INQUEST INTO THE DEATH OF

L I S A S H O R E

THE EVIDENCE OF DR. JEAN REEDER

TAKEN FEBRUARY 8, 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 THE CORONER: Just before we call the next
2 witness, you did have a question of me the
3 other day that I indicated that I would get
4 an answer for you and I've discussed this
5 with all Counsel and they have no objection
6 for me to give you the answer. You
7 questioned was there an antagonist or an
8 antidote to gabapentin.
9 JUROR #1: Yes.
10 THE CORONER: No, there is no antagonist to
11 gabapentin. There is an antidote or an
12 antagonist to morphine and that's what you've
13 heard, narcan.
14 JUROR #1: Yes.
15 THE CORONER: But gabapentin itself, there
16 is no specific drug that will counteract the
17 effect of gabapentin.
18 JUROR #1: Thank you, sir.
19 THE CORONER: Mr. Hawkins, I think you have
20 the next witness?
21 MR. HAWKINS: Yes, I would call Dr. Jean
22 Reeder.
23 JUROR #1: Mr. Coroner?
24 THE CORONER: Yes?

1 JUROR #1: May I see something, there is
2 something I would like to look at, a piece of
3 evidence?
4 THE CORONER: Certainly.
5 JUROR #1: I wonder if you could put up the
6 hospital ---
7 MR. GOMBERG: Flow sheet?
8 JUROR #1: No, not the flow sheet, I'd like
9 to see the floor again, the floor of the
10 nursing station area and so on. The floor
11 plan.
12 CONSTABLE CULLETON: Exhibit 10?
13 JUROR #1: Yes. I can't see it very well
14 from here.
15 THE CORONER: Well, why don't we put it down
16 closer to the jury.
17 JUROR #1: Thank you.
18 THE CORONER: There was also -- do you want
19 the blow-up of the photographs of the nursing
20 station in the room, as well? I'm not sure
21 exactly what exhibit that was, Constable.
22 CONSTABLE CULLETON: Exhibit 19.
23 JUROR #1: Thank you.
24

1
2
3 DR. JEAN REEDER, SWORN
4 EXAMINATION IN-CHIEF BY MR. HAWKINS:
5 Q. Dr. Reeder, I understand you're the
6 Chief of Nursing at the Hospital for Sick Children?
7 A. That's correct.
8 Q. Can you tell the jury what that position
9 involves?
10 A. Certainly. As Chief of Nursing, I have
11 several responsibilities subsumed under my role.
12 Primarily I'm responsible for the practice and the
13 profession of nursing at the Hospital for Sick Children
14 and I'm also -- my role is to create and sustain an
15 environment and a culture that attracts and retains
16 nurses, because they find it's a good place to practice
17 nursing and to develop a nursing career.
18 My third primary role is as a member of
19 the senior executive, I'm a member of the Executive
20 Committee, I report to the CEO, and in that capacity, I
21 assist with the development and achievement of our
22 organization's strategy, strategic plan and operations
23 as it relates to patient care, education and research,
24 which are the three primary foci of our organization.

1 JUROR #1: Sorry, what were those?
2 THE WITNESS: Patient care, education and
3 research. And together those of us on the
4 senior management team provide that direction
5 and vision to the organization in support of
6 our board of trustees.
7
8 BY MR. HAWKINS:
9 Q. I understand, Dr. Reeder, that there is
10 something you would like to say on behalf of the
11 Hospital to the family?
12 A. I would. Mr. and Mrs. Shore and your
13 family members, I have sat here throughout the inquest,
14 we've met on two previous occasions, and on behalf of
15 our institution, let me say how terribly sorry we all
16 are, because we failed you as an institution. We are
17 terribly sorry.
18 Q. Dr. Reeder, I have a copy of your CV,
19 which I will mark as an exhibit, a copy.
20 CONSTABLE CULLETON: Exhibit 65.
21
22 EXHIBIT NO. 65: CV of Dr. Jean Reeder
23
24 BY MR. HAWKINS:

1 Q. And I'd like to just go through that
2 briefly before we talk about some of the things that
3 relate to Lisa's care. You are a nurse?
4 A. I'm a registered nurse. Yes, I am.
5 Q. When and where did you take your
6 training in nursing?
7 A. My undergraduate education is from
8 Arizona State University.
9 Q. And you received that in or a Bachelor's
10 Degree of Science in nursing in 1971?
11 A. That's correct.
12 Q. And have you practised as a nurse since
13 that time?
14 A. Every year for 28 years.
15 Q. Beyond your Bachelor's degree, I
16 understand you've taken a Master's Degree and a PhD in
17 Nursing?
18 A. Yes, I have a Masters of Science in
19 Medical Surgical Nursing and a PhD in Nursing, through
20 the University of Maryland, Baltimore.
21 Q. And your Masters, or, I gather at the
22 Masters level you developed a specialization in nursing
23 education and staff development?
24 A. Yes, I have been -- my clinical

1 background is in operating room nursing, but through my
2 graduate and my doctoral education, I continued to
3 specialize in nursing education, staff development and
4 then my doctoral degree prepared me to be a nurse
5 researcher and assume other leadership roles in the
6 future.
7 Q. I understand that the early part of your
8 career was spent as a nurse in the Army Nurse Core in
9 the United States?
10 A. That is correct.
11 Q. What capacities or how did you work your
12 way up in the Army Nurse Core?
13 A. I was in a scholarship program during
14 Viet Nam and was -- initially served for three years,
15 because they paid for my education and it is during
16 that first three years that I became an operating room
17 nurse. I took special education and then subsequent to
18 that, I served as an operating room staff nurse for
19 several years in different community and teaching-size
20 hospitals, both in the United States and in Europe.
21 Q. And as you progressed through your
22 studies and your career, I gather you developed a
23 speciality within the army in nursing research, nursing
24 education?

1 A. Yes. In the last ten years of my
2 career, I did focus in on nursing education and nursing
3 research, but my clinical background is and always will
4 be perioperative nursing.
5 Q. And you retired from the army nurse core
6 in 19 ---
7 A. 1995.
8 Q. And what was your position and rank at
9 the stage?
10 A. I was a colonel, full colonel.
11 Q. And you were at that stage Chief of
12 Nursing research?
13 A. At Walter Reed Army Medical Centre in
14 Washington, DC.
15 Q. And since 1995, you have practised at
16 the Hospital for Sick Children?
17 A. Yes. I've been registered to practice
18 as a registered nurse and as Chief of Nursing at the
19 Hospital for Sick Children, which still is my role.
20 Q. Just a couple of other things that are
21 sort of listed on your CV that I would ask you about.
22 I understand in 1992, you were inducted as a fellow in
23 the American Academy of Nursing?
24 A. Yes, that's correct.

1 Q. What is that or what does that involve?
2 A. The American Academy of Nursing is a
3 group, I think there are about 1300 members now, out of
4 the 2.6 million nurses in the United States, that are
5 recognized for outstanding international nursing
6 leadership in the areas of clinical practice,
7 education, research and health policy.
8 Q. And in 1999, you received the award for
9 excellence in perioperative nursing from the
10 Association of Operating Room Nurses?
11 A. I did, and that's a lifetime achievement
12 award in perioperative nursing with respect to
13 practice, education and research in that clinical
14 field.
15 Q. Before we look at some of the changes
16 that have happened at the Hospital for Sick Children
17 since Lisa's death, I'd like to talk about the
18 Hospital's investigation and we've heard a lot of
19 evidence that that investigation was delayed and that
20 things were missed and that mistakes were made. Can
21 you comment on that?
22 A. I, too, have heard a lot of -- all of
23 the evidence, and I would agree that there have been
24 delays in the investigation, both internally, delays

1 and communications gaps between Sick Kids and the
2 Coroner's Office. I think that there were some gaps in
3 the kind of internal communication we had and, you
4 know, gaps in the Kidcom system, as well, that, you
5 know, we've learned about during the course of this
6 inquest. I'm not happy with those, but we don't have
7 very much experience dealing with Coroner's inquests
8 and Coroner's deaths, really.
9 Q. The suggestion that has been made that
10 in the course of the investigation, some of those
11 mistakes were intentional. Can you comment on that?
12 A. I find that outrageous and I absolutely,
13 totally disagree with any insinuation that there was
14 intentional things that happened.
15 Q. So that we can understand the context, I
16 gather you have looked at the statistics for the unit
17 in question?
18 A. Yes, I have.
19 Q. Can you tell me the statistics for
20 deaths and reports to the Coroner's office?
21 A. We've looked back through medical
22 records on the number of patients that have been cared
23 for by this unit, both before we moved into the new
24 part of the hospital, the atrium, and we went back 11

