

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

1 happened in the course of care of Lisa Shore.

2 And on sitting back and hearing the
3 evidence, it seems to me that the challenge
4 we face in this inquest is how to deal with
5 human errors. And human errors are really
6 very difficult to address.

7 And I'll attempt to do so within
8 the course of my submissions, and ultimately,
9 our recommendations are targeted to put in
10 other prompts or institutional safeguards in
11 order to get around and avoid additional
12 human error from happening. The sad thing
13 is, is that ultimately, you can't avoid all
14 human errors, and perhaps that is one of the
15 things that may have happened in this case,
16 but you folks will be the determiner of that.

17 On reviewing the course of care
18 received by Lisa Shore, I have categorized
19 five primary issues. The first issue is the
20 failure to look at or review the Kidcom
21 orders, and incorporated in that is the
22 failure to review the chart carefully.

23 The second area is the failure to
24 follow the standard protocol orders for the

1 PCA monitoring, and we had a manual on that.

2 The third was the failure to
3 respond to the abnormal vital signs that were
4 noted on the Flow Sheet.

5 The fourth was the failure of the
6 Corometric monitor to alarm, and we've heard
7 from Mr. Krkachovski on that.

8 And the fifth is the inadequacies
9 of the investigation that we've all been
10 grappling with throughout the course of this
11 inquest.

12 I am going to focus my address
13 primarily on the first three issues, because
14 they focus, or most directly impact on our
15 physician, Dr. Schily. Turning then to the
16 issue of Dr. Schily and his evidence before
17 you, you will recall that Dr. Schily was
18 called as the first witness and he was called
19 out of chronological order, which made it
20 very difficult for all of us to place his
21 evidence in sequence. We did this to
22 accommodate Dr. Schily, who came over
23 voluntarily from Israel, and he wasn't able
24 to arrange a more convenient time.

1 of Lisa. And later after myself, you will
2 hear first Mr. Gomberg, and then Mr. Hawkins.

3 What I would ask you to do is try to keep
4 this distinction in mind when you listen to
5 the description of the course of events.

6 There is a difference between
7 failing to perform a mandatory duty or a
8 mandatory obligation, and a failure to take
9 extra steps which may have changed the course
10 of events, and I'm suggesting to you, jurors,
11 that the human errors that we must focus on
12 in this inquest to try to correct the next
13 time, are the failure to follow the mandatory
14 orders, not the failure to take extra steps
15 that may have changed the course of conduct
16 here, or the ultimate outcome.

17 It is not reasonable to suggest
18 that the failure of Dr. Schily to take extra
19 steps which would be beyond the scope of
20 normal practices is comparable to nurses
21 failing to perform mandatory obligations.

22 The evidence of Dr. Schily is
23 really located in four different areas of the
24 information that is before you. First of

1 all, the transcript, and I'm going to turn
2 you to specific pages, the letter that he
3 wrote on October 22nd, that's been called the
4 "CMPA letter." In the chart itself, you have
5 the handwritten doctor's orders, and the
6 Kidcom orders, and the last thing you have is
7 a note of Dr. Desparmet, and I will find that
8 for you when I am going to refer to that.

9 I'd like to turn first to the
10 letter written by Dr. Schily to the
11 Association -- well, it wasn't really to the
12 Association, it ultimately ended up to the
13 Association, which is the organization that
14 assists physicians when they are facing legal
15 issues.

16 This is a letter written October
17 22nd, following the death of Lisa Shore.
18 This letter was written by Dr. Schily before
19 he knew any of the issues dealing with the
20 death of Lisa Shore, before he reviewed the
21 Flow Sheet. He didn't know that the Kidcom
22 orders had not been followed. He didn't know
23 there was a dispute between his evidence and
24 the evidence of Nurse Soriano regarding the

1 4:05 phone call.

2 And it is my submission that, given
3 the knowledge of Dr. Schily when he wrote
4 this letter, it is a very reliable piece of
5 evidence that was written very close to the
6 time of the events, the day after the death,
7 within 12 hours of the phone call, and before
8 any specific issues had been raised, as
9 against Dr. Schily and any conduct he had
10 done, so he was not on the defensive when he
11 wrote this letter.

12 I'm going to read to you certain
13 excerpts from this letter. You have the
14 letter and I think it's important to refresh
15 Dr. Schily's testimony at this time.
16 Starting on the first page, the third
17 paragraph:

18 "... I was contacted about 21:30, 21:50,
19 [which is 9:30, 10 to 10:00] from the
20 Emergency Room for pain treatment for
21 Lisa Shore. The Department knew about
22 the possibility that Lisa would contact
23 us this night for Pain Service. Lori,
24 our pain nurse, had received the same

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day a phone call from Family Shore about increasing pains of Lisa Shore. After consulting my staff, and after having finished the OR, I went to the Emergency Room. The patient, Lisa, an 11-year-old girl, was in Room 5. She was known of suffering of chronic strong pain, and had been treated in our hospital and in Boston for post-traumatic pain in her right leg. I found her moaning and complaining about stabbing pain which was constant, existing, keeping her from resting and sleeping. Parents' request were a pain treatment. After consulting the staff on OR, Dr. MacLeod, who was the staff anaesthetist and who was on call as well, we decided to start PCA overnight after titrating morphine in the Emergency Room, and lowering her reported pain level, close to a 10, to about a pain level of 5. I ordered morphine I.V. in boluses of two milligrams for titrating in the Emergency Room before proceeding with

1 the PCA device ..."

