes, what have you,
3 there's a good deal of inconsistency. I find
4 it puzzling that she didn't take note of the
5 monitor as she entered the room when Lisa was
6 discovered dead, even though that was her
7 practice on each of the prior visits. You
8 may recall her evidence that as she walked
9 into the room, she would glance at the
10 monitor, then do her -- take her vital signs
11 manually, and then correlate to the monitor.

12 Inexplicably, she didn't glance at the
13 monitor on this occasion. One must ask why,
14 because it wasn't until she entered the room
15 that she realized there was something unusual
16 about this trip to Lisa's room.

17 But again more importantly, she
18 sees the child dead in her bed. She says at
19 6:00 a.m. "I had her on a monitor." A
20 natural, expected reaction would be to look
21 at the monitor and say, "Why didn't that
22 alarm?" Yet her evidence is it's not until
23 she goes away, comes back with the equipment,
24 the crash cart, I believe, that she actually

1 takes note of the monitor. That to me makes
2 no sense. If you have a patient on a piece
3 of equipment that's supposed to warn you, to
4 me, an instant, automatic, expected reaction
5 is to look at it and say, "Why didn't that
6 tell me there was a problem?" It didn't
7 happen.

8 As the code is taking place, Nurse
9 Doerksen pulls aside Mary Douglas and tells
10 her that she doesn't know why she turned the
11 apnea alarm off. In the note that Nurse
12 Doerksen made after the fact, there is no
13 mention of false alarms; there is no mention
14 of Lisa being kept awake by the alarms; there
15 is no mention of Mrs. Shore being kept awake
16 by the alarms. She simply states, "I don't
17 know why I turned off the alarm." And that
18 might explain why there's no mention of the
19 monitor for some time, to either Dr. Reingold
20 or even Dr. Wright. Dr. Wright acknowledged
21 in his testimony that no one said anything
22 about the monitor.

23 I come back to the point that I
24 made a few minutes ago. Why not? If they

1 had the child on a piece of equipment that
2 was turned off by somebody, why would not
3 have something been said by the nurses to the
4 powers that be, that "Hey, we've got to find
5 out why somebody did this."

6 Again, bearing in mind, Lisa's not
7 the only child on this ward. You've got
8 another eight patients on the ward, and I
9 think the evidence was four in constant care.

10 All of them are there in some way, for pain
11 management. How do we know that what
12 happened to Lisa may not happen to one of the
13 other kids? None of that type of inquiry,
14 investigation, curiosity, even, seemed to
15 have taken place.

16 In her added nursing note which is
17 in her chart, it appears at page 10 of the
18 material -- I won't ask you to turn it up now
19 -- again, you'll have it to look at in the
20 jury room. But again, no notation about
21 false alarms, or Lisa being kept awake, or
22 any reason for the apnea being turned off.
23 In fact, she states in the note:

24 "... Corometric monitor applied since

1 arrival to unit and in situ throughout
2 the night. Child settled to sleep and
3 was asleep all night, except when woken
4 by nurse for vital signs. Mom at
5 bedside, settled to sleep ..."

6 Now, this is made at, according to
7 the note, at 9:00 a.m. after Nurse Doerksen
8 has her conversation with Nurse Douglas. One
9 would expect, given that these two events
10 take place within a very short time frame,
11 some level of consistency in what she's
12 saying. Yet in the verbal conversation with
13 Nurse Doerksen, she's saying one thing about
14 the apnea; in the added nursing note, she's
15 saying something completely different.

16 I also find it interesting, as you
17 know, in the end of the added nursing note
18 that Nurse Doerksen goes out of her way to
19 indicate that the monitor was not simply in
20 the room, but on and functioning. You will
21 recall that she crossed out the words "in
22 situ" and specifically substituted -- she
23 writes in the word "error," and specifically
24 substitutes "on and functioning." Why?