1 years and of the approximately 25,000 patients that
2 have been cared for on that unit, there have been three
3 deaths over 11 years.
4 Q. And of those, how many involved the
5 Coroner's office?
6 A. One, Lisa Shore's death.
7 Q. And what does that experience of the
8 unit tell us about their knowledge there, their
9 emotions and what was going on that day?
10 A. For me, first and foremost, it means
11 they didn't have much, if any, experience in dealing
12 with deaths in general and specifically sudden,
13 unexpected deaths. For me, it also tells me that most
14 of the nursing staff, if not all, had no experience in
15 dealing with a Coroner's investigation. Thirdly,
16 whenever a child dies, regardless of whether it's an
17 expected or unexpected death, it has a very profound
18 emotional impact, not only on the nursing staff and the
19 families, but other people who work in and around that
20 unit. People care about children greatly that work at
21 the Hospital for Sick Children and it's pretty
22 devastating to see children die, it doesn't happen
23 every day and it's tough to deal with.
24 Q. And what do you, what does the hospital

1 plan to do to try to address some of the affairs or
2 delays that there were in this investigation?
3 A. Well, there's no question that we take
4 any death seriously, any catastrophic incident
5 seriously and we see this as an opportunity to learn
6 from, to identify the gaps in our system, if there is a
7 need for different kinds of education, to review best
8 practices in other hospitals so that we can continue to
9 improve the patient care that we provide, as well as
10 assist our staff in, you know, improving their
11 practice, as well. That's really important for an
12 organization, any hospital, that is charged with
13 providing safe care to patients.
14 Q. We've heard a lot about clinical
15 judgment that's used by nurses and physicians. Can you
16 tell me your understanding or your definition of
17 clinical judgment?
18 A. I would prefer to limit my comments to
19 the development of clinical judgment in nursing,
20 although there may be similarities in medicine, as
21 well. Clinical judgment really is using and helping
22 nurses to acquire and use the knowledge, the skill, the
23 judgment and the experience that they acquire, starting
24 in nursing school and help them over time put the

1 pieces together, so that they can develop a bed of
2 experience and eventually expertise in recognizing
3 similar patterns as well as dis-similar patterns among,
4 you know, different groups.
5 You've heard they look after general
6 surgery patients, ear, nose and throat patients, as
7 well as orthopedic patients. And what one might see in
8 one group of patients would be different than another,
9 so that the dis-similar and similar patterns, as well
10 as their ability to hone in on particular problems or
11 areas of concern, so that they can shape their patient
12 care through their clinical judgment, knowledge, skill
13 and experience.
14 Q. And what does the hospital do to assist
15 its nurses in developing clinical judgment?
16 A. Well, first of all, we hire registered
17 nurses who need the qualifications for registration or
18 licensure, so they do meet the requirements of the
19 College of Nurses. Secondly, we do provide a formal
20 orientation that is applicable for all nurses. It's
21 called the "general orientation." Thirdly, then,
22 there's a follow on unit level orientation that begins
23 to focus in on the more detailed knowledge and skills
24 that nurses need to look after specialty populations of

1 patients.

2 And then through the preceptorship that
3 you heard described previously, that continues so that
4 the preceptor can observe their practice, can be there
5 on the spot to give them feedback or coaching and over
6 time, then, they begin to attend unit level formal or
7 informal educational opportunities, like those that
8 Mary Douglas does that she described to you, as well as
9 many hospital-wide education programs, such as nursing
10 grand rounds or visiting professors and things like
11 that. We also support them to attend conferences,
12 workshops, and symposiums with special funding that we
13 have from our foundation.

14 So it's an ongoing process, it really --
15 the basis of this, the philosophical basis is lifelong
16 learning. We want to make sure that nurses acquire and
17 attain a level of knowledge, but then continue to
18 acquire new knowledge and get rid of the old knowledge
19 so that they're not -- so that they maintain their
20 competence and clinical judgment.

21 Q. How does the hospital go about
22 evaluating clinical judgment?

23 A. Well, I think I alluded to that before,
24 Mr. Hawkins, you know, starting with the preceptorship.

1 The preceptor can provide feedback and evaluate the
2 development of a nurse new to the institution. I think
3 on unit 5A and other units, we have -- there are some
4 practice committees that discuss, on a regular basis,
5 particular patients or care.
6 And finally we do have a peer review
7 process whereby nursing colleagues can give formal
8 feedback to their colleagues in terms of what they are
9 doing well, what they might need to improve, what
10 changes could enhance their nursing practice, and that,
11 then, is the basis for our performance appraisal system
12 or their performance evaluation that occurs on an
13 annual basis.
14 Q. In looking at nurses, does the novice
15 nurse or the new nurse have clinical judgment?
16 A. Yes, they do. It's beginning clinical
17 judgment that is developed during their education, the
18 beginning part of their career which is in an
19 educational institution.
20 Q. And how is that nurse supported in his
21 or her exercise of clinical judgment?
22 A. I would say in very similar ways to the
23 way all nurses new to the organization are supported,
24 but at the same time, I would say novice nurses need

1 more support, more feedback, more coaching than nurses
2 that come to us with previous experience but then are
3 new to the organization. They basically are able to
4 get up and running and more familiar and, you know,
5 function on their own more quickly than novice nurses
6 do. And they have a probation period, as well.
7 Q. Now, I'd like to talk to you about some
8 of the changes, some of the steps that have been taken
9 at the hospital since Lisa's death, but before I do,
10 you have been here to hear all of the evidence?
11 A. I have.
12 Q. Why is that?
13 A. For a number of reasons. First of all,
14 I'm representing the senior team of the organization at
15 a very important public forum to learn about the facts
16 and circumstances of Lisa's death. Secondly, we are
17 very committed as an organization to learning from
18 this, so that we can improve -- you know, the things
19 that support our patient care mission as well as learn
20 from this to improve our care and share our experience
21 with other hospitals throughout Canada. We're very
22 committed to that as an organization.
23 Thirdly, since nursing has been
24 portrayed in many different ways as the focal point of

1 this entire investigation and Coroner's inquest, it is
2 my absolute, you know, duty, commitment, obligation,
3 however you want to say it, to be here to support my
4 nursing colleagues, to learn from them because this has
5 had quite an impact on individuals and our entire
6 nursing staff as well as it has in other hospitals, I'm
7 told.
8 Q. We've heard evidence, I think, primarily
9 from Mary Douglas and Jennifer Stinson about some of
10 the things that the hospital has done to try to address
11 the issues that come up out of Lisa's care. The jury
12 has a copy, I believe it's Exhibit 17. Dr. Reeder, do
13 you have a copy of that, as well, or ---
14 A. I do.
15 Q. --- you brought a copy?
16 A. I do.
17 Q. Okay. If we can go through that list,
18 which is -- which was provided to Counsel in November,
19 of just some of the steps or the steps that have been
20 taken by the hospital, and I'd like to ask you some
21 questions about that. The first relates to a review of
22 the practices in respect of the pain service with other
23 leading pediatric hospitals. Can you comment on what
24 that's about?

1 A. I think what the pain service has done
2 is very appropriate. They did, in fact, consult with
3 at least 12 other hospitals that we know of world-wide
4 and we view many of these hospitals as leaders in
5 pediatric care, to ascertain or identify the best
6 practices in the use of pain management as well as use
7 of PCA pumps. What struck me and I think the committee
8 was that the -- our standards are, in fact, higher than
9 all of these other hospitals throughout the world that
10 they consulted with. But, as well, the pain service
11 decided to actually make our guidelines more stringent
12 based on Lisa's unfortunate outcome.
13 Q. And that's specifically in regards to
14 oxygen saturation?
15 A. Oxygen saturation, and also with respect
16 to the morphine loading dose, I think it is, that we'll
17 talk about.
18 Q. Point number two is that the department
19 of anaesthesia chronic pain management services now has
20 admitting privileges for chronic pain?
21 A. They do, and I think that's a good
22 thing. There are more patients now that we are looking
23 after experiencing chronic pain. I think the jury, the
24 Shore family, all of us heard some of the challenges

1 that Dr. Wright and the pain service had the night Lisa
2 was admitted as it relates to, at that time, it was
3 difficult to having her admitted because pain services
4 didn't have that privilege, so hopefully now -- well,
5 we know now that has been smoothed out and the pain
6 service will be more directly responsible for not only
7 admitting these children, but managing their care.
8 Q. And so now it doesn't come through
9 orthopedics or another service?
10 A. No.
11 Q. It's directly ---
12 A. Directly to the pain service.
13 Q. Okay. The next issue, which Jennifer
14 Stinson talked about, is the dosing guidelines for
15 morphine, which I understand is not your specific area
16 of expertise?
17 A. No, Jennifer really is the expert in
18 pain management, but it does seem conservative to me in
19 relation to other practices that I have heard again
20 continue in other hospitals, but, you know, we have
21 chosen to err on the conservative side as it relates to
22 loading doses of morphine.
23 Q. There was also a morphine task force
24 group that studied the use of morphine and in

1 particular at another inquest that was held earlier in
2 -- well, I guess last year?
3 A. Mm-hmm, that's correct. The Morphine
4 Task Force Group has really broadened the focus to
5 include not only use of morphine, but other highly
6 toxic drugs such as digoxin, insulin, heparin and other
7 opioid products and those would be things like demerol,
8 phentanyl and synthetic narcotics.
9 Q. And what is the effect, I guess, they're
10 put on a potentially highly toxic drug list and what is
11 the effect of that?
12 A. Well, by broadening that list, I think
13 that will serve a wider array of patients with respect
14 to the protocol that is used to not only administer,
15 but monitor the patients who have received these drugs
16 and, you know, I think that is an improvement in the
17 system and the safeguards we have for use of, you know,
18 many more dangerous drugs.
19 Q. And now, as well, the policy has become
20 that all children receiving parenteral opioids will be
21 continuously monitored with oxygen saturation?
22 A. That is correct.
23 Q. And point number 6 comes back to that;
24 you have purchased additional oxygen saturation

1 monitors?