2 And, just stopping there, you will
3 recall there was two milligrams of morphine
4 given by way of I.V. The PCA pump was then
5 started, and then when the pain relief was
6 not immediately effective, an additional two
7 milligrams of morphine was given. So we had
8 four administered manually, and the rest was
9 by way of the PCA machine, all in the
10 Emergency Department.

11 "... Asking Mom about the success of
12 pain treatment, she told me that Lisa is
13 on amitriptyline and gabapentin. Both
14 were not helping to relieve her
15 daughter's pain, and Mom reported that
16 under this medication, her daughter
17 experienced increasing terrible pain and
18 didn't sleep that night. She gave her
19 daughter her medication by her own at
20 23:00 ..."

21 And we've heard that there's three
22 different medications she was on. They had
23 been prescribed by the Boston chronic pain
24 team down there. The gabapentin, the

1 carbamazepine, and the amitriptyline. The
2 gabapentin and the carbamazepine, I believe,
3 had been given by Mrs. Shore before Lisa
4 arrived at the hospital. The amitriptyline
5 was given to Lisa Shore while she was in the
6 Emergency Department, and Dr. Schily knew
7 that. Skipping a paragraph:

8 "... Dr. MacLeod and I stayed during the
9 initial treatment in the Emergency Room,
10 and I helped the nurse, Pauline, to get
11 the PCA pump, keys, and PC line, the
12 usual non-reflux valve. The PCA
13 settings were morphine, one milligram,
14 in one CC volume, bolus 1.5 milligram,
15 lock out six minutes, no background
16 infusion, total dose 20 milligrams in
17 two hours ..."

18 They flushed the PCA line, and then
19 he goes on to say:

20 "... I discussed in detail the use and
21 the dangers of the PCA device,
22 mentioning that misuse may cause death.

23 Both parents and the child, as well,
24 heard the explanations. I ordered

1 saturation monitoring, apnea and vital
2 signs monitoring, sedations score
3 checkup, emergency equipment and gave
4 exact orders when to call me, or call
5 Anaesthesia OR desk ..."

6 So he's identified his specific
7 orders within this letter, not knowing that
8 they hadn't been followed.

9 "... The PCA was started in the
10 Emergency Room. I don't recall the
11 exact times, but I remember that some
12 time after Lisa started the PCA, I
13 walked up to the OR to get dressed and
14 returned after that to the Emergency
15 Room for re-assessing Lisa. This was
16 about 12:30. I recall that I came home
17 at about 1:00. I found Lisa awake,
18 sitting in her bed, complaining about
19 strong pains in her leg, which didn't
20 really improve. She didn't want to
21 sleep. Mother was sceptic about the
22 effect of morphine. She said that her
23 daughter had been on morphine in the
24 past, and that it didn't really help

1 her. Before I left, I asked again
2 Pauline, Emergency Room nurse, not to
3 discharge Lisa from Emergency until she
4 has a pain score of 5, and to check her
5 vital signs and to follow vitals up for
6 a certain time before discharging her to
7 the ward ..."

8 Just stopping there, there's been
9 an issue raised after the testimony of Dr.
10 Schily about whether or not there were any
11 orders for monitoring while Lisa was in the
12 Emergency Department. We've heard that Dr.
13 Schily was in and out of the Emergency
14 Department while Lisa was there, and based on
15 this line, it is my submission that he gave
16 oral orders to Pauline Matthews to continue
17 to monitor the vital signs, and that we've
18 heard from Nurse Matthews that she definitely
19 did that.

20 "... Back at home, I was called from
21 Emergency about 1:30 and Pauline
22 reported that Lisa is still complaining
23 of strong pain, pain score 7 and higher.
24 I asked her to send her, despite the

1 pain, to Ward 5A. The last reported
2 morphine Lisa received was before
3 1:45 ..."

4 So that's before she goes to the
5 ward.

6 "... At about 4:00 I was phoned from 5A.
7 The nurse reported that Lisa's
8 respiratory rate was just above 10 per
9 minute. The nurse reported that all
10 vital signs are good; that Lisa is
11 arousable and when I asked if she needs
12 me to come to 5A to assess Lisa, the
13 nurse said that there is no need for
14 coming ..."

15 He explains about the on-call system.

16 "... Again, I reminded the nurse to look
17 up saturation and carefully check after
18 sedation, respiration, and all other
19 vital signs. I informed her that any
20 further deterioration, especially
21 problems with saturation or sedation and
22 respiration should be reported
23 immediately to me. I asked the nurse to
24 make sure that the PCA is off and to

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remove it from patient's bed ..."

It was stopped before that, as the nurse had said, and you will recall that the nurse had stopped the PCA at 2:50 when the respiration rates had gone down to 8 and 10.