1 She uses the term "in situ" before
2 in the added nursing note. She uses the term
3 "in situ" in the progress note that was made
4 at 1:50 a.m. What does it matter now to
5 specifically state in the added nursing note,
6 made after the fact, that it's not just
7 there, but it's on and functioning.

8 To me, that suggests some level of
9 anticipation of some questions that may be
10 asked down the road. And, of course, it's
11 not until she prepares her private notes,
12 which is a day later, and in terms of
13 recording, there is first mention made of
14 turning off the apnea alarm because of false
15 alarms, because of Lisa having trouble
16 getting to sleep, et cetera. And of course,
17 these notes don't get to Mr. Hawkins for some
18 period of time, and don't get to us for an
19 even longer period of time.

20 There is also the all-important
21 question, if the monitor was on, why would
22 anybody turn it off? And seemingly not
23 someone responsible for Lisa's care, because
24 Nurse Doerksen and Nurse Soriano testify they

1 didn't turn the monitor off. Mrs. Shore says
2 there was no monitor to turn off anyway.
3 Maureen's in the constant care room. There
4 is no evidence to suggest that a doctor came
5 into Lisa's room, particularly after or in
6 between 6:00 a.m. when Nurse Doerksen states
7 that she last saw the monitor on, and 7:15
8 when Lisa is found dead. Nurse Doerksen
9 testified you can't inadvertently turn a
10 monitor off, which would mean that a stranger
11 to Lisa's care came into the room and turned
12 the monitor off. Why? I don't have an
13 answer.

14 Irrespective of what conclusions
15 you might draw regarding the Corometric
16 monitor, I suggest to you it's clear from the
17 evidence that it was wrong equipment anyway.

18 She should have been on a pulse oximeter.
19 It's a more sophisticated piece of equipment.
20 You've heard that now they're mandatory,
21 when used -- or when a patient's on a PCA
22 pump. You heard Dr. Schily's testimony that
23 in his mind, a pulse oximeter is a better
24 tool for detecting the side effects of

1 morphine. In his mind, a Corometric monitor
2 is a good secondary tool, but the first thing
3 that should be applied is the pulse oximeter.

4 You also heard from Pauline
5 Matthews that using clinical judgment, she
6 had Lisa on a pulse oximeter in Emergency.
7 You also heard the evidence of Jennifer
8 Stinson that the majority of physicians order
9 a pulse oximeter when they have a patient on
10 medication such as morphine. So that I
11 suggest to you it's clear from the evidence
12 that what Lisa should have been on was a
13 pulse oximeter. Now, Nurse Doerksen says, "I
14 looked, I couldn't find one." But she
15 doesn't do anything more.

16 And the evidence of Jennifer
17 Stinson was that if you need a piece of
18 equipment like a pulse oximeter but you can't
19 find it, you call the Pain Service, and as
20 you'll see from the electronic monitoring
21 guidelines, there is a whole protocol now as
22 to what a nurse ought to do if she needs a
23 piece of equipment and can't get it and as
24 Dr. Reeder agreed with me yesterday, it's

1 inappropriate to do nothing. Again, this
2 inquest is not about medical equipment; it's
3 about medical care.

4 Lisa did not receive the care that
5 she deserved, and it's up to us as a group to
6 make sure that the same fate doesn't befall
7 another child. Now, Mr. Gomberg will be
8 putting to you some recommendations that the
9 family have drafted. I'm not going to
10 comment on those, except to say that I fully
11 endorse those recommendations and they
12 include implementing the electronic
13 monitoring guidelines. Thank you.

14 THE CORONER: Thank you Mr. Krkachovski.
15 Ms. Posno?

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18 SUBMISSIONS BY MS. POSNO:

19 As you know, we represent Dr.
20 Schily, and we also represented Dr. Wright at
21 the inquest before you. Now, the goal of
22 this inquest is to prevent a similar death in
23 the future from occurring. To do this, what
24 we have tried to do is to figure out what