2 A. Yes, we have. But again as both Mary
3 and Jennifer emphasized in their testimony, they are
4 not a substitute but rather an adjunct to monitoring of
5 patients.

6 Q. And we've heard comments from some of
7 the nurses about difficulties in obtaining saturation
8 monitors. Was the purchase of new monitors an attempt
9 to address that?

10 A. Yes, it was. And it's interesting, I'm
11 told that again all these other hospitals that were
12 consulted around modifying our, you know, policies and
13 procedures, many of them don't engage in any electronic
14 monitoring of patients receiving morphine through PCA's
15 and so again this is over and above, you know, what
16 many other benchmark organizations do than we are.

17 Q. Point number 5 there indicates that a
18 proposal has been made to the Ministry of Health for a
19 chronic pain service?

20 A. That's correct. The number of chronic
21 pain patients has increased substantially in the past
22 year or more and as Jennifer testified before, we
23 really didn't have a formal consultation service and
24 sufficient expertise to provide comprehensive

1 management to chronic pain patients, and so in part as
2 a result of this, but also having Dr. Desparmet from
3 Montreal be with us for a year, the anaesthesia service
4 in conjunction with the Chief of Surgery and Chief of
5 Pediatrics decided it was important for us to seek new
6 funding for a chronic pain service in the pain
7 management division.
8 Q. And one of the things that is included
9 there is a fellowship in pediatric chronic pain to
10 start this July?
11 A. Yes, that's correct.
12 Q. What will that involve or what does that
13 involve?
14 A. I'm not the best person to answer that,
15 but my understanding of any medical or surgical
16 fellowship is that it's specialized training offered to
17 physicians who are already, for instance, a
18 pediatrician or a surgeon, in this case, it would be an
19 anaesthetist, to continue to develop their
20 specialization or sub-specialization, in this case, in
21 the area of chronic pain. As well, many fellows also
22 begin to shape a research program on some aspect of
23 chronic pain in children that they wish to pursue, so
24 it's a combination of both increased or more

1 specialized clinical practice as well as the research
2 aspect of a fellowship.
3 Q. Jennifer and Mary talked about various
4 education sessions that have been held both on the unit
5 and more generally for staff at the hospital. Can you
6 give us an overview of that?
7 A. Well, I think that part of our response
8 to Lisa's death was really taking a look at the
9 knowledge level and the in-depth understanding that
10 nurses on 5A have as it to relates to monitoring
11 administration of morphine, use of PCA's and other
12 pumps and so -- as well as documentation. And so a
13 number of education sessions have been held over the
14 past year for this staff in particular, but we're doing
15 it on other units, as well.
16 I think, you know, this is the kind of
17 event where all of us take pause and reflect on what
18 can we learn from this to improve our own practice.
19 And we will continue to do that. As well, as they have
20 had mock code sessions. You heard about the code or
21 the cardiac arrest event and that's not a commonplace
22 thing on this or many other units and so it's important
23 for the staff to practice through a, you know, a mock
24 scenario so that everyone understands the different

1 roles and priorities that occur during a cardiac or a
2 respiratory arrest.
3 Q. A Nursing Practice Committee has been
4 established on unit 5AB. What is the focus of that
5 committee?
6 A. It's been established not only on 5AB,
7 but several other units, as well. And the focus of a
8 Nursing Practice Committee is to allow the nursing
9 staff to explore in a bit more formalized way
10 different, oh, different cases that they may be looking
11 after that week or the previous week to discuss things
12 they might have done differently, the things that they
13 have learned. If there's a new kind of patient that's
14 coming to a unit or a new procedure being done on a
15 surgical patient, then they can discuss that as a group
16 to plan the care for patients that are new and
17 different from the usual patients they look after.
18 It's also a way to evaluate the care that has been
19 provided with the eye on improvement.
20 Q. I understand there is also a hospital-
21 wide nursing practice committee?
22 A. There is and the nursing practices
23 committee has representatives from every unit, every
24 clinic and from different specialty groups of nurses

1 such as the nurse educators, the nurse practitioners
2 and the clinical nurse specialists, and they come
3 together on monthly basis to review issues of nursing
4 practice that cross the organization.
5 Q. Mary talked about the increasing, sort
6 of, the education complement for unit 5AB. I
7 understand, as well, that there have been some further
8 nurse hirings on 5AB?
9 A. That is correct. We have increased the
10 number of staff nurses on that unit, moved from a part-
11 time nurse educator to a full-time nurse educator and
12 last year we hired a clinical nurse specialist who is a
13 Masters prepared (ph.) nurse that has special expertise
14 in clinical aspects of nursing practice. So they have
15 graduate education like I do, as well.
16 Q. One of the things that the nurses
17 commented on is that that night through breaks they
18 were caring for nine patients. What is your opinion on
19 a nurse caring for nine patients?
20 A. Well, I don't like that, I think that's
21 too many patients. However, there are times in every
22 hospital that there are shortages of nurses for one
23 reason or another and we're not immune to that at Sick
24 Kids, but I will say in the past year, we have

1 recruited well over 100 nurses across the organization
2 to increase the proportion of nurses that we have to
3 provide patient care.
4 Q. You have also prepared and this has been
5 shared with Counsel, a list that sort of updates some
6 of the steps that were talked about in Exhibit 17. If
7 we could perhaps mark that one as the next one?
8 CONSTABLE CULLETON: 66.
9
10 EXHIBIT NO. 66: Updates of steps talked about
11 in Exhibit 17
12
13 BY MR. HAWKINS:
14 Q. The first point talks about a review of
15 medical technology and device health care practices in
16 caring for Sick Children. Can you explain what that is
17 about?
18 A. We use many, many medical devices and
19 technology to support or assist us in providing care of
20 patients and in this case, we're focusing on monitoring
21 equipment which serve as adjuncts to our patient care
22 and so, yes, a task force was created to really take an
23 across the board review of all of our monitoring
24 devices so that we can standardize some of these

1 devices, I would say upgrade some of the outdated
2 devices and also function on improving the tracking and
3 medical, you know, routine preventive maintenance of
4 these medical devices so that we know exactly where
5 they are in terms of in use, exactly where they are in
6 terms of their medical maintenance schedule and also
7 when there are problems with devices, that they are
8 taken out of the system and fixed as opposed to losing
9 track of them.
10 Q. And currently and I know there are
11 guidelines or there is a monitoring protocol that's in
12 draft form ---
13 A. Yes.
14 Q. --- to deal with these issues?
15 A. Yeah, we started developing this fairly
16 recently. We have part of the -- an offshoot of this
17 task force is to develop guidelines around the use of
18 monitoring devices and we have a first draft and we're
19 continuing to have a number of different kinds of
20 people review this, continuing to review the literature
21 so that we're, you know, we have the best practices as
22 far as monitoring guidelines and hopefully that will be
23 approved and implemented in the next few months and,
24 you know, this is also something we hope to share with

1 other pediatric hospitals because from our stand, there
2 are no other hospitals that have monitoring guidelines.
3 Q. We've heard a lot about Kidcom and I
4 guess the points you raise there are patient care
5 information systems task force. What is that designed
6 to address?
7 A. That particular task force was struck by
8 the Patient Care Committee which is the primary
9 committee responsible for the oversight of patient
10 care, and that committee was struck based not only on
11 Lisa's case, but on other incidents and complaints that
12 we've heard from, physicians as well as nurses, around
13 Kidcom to take a broad, you know, review of that and
14 help us see how we can use the system in ways to
15 improve both the flow of information as well as the
16 documentation of patient care. And then subsequently
17 revise any existing policies or create new policies.
18 Q. And we've heard from the Kidcom people
19 that one change so far has been made in that respect to
20 create an extra automatic print of the orders?
21 A. Yes, that's correct.
22 Q. And is that designed as an additional
23 prompt to the nursing staff?
24 A. Yes.