"... And follow vital signs and check saturation and respiration rate, and inform me of any further deterioration or need for re-assessing of Lisa would be. I received no further calls this night ..."

And then he talks about when he was in the hospital.

Now, as I have suggested, this letter, I think, is a very reliable narrative account of what happened given the time that it was written, and the level of understanding of the issues at the time that it was written.

Dr. Schily's testimony on the stand in November was consistent with that, and I am going to do the monotonous thing, and take us through the various pages and read that to you, so that you can tell that it was

1 consistent, because I think it's important
2 that his credibility be re-established for
3 you.

4 Page 52 of the transcript is where
5 I'm looking, so that you know where I'm
6 reading from. Just past half-way down, the
7 paragraph starting at line 16, and you'll
8 notice when you look at your transcripts,
9 there's numbers along the sides. When I say
10 line 16, that's where I'm starting from.
11 Page 52, line 16. This is Dr. Schily
12 speaking:

13 "... I indicated 11, simply because of
14 one reason. I tend to put a little bit
15 on the outstanding number, not 10, like
16 in order to get the attention of the
17 nurse. That is something individual. I
18 confess that I do that so if it's 10,
19 normally people would put 10 ..."

20 I read that to you because I'm
21 going to emphasize later that Dr. Schily is a
22 diligent physician. He uses points within
23 his orders and within the course of his care
24 that should have brought things to the

1 attention of the nurses, establishing that he
2 is a diligent physician. On page 66,
3 starting at the top of the page. This is
4 about the 4:05 phone call:

5 "... What I recollect is that I was
6 reported about respirates or breaths per
7 minute, just about 10, 11, I don't
8 remember exactly what it was, 10 or 11.

9 And I asked if otherwise everything is
10 all right, and I remember having heard
11 that 'well, the vital signs are okay,'
12 and at the time I asked if Lisa is
13 arousable ..."

14 And sorry, I have to go back:

15 "... As I heard the thing about
16 respiratory rate as a first reflex I
17 said, take the machine away, take the
18 machine out of the room. I don't think
19 since that is the sort of pain
20 treatment, always our first instinct,
21 our first feeling that someone else
22 except a patient was hitting the button,
23 that is the way you can trick these PCA
24 machines ..."

1 starting at line 7.

2 "... Again, I want to emphasize here, I
3 say this, she is arousable. This is the
4 context of the thing, yeah. I didn't
5 tape this phone call, and it is more
6 than one year ago, so please take it,
7 put this together with what I am saying
8 now, and that it is more than one year.

9 As the context, I remember having
10 heard, she is arousable ..."

11 Stopping there, Nurse Soriano
12 specifically testified she told Dr. Schily
13 "she is arousable."

14 "... And that's another thing, I'm not
15 new in doing shifts. In my country, we
16 do the same, and we are trained in
17 reacting in certain pathways, so if
18 there would have been something
19 different, a pulse that's high or a low
20 blood pressure, or a saturation which is
21 wrong, the minimum of things would have
22 been that I would have asked more, and I
23 would certainly also have gone over.
24 These are things which I know longer

1 than ten years' practice in anaesthesia,
2 they are basic reactions ..."

3 What I will be suggesting to you
4 later during my submissions, is that if Dr.
5 Schily had been -- had any concern expressed
6 to him, he would have asked questions. It's
7 a natural response of a physician. You heard
8 it from Dr. Williams; you heard it from Dr.
9 MacLeod. If they knew something was up,
10 something unusual with the vitals, they'd ask
11 more questions. If more questions had been
12 asked, the nurses wouldn't have been in a
13 position to give the information.

14 Page 100, and this is during the
15 cross-examination that's conducted of Dr.
16 Schily by Mr. Hawkins at this time. The
17 previous comments were for the most part,
18 during the examination-in-chief by Ms.
19 Browne. Okay, line 1:

20 "... May I explain my side? I wasn't
21 next to the nurse. I can assume many
22 things. I was at home, in the bed, and
23 I have my recollection of today, and my
24 recollection is that I heard something

1 global about vital signs, and I don't
2 recollect anything else and you also
3 have to understand that as our point
4 before, we have our certain reflexes.
5 If I would have heard one of the vital
6 signs is wrong, is outstanding, is
7 pathological, I believe even at 4:00, I
8 would have asked more. And I would have
9 asked what is about saturation? How
10 high is saturation? What is about the
11 blood pressure? How is the blood
12 pressure? And so this is my
13 recollection, that I didn't get these
14 details. Now if the nurse had her Flow
15 Sheet or not, I wasn't there ..."

16 Two points about that passage,
17 again emphasizing the reflexes. The other
18 point is, during some discussion of one of
19 the witnesses, Mr. Hawkins and I had comments
20 about whether or not Dr. Schily knew at the
21 time what her respiration rates were, and Mr.
22 Hawkins was suggesting that Dr. Schily
23 understood through his testimony, that the
24 respirations were 8 and 10 at the time he was

1 called. And I suggest when you read this
2 carefully, he's saying, "Even if I had known
3 they were 8 and 10 at 4:00, then I would have
4 asked more questions."