1 Q. We've talked about the review of the
2 pain management practices and point (B) indicates
3 ongoing education of staff. Is that something that's
4 still ongoing?
5 A. Absolutely, and it will continue for a
6 long time. We have three, I would say, nurse experts
7 in the area of pain management and through a recent
8 capital campaign, we have received an endowment to
9 support the first chair in pediatric nursing research
10 in Canada and Dr. Bonnie Stevens, who is an
11 international expert in pain management in children, is
12 joining our team on the 1st of July and the focus of
13 all of Bonnie's research has been in various aspects of
14 pain management for children and so that will certainly
15 enhance our, you know, our critical mass of experts in
16 pain management, but as well support the many nurses
17 that have developed an interest in pain management in
18 children in the future.
19 Q. We've talked about the changes that have
20 been made on 5AB in respect of staffing and educators.
21 Is there anything further to comment on there?
22 A. Well, I think it's important to
23 recognize that whenever any catastrophic incident
24 occurs, there is always learning to be had and, you

1 know, we are an academic health science centre and our
2 commitment to learning and improving patient care is
3 part of the mission and values of our organization and
4 so we are very committed to do whatever it takes to
5 learn from this situation, to share our learning with
6 other pediatric hospitals, other hospitals in general,
7 so that we can, in part, assure Mr. and Mrs. Shore that
8 we have taken this very seriously because we have.
9 Q. The last point you raised there is a
10 review of patient care policies surrounding unexpected
11 or unexplained death.
12 A. That's true. As I said before, we do
13 have deaths of children at Sick Kids because we take
14 care of the sickest children in Canada, but
15 nevertheless, we rarely have unexpected, unexplained
16 deaths and particularly on units that -- where patients
17 usually do not die. And so we as an organization are
18 very committed to improving the process, you know, that
19 we use when there are any catastrophic events, any
20 major incidents in our organization, and particularly
21 we welcome the invitation of the Coroner to work with
22 the Coroner's office when this is over so that we can
23 provide some leadership to, you know, all hospitals in
24 the province, I would think. How we can improve, how

1 we work with the Coroner's office, you know, you know,
2 perhaps provide more clear-cut expectations on both
3 sides so that we can do the very best job we can in
4 managing these very unfortunate tragedies.
5 Q. One of the other things that has been
6 developed and I think there were some questions earlier
7 about sort of education or information available to
8 parents, and unfortunately I don't have a lot of that
9 -- bring a lot of extra copies of these. Can I maybe
10 mark these collectively, these three pamphlets, as the
11 next exhibit?
12 CONSTABLE CULLETON: Exhibit 67.
13
14 EXHIBIT NO. 67: Set of three pamphlets
15 describing Kidcom, Corometric
16 monitors and PCA devices
17
18 MR. HAWKINS: Do you have a copy of those?
19 THE WITNESS: I don't. I just gave them to
20 Dr. Cairns for the jury. I'm familiar with
21 them.
22
23 BY MR. HAWKINS:
24 Q. These are, sort of, three pamphlets that

1 describe Kidcom, the Corometric monitor and the PCA
2 device. Those have been developed since Lisa's death?
3 A. Yes, they have.
4 Q. And why do you have sort of pamphlets
5 such as these?
6 A. We have pamphlets like those to assist
7 the parents of children at Sick Kids to more, I guess,
8 provide them more comprehensive information about, in
9 this case, it would be Kidcom, the Corometric monitor
10 or any monitors, as well as the PCA pump.
11 What has happened is that immediately
12 after this became public through the media, parents on
13 this unit and many other units began to have questions
14 and express concerns that we would expect as a result
15 of what they are reading in the press and we -- as we
16 have a family-focused care philosophy, we very often
17 provide extra information to families that may be
18 related to current issues they're hearing about or
19 reading about in the papers, and so this is really
20 important and families have expressed great
21 appreciation with this information, as well because
22 it's worded very clearly so that families can
23 understand that and put their child's care in
24 perspective to this information.

1 Q. I'd like to conclude by talking about as
2 we've gone through a number of the steps and the things
3 that you've looked at since Lisa's death. Can you
4 comment in general terms on sort of the effects of
5 Lisa's death on the hospital and the investigation and
6 the inquest process and how the institution has tried
7 to deal with that?
8 A. It's had a number of different effects.
9 I think it has galvanized our organization to take a
10 close look at how we manage all major unusual
11 occurrences, catastrophic outcomes and we're very
12 committed to improving that process and closing the
13 gaps in the system. It has, I think, caused all
14 caregivers to reflect on what this means to them in
15 their practice, if it's medical practice, nursing
16 practice.
17 Many nurses, as well as some physicians
18 have talked with me in terms of the effect that this
19 has had, what they've read in the media. Many people
20 are second-guessing themselves looking for answers, but
21 there is an absolute commitment on the part of
22 individuals, on the part of the different disciplines
23 in our organization to, you know, improve the care that
24 we give and improve the processes we have in place so

1 that, you know, the errors in judgment, the mistakes we
2 made, the lags in the investigation, the
3 miscommunications that we had with the Coroner's
4 office, the unfortunate gap in time before we were able
5 to speak with the Shores, so those things don't happen
6 to other families.
7 Q. Can you comment on sort of what effects
8 this has had on your nursing staff or on your nursing
9 colleagues at the hospital?
10 A. I can. I can say not only for nurses on
11 5A but for particularly nurses on 5A, this has had a
12 devastating and incredibly demoralizing effect on that
13 staff as a cohesive group. I indicated before that
14 nurses are second-guessing many of the decisions that
15 they make. Many of these nurses have experienced signs
16 and symptoms of critical incident stress or, you know,
17 which is similar to post traumatic stress disorder,
18 some nurses have even resigned over this.
19 We have seen an increase in the number
20 of occupational related injuries and illness, an
21 increase in absenteeism; certainly, demoralization of
22 the staff as they have read the media coverage
23 throughout this inquest. They are very hurt by some of
24 the assumptions and perceptions of care that they

1 believe is generalized to all care of patients at Sick
2 Kids, which we all know is not true.
3 Nurses work at the Hospital for Sick
4 Children because they love children and they to
5 practice pediatric nursing. And what I have learned
6 since I have been there is that pediatric nurses are a
7 special breed. They have astounding, unending care and
8 compassion for children and families in ways I have
9 never seen before.
10 You saw nurses up here who are taken out
11 of their environment who are asked very difficult
12 questions, whose trustworthiness and moral integrity of
13 nurses have been questioned and doubted. This is not
14 what they do for a living; what they do for a living
15 day after day is take care of patients. In doing so,
16 they are not just doing tasks and activities, they are
17 just not giving medications and bedbaths, they have a
18 profound commitment to providing safe passage for
19 children as well as their families during their illness
20 experience. Many of these patients come back and they
21 form relationships with nurses, and all of that has
22 been impacted in a very negative way by this inquest.
23 Q. Thank you, Dr. Reeder.
24 THE CORONER: Ms. Browne?

1 MS. BROWNE: If I can wait until everybody
2 else has gone, I'd appreciate that.
3 THE CORONER: Sure.
4 MS. BROWNE: May I just ask Mr. Hawkins if
5 he has got another one of the Corometric
6 monitor? I've only got two of those
7 pamphlets.
8 MR. HAWKINS: Sorry, I thought I gave you
9 all three ...
10 THE CORONER: Mr. Krkachovski?
11 MR. KRKACHOVSKI: Thank you, Mr. Coroner.
12
13 CROSS-EXAMINATION BY MR. KRKACHOVSKI:
14 Q. Dr. Reeder, you spoke about clinical
15 judgment and just to be clear, can we assume that
16 clinical judgment does not apply to the PCA protocol?
17 That is to say that whatever is set out in the PCA
18 protocol must be done?
19 A. Clinical judgment applies to every
20 aspect of patient care and nursing practice, however,
21 when protocols are developed, when protocols or
22 guidelines are developed, they are developed for a good
23 reason and so, no, I think nurses, except in
24 extraordinary instances, I expect them to adhere as

1 much as possible in the context of everything else
2 that's going on on a unit or clinic to, you know,
3 follow the protocols or follow the guidelines. There
4 are certain times that they just can't do that, but as
5 an overall general statement, I would say yes, I expect
6 people to follow protocols and guidelines.
7 Q. Do you know of anything that transpired
8 the night that Lisa died that would have prevented
9 either Nurse Doerksen or Nurse Soriano from the
10 following the PCA protocol?
11 A. I will say that I don't recall hearing
12 very much else in terms of details regarding other
13 patients they were looking after that night and so
14 again that's part of the context under which nurses may
15 or may not adhere to protocols or guidelines 100
16 percent, because if they are engaged in the care of
17 other children who may have more pressing patient care
18 needs, then I wouldn't be surprised that this occurs
19 occasionally. But as I said, overall, I do expect
20 nurses to adhere to adhere to protocols and guidelines.
21 Q. What, apart from the evidence you've
22 heard here, has anything arisen out of any
23 conversations you've had with Nurse Doerksen or Nurse
24 Soriano or any information developed by the hospital or

1 any investigation conducted by the hospital which would
2 lead you to believe that there was something -- I think
3 your word was "extraordinary" ---
4 A. Mm-hmm.
5 Q. --- that night which would have
6 prevented all aspects of the PCA protocol being
7 followed?
8 A. Not to my recollection.
9 Q. All right. And I gather the same would
10 be true of the Kidcom orders, that is to say, you don't
11 apply clinical judgment to the Kidcom orders?
12 A. That would be correct.
13 Q. And I would assume that if a nurse has a
14 question about an order or to be fair to the nurses, I
15 think it was Mary Douglas who mentioned that a nurse
16 may find an order not to be appropriate, one would
17 expect the nurse to call the doctor as opposed to
18 simply ignoring the order?
19 A. Yes.
20 Q. All right. And you spoke of some
21 education that has taken place since Lisa's death.
22 Just to be clear, as part of that process, has there
23 been further education or instruction to the nurses
24 about following Kidcom orders and following the PCA

1 protocol, such that it's not up to -- it's not left to
2 your discretion, you have to do these things? Has
3 there been any education that way?
4 A. I can't say for certain that -- I can't
5 respond to the details of the education provided, but
6 hearing what you're saying, that would be an
7 expectation of mine and I would ask that our nurse
8 educators follow up on that, if it hasn't already been
9 addressed. You know, I don't know the nitty-gritty
10 details of the specific education blocks that have been
11 provided.
12 Q. And in that same vein, and you may not
13 be able to answer this as well at the moment, has there
14 been further education or instruction about record-
15 keeping? Nurse Soriano in particular talked about --
16 and I think Nurse Doerksen as well -- having done
17 certain things but not recording them.
18 A. Mm-hmm.
19 Q. Has there been further instruction
20 education on that?
21 A. I do know that there has been additional
22 education provided to everyone on the unit around
23 documentation, which would include use of a flow chart.
24 Q. Now, we've heard that since Lisa's

1 death, 13 additional pulse oximeters have been
2 purchased and I apologize, I've forgotten whether it
3 was specifically for 5AB or for the hospital?
4 A. For the organization.
5 Q. All right, and do we now have a matching
6 number of pulse oximeters to PCA pumps, do you know?
7 A. I don't know the answer to that
8 question.
9 Q. All right. I gather part of that, and I
10 think you've indicated as did Mary Douglas, I believe,
11 that a pulse oximeter is now mandatory when a PCA pump
12 is used?
13 A. That's correct.
14 Q. And can we take from that that as
15 between a Corometric monitor and a pulse oximeter, the
16 pulse oximeter, as Dr. Schily testified, is a better
17 tool in detecting side effects with use of morphine?
18 A. You're starting to get into areas that I
19 have less expertise in.
20 Q. If you're uncomfortable, you tell me.
21 A. I'm uncomfortable answering that
22 question.
23 Q. All right.
24 A. That would be something that Jennifer

1 could answer.

2 Q. Nurse Doerksen testified that there was

3 a couple of meetings at which the staff -- "complained"

4 is my word, I'm not sure if it was that strong, but at

5 least raised the fact that there were too few pulse

6 oximeters. Did this come to the attention of the

7 powers that be at the hospital that this was a concern

8 before Lisa's death?

9 A. Well, it was brought to my concern, as

10 well as other people's concern by individual nurses, by

11 the RN Council and by some managers, as well, and I did

12 surface that to other individuals on the executive

13 team.

14 Q. And was there any process in place even

15 before Lisa died with respect to buying more pulse

16 oximeters? Or did that all happen after the fact?

17 A. I can't, you know, I can't give you a

18 for certain answer, but I know that it has been a topic

19 of discussion for several years.

20 Q. I'd like to refer you to this document,

21 I'm not sure of the exhibit number, but the internal

22 hospital response regarding ---

23 A. Right.

24 Q. --- Lisa Shore, and I should also

1 mention a second document that I have because the two
2 may go hand-in-hand. When we attended last week for
3 the Kidcom demonstration, I picked up a draft of a
4 document. It's head "Electronic Monitoring
5 Guidelines." Do you have a copy?
6 A. I'm familiar with that, but I do not
7 have a copy.
8 Q. I've got an extra copy, I can give it to
9 you. I'm not sure we have enough for the jury at the
10 moment, Mr. Coroner.
11 MR. HAWKINS: I do have extra copies.
12 MR. KRKACHOVSKI: Thank you, Mr. Hawkins; I
13 appreciate that.
14
15
16 BY MR. KRKACHOVSKI:
17 Q. Now, just for the moment referring to
18 the initial exhibit, the internal hospital response,
19 under 1(A) it states:
20 "... Created a task force to examine
21 patient care monitoring that has
22 resulted in new standards on patient
23 care monitoring ..."
24 What new standards are being referred to

1 there? That document.
2 A. Yes, and again it's in draft form.
3 Q. I recognize that. Is there anything
4 else other than the draft document that you know of?
5 A. Anything else in terms of ...
6 Q. Well, for my purposes, other Counsel may
7 put it more broadly, but for my purposes, anything in
8 terms of monitoring equipment; are there any other new
9 standards than the Electronic Monitoring Guidelines
10 which are in draft form?
11 A. I don't believe so, but I'm not 100
12 percent certain.
13 Q. All right. And then similarly under
14 2(C):
15 "... Specific policy changes for use of
16 monitors in conjunction with ongoing
17 infusion of narcotic medications
18 (morphine) ..."
19 Are we talking about the same document?
20 A. Yes.
21 Q. The Guidelines? Now if I can then just
22 turn to the draft guidelines, quickly going to the
23 third page, just for the jury's benefit, it states, the
24 very last line, "Revised February 1." I assume "00" is

1 2000?

2 A. Yes.

3 Q. All right. And the word "revised"

4 suggests there was an earlier draft of this document?

5 A. Yes.

6 Q. All right. Am I correct that there was

7 no such document prior to Lisa's death?

8 A. You are correct.

9 Q. All right. And that whatever draft

10 preceded this one came afterward?

11 A. Yes.

12 Q. And just to be clear, at the time Lisa

13 was admitted to the hospital in October of '98, were

14 there no written monitoring guidelines at all?

15 A. No, there were not.

16 Q. Looking at the introduction, it reads:

17 "... Monitors are used as an adjunct to patient care

18 for continuous monitoring of vital signs and to alert

19 nurses to potential changes in patient status.

20 Monitors are frequently initiated when deemed necessary

21 by nursing judgment, physician's orders and Hospital

22 for Sick Children policies and procedures. Monitoring

23 does not replace hands-on nursing assessment ..."

24 I think you testified to that effect a

1 few moments ago in answering Mr. Hawkins' questions
2 that monitoring is an adjunct to what the nurses are
3 expected to do?
4 A. That's correct.
5 Q. And as indicated in the second sentence,
6 it's open to a nurse to use a piece of monitoring
7 equipment rather than simply waiting for it to be
8 ordered?
9 A. Yes.
10 Q. Referring to page 1, the second point
11 from the bottom, which reads:
12 "... Document the HSC control or serial
13 number of each monitor on the patient's
14 flow sheet at the start of shift and/or
15 if the monitor changes ..."
16 While it may be self-evident from that,
17 I take it what that is instructing the staff to do is
18 record on the flow sheet the actual number from the
19 piece of equipment so you can track it?
20 A. That's my understanding, yes.
21 Q. And on this particular Corometric
22 monitor, there's a red stamp at the top of it, and I
23 think it has the number "127," it doesn't matter, but
24 that's what they would be expected to record?