5 As I'm going to submit to you, this
6 phone call at 4:05 by Nurse Soriano was not
7 because of the concern she had at the time;
8 she was following up to say, "Look, I'm just
9 letting you know that the respiration rates
10 had fallen at 8 to 10. She's fine; the
11 vitals are fine now. She's recovered, we've
12 taken away the PCA machine." That was the
13 primary purpose of the call. That's what was
14 noted on the Flow Sheet. It wasn't to raise
15 any alarms with Dr. Schily.

16 The next page, 101, again during
17 cross-examination, starting at line 6:

18 "... What I did at that night, coming to
19 the judgment that clinical vital signs
20 are all right, and that she is
21 arousable, and assuming that things like
22 saturation and blood pressure and pulse
23 are all right, I concluded that there is
24 no need right away to go. But I remind

1 that I was asking even if her opinion is
2 that I -- if I should come over. And I
3 offered that as another thing, as I
4 asked her to go again and to re-check
5 all the vital signs, including
6 saturation and to call me right away if
7 there would be anything else ..."

8 So, again, he's emphasizing he
9 understood that his orders were being taken,
10 and were being followed and that he is
11 acknowledging it is his judgment call based
12 on the information he's told, whether or not
13 to return to the hospital. He made the
14 judgment call that things were fine. He
15 still extended the offer to return to the
16 hospital, to continue to follow up this
17 child, and if there is anything unusual, to
18 call him back. No such call was made.

19 Page 150, this is during my
20 examination of Dr. Schily now. Line 5:

21 "... And before that, and before you
22 received the code, had you been aware of
23 any problem with her condition, with her
24 level of stability? No, absolutely not.

1 Q. Why was it you did not return to
2 the hospital at 4:00 when you received
3 the page?

4 A. Well, since I assumed that
5 everything is fine, since I assumed she
6 is properly monitored, and since I
7 didn't get a second page, and I actually
8 asked for re-checking all the vital
9 signs and the saturation, I went back to
10 sleep and was getting up as normal and
11 going to the hospital. My intention was
12 actually to go and look after Lisa in
13 the morning and find her fine ..."

14 And the last one I'm going to turn
15 you to is a point that Madam Juror raised
16 yesterday actually during one of her
17 questions, is page 163, the reference in the
18 transcript with -- that reverts or is leading
19 to the issue of the "see Kidcom orders"
20 written in the handwritten notes. Mr.
21 Hawkins had asked Dr. Schily whether he was
22 aware there was this written procedure where
23 the physicians are to call up to the ward,
24 and Dr. Schily indicated -- well, Mr.

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Hawkins' question is:

"... Were you aware of that standard?

A. I wasn't aware about that, but I did more than that. I was writing it in the chart, and I believe absolutely in writing things down rather than telling at the phone ..."

That's at line 17.

In my respectful submission, the testimony on the 4:05 phone call was consistent throughout Dr. Schily's testimony, was consistent with his narrative written the same day as the death, and is consistent with the comments made to Dr. Desparmet. This is the note, I'll just -- if I may just approach the jury, Mr. Coroner? This is marked as an Exhibit. I'll find the Exhibit number for you in just a moment.

This is that handwritten note that I was emphasizing the importance of before, and I just want to review with you the language in it, which I say is consistent. It's from the pain chart. While everybody else is looking for me, I'll just read from

1 the words written here, which refer to
2 comments made by Dr. Schily on the morning of
3 Lisa's death at a meeting with the Pain
4 Service team, discussing what happened:

5 "... Emergency Room told to discharge
6 patient" ---

7 THE CORONER: I think it's Exhibit number
8 32.

9 MS. POSNO: Thank you.

10
11 BY MS. POSNO:

12 "... Told to discharge patient only when
13 pain scale less than 5, and well after
14 PCA started. After 1:00 a.m. M., [which
15 is Marcus, Dr. Schily] got called that
16 [Lisa Shore] L.S., in pain and
17 screaming. Transfer. Next call from
18 ward. Respirations down to 10 ..."

19 And that's a little arrow down to
20 10. So that's what he says he was told.
21 "Arousable," specifically told arousable.

22 "... Told to stop PCA, check sat and
23 inform if low. Asked if should come,
24 said no need for it. This call occurred

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at 4:00 ..."

And in my submission, that's consistent with his previous testimony.

Okay, what I'm going to do now is I'd like to address the three issues I said related to Dr. Schily, that being the Kidcom order issue, the protocol for PCA pumps, and the failure to respond to abnormal vital signs.

The first issue, the failure to activate or look at the Kidcom orders, I suggest this is a failure that arose out of human error. Nurse Doerksen admitted that she did not look at the Kidcom orders, and this is because she thought that the handwritten orders were the only orders that she had.

And although she had only these orders to work from, it's unfortunate she did not read them sufficiently carefully to see the line "See Kidcom orders". And just so everyone is clear what I'm speaking of, this is in the hospital chart, the handwritten orders of Dr. Schily, page 7 of ours, and

1 page 36 of your brief, and it's the one right
2 in the middle. Nurse Soriano did not look at
3 the hospital chart at all. She didn't see
4 the orders.