1 A. Well, I think it's either that or the
2 actual serial number that comes with every medical
3 device that's manufactured.
4 Q. All right. And I'm sorry if some of
5 these questions get to be repetitive, but was there any
6 such instruction or direction given to the nurses
7 before Lisa's death?
8 A. I do not believe so, with the exception
9 of perhaps the operating room, but that's an entirely
10 different area and they use entirely different
11 equipment, but I know based on my clinical practice,
12 we've been doing that in the operating room for years.
13 Q. And as a lay person, I can understand
14 the importance to some degree in the operating room,
15 because you don't want to leave things inside the
16 patient, obviously, but is there some other reason that
17 in the operating room we keep track, but on the floors,
18 at least before Lisa's death, we need not?
19 A. From my experience in the operating
20 room, we track it because the preventative --
21 preventive maintenance and tuning up and, you know,
22 anticipating the redundancy of old pieces of equipment
23 is much more -- it's much bigger in an operating room
24 due to the variety of medical devices and equipment and

1 other things like that, that are used in the operating
2 room.
3 I really can't comment on floor nursing.
4 I would say maybe in the special care areas, as well,
5 but again we have changed that philosophy so that the
6 serial numbers or HSC registration number is now
7 included in the documentation.
8 Q. If you can turn the page, then, to page
9 2, the third point from the top reads:
10 "... Alarms must never be turned
11 off ..."
12 Again, was any instruction or direction
13 given to the nurses about that before Lisa's death?
14 A. I can't answer that. I don't know.
15 Q. Do you have any information as to what
16 instruction, if any, the nurses were given regarding
17 the use of a pulse oximeter or a Corometric monitor?
18 A. I don't know those details.
19 Q. The next point:
20 "... Document limit settings on flow
21 sheets at beginning of care/or as per
22 patient condition ..."
23 What does that mean?
24 A. Well, that refers to the limit settings

1 that were widely discussed in previous testimony
2 regarding the use of the Corometric monitor and because
3 -- and -- and I am fairly certain that this is a direct
4 result because of the questions that have arisen in the
5 inquest.
6 Q. So in addition to the use of the
7 equipment and the specific serial number or internal
8 number, the nurses would be required to note on the
9 flow sheet the actual settings for the alarms?
10 A. That is my understanding.
11 Q. Now I didn't ask you and I'll just pause
12 here to ask that question: at what stage is this
13 document? Is there another revision that's being
14 worked on now or what's ...
15 A. Well, the document has been revised,
16 there is ongoing review of this. When we revise a
17 document and develop a new document, it goes out to a
18 number of different people in different roles in
19 different disciplines and so right now, you know, this
20 version of the document draft is being critiqued and
21 provided back to the individuals that shaped it, and I
22 think it looks like it's fairly near in the end of its
23 development and hopefully will be approved and
24 implemented by the Patient Care Committee very soon.

1 Q. And when it is implemented, how is the
2 information contained in the document brought to the
3 nurses' attention; has that been discussed as yet?
4 A. No, but I can address that generally.
5 When new policies, guidelines or procedures are
6 approved, they are disseminated in different ways, such
7 as on our hospital internet, for number one; hard
8 copies are provided to key clinical individuals on
9 nursing units and clinics so that they can provide
10 education around this for all staff.
11 I'm not sure how that information is
12 disseminated on the medical side of the house, but my
13 guess is it would be discussed at Patient Care
14 Committee, maybe Medical Advisory Committee and perhaps
15 my counterparts in surgery and pediatrics would also
16 disseminate that information in their usual clinical
17 chiefs meetings.
18 Q. "Key clinical personnel;" would that be
19 a designated nurse on each floor?
20 A. The nurse educator, it could be for all
21 the resource persons or the charge nurses, as well as
22 the advance practice nurses. Those are the clinical
23 nurse specialists or nurse practitioners on units. As
24 well, we would disseminate through the RN Council,

1 which is our body of staff nurses that meet once a
2 month and that's another vehicle, as well as the
3 Patient Care Committee. So there are a variety of ways
4 to disseminate this information, as well.
5 Q. The ninth point, right in the middle of
6 page 2, talks about what a nurse ought to do when an
7 alarm rings and it reads:
8 "... Assess the patient and equipment to
9 determine cause for alarm, run self-
10 diagnostic on monitor, assess electrode
11 patches, lead wires and connections,
12 reposition or replace patches or leads,
13 if necessary, contact the medical
14 engineering representative if equipment
15 is defective ..."
16 I assume that turning off an apnea alarm
17 is not acceptable?
18 A. No.
19 Q. And the next two points talk about,
20 again, documenting why and when a piece of equipment
21 has been discontinued, so again I gather there's an
22 incentive on the part of the hospital to try to
23 document as much as possible so that in a forum like
24 this, it's not as much open to question what the nurses

1 did or didn't do?

2 A. I would agree with that.

3 Q. The last point before the heading

4 "Nursing Responsibilities," I take it, it reads:

5 "... If the monitor is considered to be

6 part of a patient incident, immediately

7 secure the area and contact the risk

8 management office and the medical

9 engineering representative ..."

10 That, for example, would apply to a

11 Coroner's inquest; if you have a sudden, unexpected

12 death and the Coroner has been called in and there's

13 any suggestion of the monitor being part of the puzzle,

14 if you will, that it's to be secured?

15 A. I would agree that it applies to a

16 Coroner's investigation. Whether or not that turns

17 into an inquest is ...

18 Q. Fair enough.

19 A. So you can see that many of these points

20 have been built in as a direct result to information

21 that has been surfaced throughout this inquest.

22 Q. And the next heading and the points

23 under it, "Nursing responsibilities when monitors are

24 not available" talks about assessing the monitor

1 availability on the unit, contacting the transporting
2 to request a monitor, contact other units to assess for
3 monitor availability, contact the medical engineering
4 representative and after hours, contact the
5 administrative co-ordinator, contact ordering physician
6 and/or responsible service and notify of monitor
7 unavailability. Again, you would agree with me that it
8 would be inappropriate to do nothing in that situation?
9 A. Yes.
10 Q. And just the last point, the pamphlet
11 having to do with the Corometric monitor ---
12 THE CORONER: I'm just wondering, Mr.
13 Krkachovski, refresh me, did we make that the
14 next exhibit?
15 MR. KRKACHOVSKI: By all means. I
16 apologize, Mr. Coroner.
17 THE CORONER: I think it should be the next
18 exhibit.
19 MR. KRKACHOVSKI: Sure.
20 CONSTABLE CULLETON: Exhibit 68.
21 MR. KRKACHOVSKI: Thank you.
22
23 EXHIBIT NO. 68: Corometric brochure
24

1 MR. KRKACHOVSKI: I'm sorry, we made the
2 pamphlets exhibits?
3 MS. BROWNE: Yes, 67, collectively.
4
5 BY MR. KRKACHOVSKI:
6 Q. The very last line on this Corometric
7 monitor pamphlet reads:
8 "... It is important that you do not
9 turn off the monitor ..."
10 I think you said this is intended for
11 parents?
12 A. Yes.
13 Q. All right. I'm being repetitive once
14 again; was any such direction or instruction given to
15 staff before Lisa's death?
16 A. I can't respond to that. I just don't
17 know.
18 Q. All right. Let me tell you the context
19 of my question: It seems clear from the evidence that
20 Lisa's monitor was off when she was found. Nurse
21 Doerksen testified that as of 6:00 a.m. it was on,
22 which begs the question who would have turned off the
23 monitor and why. Was any type of instruction given to
24 staff, I'm not just talking about nurses, but staff,

1 period, before Lisa's death, that if you're not
2 involved in a patient's care, this seems obvious, but
3 if you're not involved in a patient's care, don't turn
4 off a piece of equipment like a monitor? Was any such
5 direction instruction given to the staff before Lisa's
6 death?
7 A. I can't answer that question. I don't
8 know.
9 Q. Thank you.
10 THE CORONER: Ms. Posno?
11 MS. POSNO: We have no questions. Thank
12 you, Mr. Coroner.
13 THE CORONER: I think then it's probably
14 reasonable to have a 15 to 20-minute recess.
15 I think there's yourself, Mr. Gomberg, the
16 jury and Ms. Browne, so I think we'll recess
17 at this time for 15 or 20 minutes.
18
19 --- A BRIEF RECESS
20
21 THE CORONER: Mr. Gomberg?
22 MR. GOMBERG: Dr. Cairns, thank you.
23
24 CROSS-EXAMINATION BY MR. GOMBERG:

1 Q. Dr. Reeder, I have some questions to ask
2 you and I'm not going to take you through the clinical
3 picture in any length, but I do want to ask you some
4 questions in terms of the educational function that I
5 understand you're in charge of, if I may, all right?
6 These orders that were done in the emergency room, I'm
7 talking about Exhibit 5, I think have troubled a number
8 of witnesses in the sense that Dr. Schily wrote "See
9 Kidcom orders" and apparently nobody, and by "nobody" I
10 mean neither Nurse Doerksen nor Nurse Soriano saw that.
11 Is that the type of issue that's addressed in an
12 institutional way in terms of education?
13 A. Can you elaborate a bit more, Mr.
14 Gomberg?
15 Q. Sure. Has something gone out on the
16 internet or in writing or something to the nurses
17 saying when patients come up to the ward from
18 emergency, I want you to very carefully read the
19 doctor's orders, because we had a disaster in the Lisa
20 Shore case because nobody read the Kidcom instructions?
21 A. I can't say it has been provided in the
22 manner that you have described. However, this has
23 certainly been discussed on this unit and several other
24 units. However, we will continue to provide education

1 so that everyone is clear around this and with our
2 Kidcom policy taskforce, that will be even more
3 explicit.
4 Q. All right. But, you see, I'm asking a
5 very specific question and I'm not sure that I have the
6 answer. In this particular case, a child came up to
7 ward 5A with orders made by Dr. Schily. There were
8 orders inputted into the Kidcom system and in addition,
9 this specifically says, "See Kidcom orders."
10 A. Yes.
11 Q. Okay, so we agree on that?
12 A. Right.
13 Q. All right. We also agree that we've sat
14 here now for 15 or 20 days, hearing that nobody and by
15 "nobody" I mean either Nurse Doerksen nor Nurse Soriano
16 read that.
17 A. That's correct.
18 Q. That seems to me to be either a personal
19 problem that these two nurses have, in other words,
20 they didn't read what was there to be read, or it's an
21 institutional problem in the sense that they didn't
22 read what other nurses might not have read. Do you
23 understand the question?
24 A. I believe I do, Mr. Gomberg.

1 Q. All right. So I'm asking about the
2 perception that you have as the head of nursing at the
3 hospital as to whether this is an individual issue or
4 an institutional issue.
5 A. It is my view that this was a one-time
6 occurrence that happened.
7 Q. Can you be sure about that?
8 A. I can never be sure about anything, Mr.
9 Gomberg, but I am fairly confident this was a one-time
10 event and it was an unintentional oversight.
11 Q. Well, I never suggested that it was an
12 intentional oversight, but what I am suggesting is that
13 if you're not sure whether it's an individual issue or
14 an institutional issue, that one errs on the side of
15 caution and sends something out to everyone to say,
16 look, this may not be an institutional issue, but on
17 the off-chance that it is, they better read these
18 things very carefully because we had a child die when
19 they weren't read. So that's why I'm asking you as the
20 Head of Nursing whether that's something that might
21 usefully be done.
22 A. It will be useful and we will happily do
23 that tomorrow.
24 Q. All right. Now, in terms of the flow

1 sheet -- first of all, I take it we could agree that
2 because these Kidcom orders never made it up to the
3 floor, the Kidcom orders themselves weren't followed.
4 We can agree on that?
5 A. Yes.
6 Q. All right. And that surely is an
7 institutional problem, isn't it, in the sense that
8 orders are made, put into the computer, if somehow
9 they're not opened or they're opened and looked at but
10 they're not activated, that's an institutional problem?
11 A. Do you mean institutional in terms of
12 generalizing that this happens everywhere?
13 Q. No, what I mean is institutional in the
14 sense that we know it happened at least here ---
15 A. Yes.
16 Q. --- and without pointing the finger at
17 whether that's a problem from emerg or that's a problem
18 from upstairs, it's a problem that had consequences in
19 this case because the child didn't have monitoring
20 done?
21 A. That's correct, and the institution
22 takes responsibility for errors in judgment made by
23 many staff in this particular situation.
24 Q. Okay, and my question is has a directive

1 gone out or an internet or whatever gone out dealing
2 with the mandatory nature of not only reading what's
3 written in emerg, but of activating the Kidcom orders?
4 A. I don't know that, Mr. Gomberg.
5 Q. Now, without being mean-spirited about
6 it, isn't it surprising that you as the Head of Nursing
7 are here on the last day of evidence of an inquest and
8 you don't know the answer to that question?
9 A. No, Mr. Gomberg, it's not.
10 Q. Well, I guess the jury will decide that.
11 Now, you were talking about the issue of clinical
12 judgment on the part of the nurses.
13 A. Right.
14 Q. Mr. Krkachovski asked you a question, I
15 think, which dealt with the issue of whether or not
16 clinical judgment could ever dictate that orders not be
17 implemented. Do you remember that question?
18 A. Yes, I do.
19 Q. All right. And your answer was
20 something like, well, generally speaking, the orders
21 should be implemented but we have to figure out what
22 the context was in which those nurses were working that
23 night. Have I fairly summarized your evidence?
24 A. Yes.

1 Q. All right. And that the only way to do
2 that would be, I suggest to you, to look at the care
3 plans and the charts of the nine patients that nurses
4 Doerksen and Soriano were working with, and to see what
5 was going on from time to time that night? Is that
6 fair?
7 A. Well, that's not possible now, as you
8 and I both have heard.
9 Q. Yeah, that's my point. You see, I'm a
10 little confused by that. On the one hand, Mr.
11 Krkachovski asked you what was going on in terms of the
12 clinical judgment as asserted or as exercised by Nurses
13 Doerksen and Soriano and your answer was well, we can't
14 really say for sure without the nine patient charts,
15 and now I'm saying to you ---
16 A. No, I didn't say the nine patient
17 charts.
18 Q. Well then what, then what?
19 A. I said the context of the other patients
20 that were on the unit that night.
21 Q. And my understanding is that between the
22 two of them, they were looking after a total of nine
23 patients? Is that your understanding?
24 A. Yes.

1 Q. All right. So to get back to my
2 question, the only way to put the care of Lisa Shore in
3 context in terms of figuring out whether or not the
4 clinical judgment being exercised by those two nurses
5 was appropriate or inappropriate would be to look at
6 what they were doing with the other eight patients?
7 A. And you referred to the nursing care
8 plans, I believe, and that's not possible to do now
9 because ---
10 Q. Okay.
11 A. --- those are simply working documents
12 for staff.
13 Q. Okay, it was a slip on my part. I
14 didn't mean the nursing care plans, I meant the patient
15 charts, all right? So if we substitute instead of
16 "nursing care plans," which was inadvertence on my
17 part, and we plug in the words "patient charts," then I
18 take it you'd agree with me?
19 A. Yes.
20 Q. Are you aware of the fact that we asked
21 for those patient charts and we were told that we
22 couldn't get them?
23 A. No, I'm not aware of that.
24 Q. Certainly if we'd gotten them, we would

1 be in a position to have a better insight into the
2 clinical judgment that was exercised from time to time
3 by Nurses Doerksen and Soriano?
4 MR. HAWKINS: If I can interject here, in
5 the questioning by Mr. Krkachovski, Dr.
6 Reeder indicated that you'd have to consider
7 context factors. She then indicated in
8 response to a further question from Mr.
9 Krkachovski that we've heard from the nurses
10 about generally what was going on and there
11 were certainly no other incidents reported,
12 et cetera.
13 In terms of other patient charts, that
14 was the subject of an earlier motion and I
15 think to raise it at this stage, aside from
16 relevance, there are issues of patient
17 confidentiality and that was the subject of
18 an earlier motion before yourself in the
19 absence of the jury. So to raise it with the
20 last witness in the presence of the jury ...
21 THE CORONER: Well, certainly it was my
22 feeling that for us to have those other
23 charts may well pose issues of
24 confidentiality in other patients. My

1 assumption would be that an institution would
2 not be hindered by those same restrictions
3 about reviewing other hospital charts
4 internally that we may be here, since we're
5 dealing with a death and the confidentiality
6 of other patients being involved.
7 So that all I understand Mr. Gomberg's
8 question is from an internal point of view,
9 did the hospital look or confirm the evidence
10 that we heard, basically, from Nurse Soriano
11 and Nurse Doerksen, they did not indicate in
12 their testimony that the reason they did not
13 take certain vital signs is because they were
14 too busy doing other things. As part of
15 their evidence, it did not come up that we
16 did not do this because we were too busy
17 doing something else.
18 MR. HAWKINS: That's not what they
19 suggested, no.
20 THE CORONER: I think Mr. Gomberg is just
21 asking if independently of that, whether the
22 hospital internally could confirm or -- that
23 that was or wasn't the case, without getting
24 into the confidentiality of this inquest or

1 without me saying that I would allow those
2 records to come up here. At least, that's
3 the way I understand it.
4 MR. GOMBERG: Yeah, I just wanted to know
5 whether or not, I mean, if the point that it
6 being made is that the clinical judgment that
7 was exercised was faulty or defective or
8 whatever word you want to use, then I don't
9 care about what else was going on, all right?
10 If there's some rationalization for the
11 clinical judgment that was exercised and
12 we've heard all about it over the last four
13 weeks, I suppose, and if there's some
14 rationalization as to other things going on,
15 all right, with other patients, then I think
16 in a general way we should hear about it,
17 that's all. She raised it, I didn't raise
18 it. So that's the, you know, I think that
19 you got the question, Deputy Chief Coroner,
20 just as it was intended.
21 THE CORONER: Dr. Reeder, as part --
22 obviously the hospital has looked at this
23 death, as part of it, it has been the
24 evidence of both the nurses that there were

1 certain vital signs that the protocol says
2 they should do; they didn't do them. They
3 never in their evidence indicated that the
4 reason they didn't do them was because there
5 were two other cardiac arrests or seven other
6 sick patients.
7 THE WITNESS: Right.
8 THE CORONER: As part of the hospital's
9 internal review, did you find anything in
10 terms of the number of patients on that ward
11 or the seriousness of their condition that
12 would explain a reason why they did not do
13 these, other that they, in their judgment,
14 decided not to do them?
15 THE WITNESS: I can't say yes or no to that,
16 because I do not know if anyone did go back
17 and examine those nine charts that Mr.
18 Gomberg is referring to. Mr. Gomberg, I'd
19 like to say something else that in reference
20 to your previous issue regarding the nine
21 patients, I had forgotten that discussion
22 that took place earlier in the testimony and
23 I do recall a discussion around
24 confidentiality and all that, so I was mis-

1 spoken in my earlier comments.