5 Now, rather than simply
6 acknowledging this human error, during this
7 inquest, the hospital has suggested that
8 somehow the conduct of Dr. Schily has
9 contributed to this human error, and in my
10 respectful submission, this is offensive,
11 given the circumstances of these events.

12 Although there is a written
13 procedure indicating that on admission from
14 Emergency to the ward, the physician is to
15 call the ward, this is an old procedure, and
16 it is not the general practice. Some
17 physicians do it; some physicians don't. We
18 heard acknowledged by Nurse Doerksen that
19 nurses do not rely upon the phone call from
20 the physician to prompt them to activate the
21 Kidcom system.

22 Every child has admission orders,
23 and these orders must always be reviewed.
24 This is a mandatory obligation. It is

1 inappropriate to include Dr. Schily as part
2 of the problem here, especially when he wrote
3 in his handwritten orders, "See Kidcom
4 orders." The Paediatric Review Committee,
5 and you heard from Dr. Williams, considered
6 the notation of "See Kidcom Orders" to be
7 even more effective than a phone call.

8 Now, just on this issue, we heard
9 yesterday from Dr. Reeder that given the
10 uniqueness of this situation, Dr. Schily
11 could have personally attended the child to
12 the ward to communicate to the nurses the
13 nature of the circumstances. And, yeah, that
14 could have happened, but it wasn't a
15 mandatory obligation that wasn't fulfilled.
16 It was a step that could have been taken
17 above and beyond the needs or the standards
18 of duty, and it's inappropriate to criticize
19 Dr. Schily for not having done that when it
20 wasn't a mandatory obligation.

21 Mr. Hawkins no doubt will suggest
22 that proper communication was not established
23 between the Emergency Department and the ward
24 nurses regarding the condition of Lisa Shore

1 and what should have been done, and I
2 respectfully respond that if the doctor's
3 orders had been reviewed, the communication
4 would have been established.

5 The next two issues, the PCA
6 protocol orders and the vital sign
7 monitoring, I'm going to deal with those two
8 issues together, because in my respectful
9 submission, these failures occurred due to
10 poor judgment calls, and anyone can make
11 them.

12 As we heard, Nurses Doerksen and
13 Soriano placed a primary priority on sleep
14 for Lisa Shore, rather than monitoring her in
15 accordance with the PCA protocol. The
16 rationale for this was partly because Lisa
17 didn't appear as sick as other patients. She
18 didn't have any gaping wounds; she didn't
19 come from surgery. She was otherwise
20 healthy, save for the chronic pain.

21 The other reason is that one of the
22 purposes Lisa attended at the hospital was to
23 receive pain relief in order to sleep. Now,
24 as we've heard, the importance of sleep,

1 which was important, should not have been
2 more important than the monitoring.

3 The protocol was a mandatory
4 obligation, whether it was communicated by
5 the physician or not. And you'll see that I
6 continually am emphasizing the distinction
7 between what has been a mandatory order, and
8 what is not a mandatory order, because
9 hearing the evidence, I think it's unfair
10 some of the criticisms that have been made
11 about the course of conduct of Dr. Schily.
12 And it's about extra steps that he could have
13 taken, without really acknowledging fully the
14 fact that mandatory obligations were not
15 taken, and that this greatly contributed to
16 the errors that evening.

17 On the issue of the abnormal vital
18 signs, we're not suggesting that Lisa Shore
19 was ignored at all. What we're suggesting is
20 that the limited information we have on her
21 condition throughout the evening was
22 insufficiently interpreted and insufficiently
23 responded to by the nurses. Again, in my
24 characterization of this, this would be a

1 failure to act.

2 Now this issue brings about two
3 fact situations involving Dr. Schily. The
4 first is the 2:50 page, and we've heard
5 through the evidence, the hospital has
6 confirmed, there is no suggestion that Dr.
7 Schily ignored his pager at 2:50. If a page
8 was sent by Nurse Soriano, it was not
9 received, and there is no dispute on that, no
10 page was received.

11 Now the question to be addressed is
12 why didn't Nurse Soriano then re-page Dr.
13 Schily before 4:05, that's an hour and 15
14 minutes later. Well, she lost track of time,
15 but more importantly, I suggest, is she had
16 no urgent concern regarding the condition of
17 Lisa Shore. She was very much of the view
18 that Lisa Shore was stable, and while she did
19 have a decreased respiration rate and she did
20 monitor her, she had no specific concerns
21 that the patient was not stable.

22 That leads us right into the 4:05
23 conversation. Now, I've analyzed this
24 because I've had to, as exactly what was said

1 and what the conflict was, and I'm going to
2 try to give you in a little bit of a chart
3 how to break down the distinction between the
4 conversations. If you put Dr. Schily on one
5 side, and put Nurse Soriano on the other
6 side, and I suggest there is six areas to
7 cover.

8 The first area, respiration rate.
9 Dr. Schily's evidence is that he was told it
10 had fallen to in or around the range of 10.
11 Nurse Soriano testified that she told Dr.
12 Schily it had fallen to 8 and 10 as recorded
13 in the Flow Sheet. So that would be at 2:50.
14 I don't think she testified -- she told him
15 it was at 2:50, though. So that's the first
16 area.

17 The second area, heart rate. Dr.
18 Schily says he was told "otherwise vitals are
19 okay." Vital signs are fine, global. Nurse
20 Soriano says that the heart rate was -- she
21 told him the heart rate was in the range of
22 120 to 130.

23 The next area, blood pressure. Dr.
24 Schily says, and he would group this within

1 the vital signs, vital signs are okay. Nurse
2 Soriano couldn't say anything about blood
3 pressure, none was taken. So nothing was
4 communicated on that, whether she was reading
5 the Flow Sheet or not.

6 Next, fourth area, level of
7 sedation. We have agreement on this. Both
8 Dr. Schily and Nurse Soriano confirm that Dr.
9 Shily was told that the patient was
10 arousable. The language used was
11 "arousable," not "very drowsy," as indicated
12 on the Flow Sheet.

13 Next area is the general condition
14 of the child, and again, we're in agreement
15 here. Dr. Schily says he was told that there
16 was no concern expressed to him regarding the
17 condition of the child. Nurse Soriano agreed
18 with me that she did not express any concern
19 regarding the condition of the child.

20 Then lastly, this is a primary area
21 of conflict. The O2 saturation monitor. Dr.
22 Schily says he specifically asked Nurse
23 Soriano to check the saturation monitor, and
24 Nurse Soriano says no, no mention of that in

1 the call whatsoever.

2 When I look at my chart after I go
3 through this analysis, the primary areas of
4 conflict are two: heart rate and the O2
5 saturation monitor. The rest of the areas
6 are within the realm of perception,
7 interpretation. They're very similar or
8 they're exactly the same.

9 Now, before I go to addressing
10 those two distinctions, I'd like to talk a
11 little bit about Dr. Schily. As I said
12 before, he's a diligent physician and I think
13 his conduct in this case exemplifies that.

14 He identifies, firstly, he identifies a
15 respiration rate of 11 on the Kidcom orders.

16 He could put 10, but he puts 11 because he
17 thinks it will be more noticed by the nurses.

18 Secondly, Dr. Schily specifically
19 writes "See Kidcom orders" in his orders in
20 his handwritten notes, and he does that to
21 prompt someone at the other end who's reading
22 it; oh, yes, there's Kidcom orders. Third,
23 Dr. Schily orders extensive monitoring, and
24 while I acknowledge there is a standard

1 protocol that comes up as we see on the
2 Kidcom system, he checked off that he wanted
3 both apnea and saturation monitoring. Those
4 were options of the doctor. Actually, apnea
5 probably wasn't. The apnea was not an
6 option, but he checked off the saturation
7 monitoring.

8 THE CORONER: I think you should correct
9 that at that time, that both apnea and ---

10 MS. POSNO: Were both that time?

11 THE CORONER: --- were both optional at that
12 time.

13
14 BY MS. POSNO:

15 Okay, so I'll go back to my first
16 point: He's so diligent, he checked off
17 both. They were both options at the time.
18 And the last point I'd like to make on this,
19 is that Dr. Schily also prepared a detailed
20 summary of the events that occurred on the
21 day of the death, which I submit is
22 consistent with his diligence.

23 Now, place yourself in the position
24 of Dr. Schily. You've put a ten-year-old

1 child on morphine a few hours before; it's
2 4:06 in the morning and you get a call from a
3 nurse. Your natural, initial response is
4 "What's wrong, what's happening?"

5 If Dr. Schily had been told that
6 there was a heart rate of 120 to 130, I
7 submit to you that he absolutely would have
8 asked further questions. He would have asked
9 about blood pressure. He would have asked
10 about the O2 saturation level. That's
11 exactly how he testified to you, and I read
12 the passage as he said, it would have been a
13 natural reflex. Dr. MacLeod testified that
14 if he had learned that, he would have asked
15 further questions. He wanted further
16 information. Dr. Williams testified that
17 it's the kind of response you naturally would
18 have.

19 You have to recall that during this
20 phone discussion, Dr. Schily at all times is
21 assuming that his orders have been followed,
22 that the oxygen saturation monitoring is
23 being done. He's told globally that vital
24 signs are okay. The only thing he's told

1 other than that is that the patient is
2 arousable, that the respiration rate had been
3 in the range of 10, or 8 to 10, but otherwise
4 she's recovered, the vitals are fine. That's
5 the only explanation that makes sense, given
6 these events.

7 There is certainly no dispute that
8 there was no level of concern communicated to
9 Dr. Schily. Nurse Soriano agreed with that,
10 and that the patient, in her view, was
11 stable. I think the best way to approach
12 this phone call that occurred, as I said
13 before, is looking at it as the nurse phoning
14 the doctor an hour and 15 minutes after she
15 thought there was a concern with the patient
16 to tell about what had happened, and to
17 confirm that she'd taken away the PCA pump.
18 She wasn't calling to say, "Look, I have a
19 concern about the heart rate."

20 There's now been an issue raised in
21 the last couple of days whether a physician
22 is expected to ask further questions during
23 this kind of phone call, and the Paediatric
24 -- as I understand, this issue was

1 specifically addressed with Dr. Williams at a
2 meeting she had with Mr. Hawkins. She took
3 the issue back to the Paediatric Review
4 Committee, and they did not come out with any
5 kind of issue on the medical care that the
6 doctor should or was under a mandatory
7 obligation, in a situation like this, to ask
8 further questions.

9 It could have been done. We
10 weren't there, we don't know exactly what was
11 communicated. But I submit to you, given the
12 course of conduct of Dr. Schily, he was
13 diligent, he properly interpreted the
14 situation that was communicated to him, and
15 there was no reason for him to ask further
16 questions at that time.

17 Now Mr. Hawkins will suggest to
18 you, I expect, that Dr. Schily could not have
19 asked Nurse Soriano about the saturation
20 monitor because if he had asked about it,
21 Nurse Soriano would have replied, "I'm not
22 sure what you're talking about" or would have
23 gone and gotten the saturation monitor which
24 is inconsistent with what happened.

1 Now, given all the facts of this
2 case, I suggest that it is very possible that
3 Dr. Schily could have raised the saturation
4 monitor as an issue, and that Nurse Soriano
5 did nothing about it. We know for certain
6 from Nurse Soriano that Dr. Schily
7 specifically asked her to keep a close eye on
8 Lisa Shore, and that wasn't done. That was a
9 verbal order, in my respectful submissions.

10 Now, finally, just on this conflict
11 issue, I've gone through the testimony of Dr.
12 Schily and indicated that, in my view, his
13 testimony has been consistent on this phone
14 call. In comparison, Nurse Soriano's version
15 of the phone call has had inconsistencies
16 throughout her testimony; particularly, if
17 you'll look at the Flow Sheet, beside the
18 4:05 time which is when he was paged, the
19 comment is "Very drowsy. Pain Service aware
20 of decreased RR and sedation." Well, she
21 didn't say to him "very drowsy." She said to
22 him "arousable." So even though this was
23 written at the time, it's not consistent with
24 what she said.

1 Her testimony on the stand was a
2 little bit more specific as to what she said
3 and when she said it. She said that she had
4 the Flow Sheet in front of her and that she
5 essentially read the Flow Sheet, and gave him
6 the information with respect to the heart
7 rate, and then when you look at her
8 handwritten notes four or five days following
9 the incident, her description of this phone
10 call, it's on page 3 of that document, and
11 you'll recall, this is the handwritten note
12 -- it was then typed, so we have both the
13 handwritten and the transcribed, October 25,
14 on page 3 of it:

15 "... At around 4:00 a.m. or past 4:00
16 a.m., checked her again. This time I
17 was in there for at least half an hour.

18 Resps still at 10, 12, 16, it varied.
19 She felt warm. She seemed sedated but
20 slightly arousable. Called Pain Service
21 again. Got a call back. Told to take
22 away PCA, which I had already done. Was
23 told to keep a close eye on her. Back
24 into room ..."

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No suggestion that she told him heart rate.

Okay, the other two issues that I think need to be addressed as part of this inquest are the Corometric monitor, which I suggest is also human error, and has been dealt with very adequately and completely by Mr. Krkachovski. The next is the investigation.

And on hearing all of the evidence, there's a lot of institutional and systems errors that just hadn't been set in place here, that I think we're all working through together, and I'm hoping through the recommendations, we'll be able to set a process in place so that investigations like this can run more smoothly; answers can be found out on a more timely basis. As the jury, you're going to be answering five questions. The two questions that I'll address with you, because the other are name and time of death. Those are pretty straightforward from the medical records.

Cause of death and by what means:

1 Cause of death, you have to put on your
2 doctor's hat and figure out how -- what this
3 child died of. There is no question this was
4 a sudden and unexpected death in an otherwise
5 healthy child. We've had physicians testify
6 and no physician has been able to testify for
7 certain what the cause of death was. The
8 only possible cause we've been provided with
9 is that there was a potential adverse
10 reaction amongst the interaction of the
11 drugs. There is no certainty on this issue,
12 but I suggest this is the only reasonable
13 explanation provided to us, and it's
14 appropriate in these circumstances to
15 attribute her death to an interaction amongst
16 the drugs.

17 A description that I may advance is
18 "Respiratory arrest possibly related to
19 adverse interaction of morphine and
20 gabapentin." And the jury may consider
21 whether to add on the carbamazepine and the
22 amitriptyline, but I think from the testimony
23 of Dr. MacLeod, he's most comfortable that if
24 there was an adverse interaction amongst the

1 drugs, it was between the morphine and the
2 gabapentin.

3 The next issue is by what means,
4 and you have various options that will be
5 given to you: natural causes, suicide,
6 homicide, accident, and undeterminable. My
7 submission to you is this is an accidental
8 death. This death occurred due to human
9 errors. These human errors, had they not
10 occurred, the death may have been prevented,
11 but it's very important to distinguish, I
12 suggest to you, that these human errors did
13 not cause the death.

14 They may have prevented the death,
15 but there was no act taken to cause the
16 death. Now specifically, for example, if the
17 Kidcom orders had been followed, or there had
18 been better monitoring, or the Corometric
19 alarm had been on, we may have been able to
20 save Lisa Shore. But these human errors did
21 not cause whatever medical condition or
22 potential unknown interaction amongst the
23 drugs which led to her death. There is no
24 suggestion here that the human errors that

1 I've gone on at length about which were
2 performed, were intentional. And the reason
3 we're here is to learn from them.

4 In my submission, you may want to
5 consider the option of undeterminable, but I
6 think, given the human errors, that
7 accidental would be more appropriate. The
8 other possible descriptions of natural,
9 suicide and homicide, in my submission, are
10 not applicable to these facts.

11 On the issue of recommendations,
12 hearing from Dr. Reeder yesterday, and
13 reviewing the list of policy changes and
14 steps taken by the hospital, there are many
15 positive steps that are already being
16 implemented. Madam Juror raised a number of
17 issues yesterday that I think were just
18 excellent, that I know the hospital paid
19 close attention to, and they're bang on all
20 the issues that we've heard about in this
21 inquest.

22 You have heard from Mr. Krkachovski
23 that Mr. Gomberg will be advancing a number
24 of recommendations, and we, too, have

1 reviewed these recommendations, and are, for
2 the most part, in support of them. It's a
3 little difficult for me to address them with
4 you not having them in front of you, but I'm
5 going to just give them to you by numbers.
6 Are the numbers the same?

7 MR. GOMBERG: No, they've changed because
8 we've had to --

9 MS. POSNO: Give me one second. I'll just
10 confirm which numbers they are.

11
12
13 BY MS. POSNO:

14 There will be a recommendation
15 number 6, okay. Mr. Gomberg will take you
16 through each of them carefully. Number 6, I
17 don't have any strong argument against this,
18 other than I'm not sure if it will be
19 practical. The recommendation will be, and
20 it will be put much more eloquently by Mr.
21 Gomberg, that doctors and nurses should
22 initial in the chart when they review
23 portions of the chart. And I just raised,
24 not having raised -- explored this with any

1 other physicians on an expert basis, whether
2 that's practical.

3 Many people, especially in a
4 teaching institution, review the chart for
5 many purposes. And the timing of that review
6 is not always consistent, and in the end we
7 may end up with a bunch of initials all over
8 a chart that may place us in just the same
9 amount of confusion as we had before. So I
10 just throw up a bit of caution in terms of
11 how you word that recommendation, in the
12 event you are going to make that
13 recommendation.

14 And the other one, is numbered 9 in
15 the recommendations. And this deals with the
16 suspension or removal of the doctors or
17 nurses who were involved in the care of the
18 patient, if there's been an unexplained or
19 unexpected death. And I recognize the
20 rationale behind this; however, I want to put
21 up as a caution, if there are a number of
22 people involved in the care of a patient and
23 these people are all removed from being able
24 to provide patient care to other patients,

1 you may be in a situation where you're
2 dealing with shortages of nurses. We've
3 already heard about problems with having
4 enough nurses to look after people within the
5 course of 12 hours, and this may just
6 exacerbate the problem.

7 From the physicians' perspective,
8 because physicians would be incorporated
9 within this, the physicians have numerous
10 patients. If they're surgeons, for example,
11 you have surgeries the next day. You don't
12 want to take them out of their practice. In
13 any event, I put up words of caution on those
14 two.

15 The last thing I'd like to do is
16 take this opportunity, Mr. and Mrs. Shore, to
17 offer our condolences on behalf of Dr.
18 Schily, Dr. Wright, myself, Kirsten. We feel
19 very much for you.

20 We truly hope that something
21 beneficial can be gained from this untimely
22 and extreme tragic event, the death of Lisa.

23 We extend our thank you to you, the jury.
24 You've been extremely attentive and asked

1 many very important and difficult questions
2 of all the witnesses. We know you're going
3 to be very dedicated to your task in coming
4 up with the recommendations.

5 I, unfortunately, have a trial
6 starting on Monday, so I won't be here to
7 accept your recommendations, and I apologize
8 for that. Ms. Crane has to go to another
9 firm, actually, next week, so she won't be
10 here, but we will be receiving them, and we
11 will read them very carefully, and we thank
12 you ahead of time for the work that you will
13 put into that. Thank you.

14 THE CORONER: Thank you, Ms. Posno. So as
15 not to interrupt the summations by both Mr.
16 Gomberg and Mr. Hawkins, it's a reasonable
17 time to recess. I'm going to reduce your
18 lunch hour, for once, to three-quarters of an
19 hour, if you don't mind, because I want to
20 try and get all the summations by both Mr.
21 Gomberg, Mr. Hawkins and Ms. Browne and
22 myself in this afternoon. So we'll recess
23 until 1:30 for the lunch break.

24