2

3 BY MR. GOMBERG:

4 Q. No, no, that wasn't really the major
5 issue. I think to get back to the question, just to
6 make it -- I think you've answered it and that is that
7 in the context of what was going on with the other
8 eight patients, that hasn't been looked at in detail,
9 so therefore one can't say that she didn't take a blood
10 pressure at 4:00 in the morning because there were
11 three cardiac arrests going on because you don't know.
12 Is that fair?

13 A. Yes.

14 Q. All right. And my question to is as the
15 Head of Nursing, that surely you've appreciated now the
16 limitations of a Coroner's inquest in the sense that's
17 not something that we're going to be able to do within
18 the confines of this room, right, for the reasons that
19 we talked about? In other words, we're not going to be
20 able to get those charts ---

21 A. Yes.

22 Q. --- and go through them? Is that
23 something that the jurors may usefully recommend in
24 terms of an internal audit of what went on that night?

1 A. I think that -- I don't know how helpful
2 that recommendation would be. However, I certainly
3 think that we as an organization will go ahead and do
4 that retrospective review, but regardless of that, as
5 you have heard both nurses say, in retrospect, you
6 know, they've told us they've made some mistakes or
7 errors in judgment and I certainly agree with that.
8 So that's the jury's call in terms of
9 whether or not you'd like to make that as a formal
10 recommendation, but I will -- I will say that we will
11 certainly go ahead and review that, but I don't think
12 that's going to have a big effect in terms of, you
13 know, the fact that the nurses have told us they've
14 made some mistakes and errors in judgments, as well as
15 they made some good decisions that night.
16 Q. Right. Well, I want to ask you about
17 what I think have come to be called "prompts," all
18 right?
19 A. Yes.
20 Q. And whether or not that is an
21 institutional issue in terms of education, right, and
22 you've been here for the whole thing so if I mis-speak,
23 I'm sure you'll tell me or Mr. Hawkins will, but there
24 was a call that came up from emergency at roughly

1 midnight, you've heard that?
2 A. Yes.
3 Q. And there was a call that came up at
4 roughly 1:30 ---
5 A. Yes.
6 Q. --- in the morning, you've heard that?
7 And then Lisa came up at roughly 1:37 or 1:40, and
8 you've heard that. So those are supposed to, as I
9 understand it, be prompts or whatever you want to call
10 them, to the nurses to look at and thereafter to
11 activate the orders in Kidcom. Is that an
12 institutional problem that that wasn't done?
13 A. Before I respond to that as an
14 institutional issue, I guess I would modify the notion
15 of prompts but rather they're a series of different
16 communications along the way, you know, that should
17 prepare those nurses who are receiving the patient and
18 it was Lisa in this case, to get ready for the patient.
19 Now, yes, they could be prompts but they're not. I
20 think all nurses would view those as more as
21 communication devices between the various areas of
22 patient care to, you know, to smooth the transference
23 of care from emerg to the unit.
24 But the issue of prompts, I guess, my

1 personal opinion is that the extra automatic printing
2 of Kidcom now, you know, and printed out on a different
3 colour piece of paper is a much more visible prompt
4 than perhaps how you've depicted the prompts that are,
5 you know, more communications things.
6 Q. You see ---
7 A. They both can work.
8 Q. They both can work, and I guess without
9 descending into absurdity, the more prompts you have
10 the better although at some point, I think, one of the
11 witnesses said, and I can't remember who it was that --
12 I think it was the Kidcom person when we were at the
13 hospital said something, Ms. Patterson, I think, said
14 that ---
15 MR. HAWKINS: Anderson.
16
17 BY MR. GOMBERG:
18 Q. --- Anderson that you can go through --
19 you can miss all of the prompts, all right, and that's
20 what I'm asking you as an institutional issue, is if a
21 phone call comes up and another phone call comes up and
22 then the patient comes up, and we also know about the
23 Kidcom directive, which has been made an exhibit and
24 that says, "Look at the Kidcom" ---

1 A. Mm-hmm.
2 Q. --- all the time when a patient comes up
3 from emerg and activate the orders, I'm paraphrasing
4 it, all right, but if you're going to miss the prompts,
5 is there anything that you can think of, short of
6 conking somebody on the head, which is going to make
7 them do what the prompts are telling them to do?
8 A. No.
9 Q. All right. Now, the PCA protocols, as I
10 understand it, those weren't followed either and we
11 don't have to debate that, but is that an institutional
12 issue in terms of education?
13 A. Yes, it is.
14 Q. All right. And I think we've heard that
15 the manual is being modified or has been modified?
16 A. The PCA education resource manual?
17 Q. Right.
18 A. That is my understanding that I believe
19 more attention has been focused on the development of
20 monitoring guidelines and use of the, you know,
21 morphine and toxic drugs.
22 Q. All right. Well, has an internet
23 directive or message gone out or a memorandum gone out
24 or anything gone out to anybody in the hospital; by

1 "anybody" I mean the nurses. I'm not talking about the
2 janitor, now, who deals with PCA's saying there may be
3 a problem here; we had some people who for one reason
4 or another didn't follow the monitoring in the manual
5 and we want you to know from the head nurse on down
6 that you've got to pay attention to what's in the PCA
7 manual. Has that been done?
8 A. I don't know if it has or has not, Mr.
9 Gomberg. I can't answer that question.
10 Q. Didn't you ask?
11 A. Pardon me?
12 Q. Didn't you ask before you came here to
13 testify before Dr. Cairns and the jury whether that's
14 been done?
15 A. No, I didn't.
16 Q. I guess it would be a good thing to find
17 out, wouldn't it?
18 A. I plan to.
19 Q. All right, you've heard evidence about
20 whether or not monitoring starts in the emergency room
21 after the initiation of therapy or whether it starts on
22 the floor, and I think it's fair to say that there was
23 confusion amongst many of the witnesses on that issue.
24 A. I agree.

1 Q. Do you agree with me?
2 A. I agree.
3 Q. All right. Is that an institutional
4 issue?
5 A. Yes, it is.
6 Q. What has been done to address that
7 institutional issue?
8 A. Nothing yet, but we will certainly
9 address that in our follow-up.
10 Q. You see, what concerns me is that you
11 don't really need a lawyer sitting in a Coroner's
12 inquest to make these suggestions to you, do you? I
13 mean, surely there's some system that's been set up at
14 a world-class institution like Sick Kids with the best
15 pediatricians in the world to figure these things out
16 and you don't need somebody like me sitting here
17 shooting questions at you to figure this out, do you?
18 That's a question.
19 A. We're not a perfect organization. No
20 one is perfect in anticipating any and every nuance of
21 perfecting patient care, but we are committed to
22 continue to identify these issues and put things in
23 place and to improve the education so that we can
24 continue to improve as an organization, and I find your

1 suggestions helpful.

2 Q. All right. Seeing as though they're
3 helpful, I may make a few more. This business about --
4 and, again, if I mis-state this, please tell me --
5 there was evidence adduced that Ruth Doerksen printed
6 up the nursing care plan on October 27th and took it
7 home. In terms of sharing information and getting
8 answers to serious questions, that surely is an
9 institutional issue. And there's some problem with
10 that, isn't there?

11 A. The problem with her taking information
12 home or sharing the information with the institution?

13 Q. Well, I don't care that much about her
14 taking it home, the only reason I care about her taking
15 it home is it happens to be a reflection of the fact
16 that she wasn't sharing it with anybody, but as far as
17 I'm concerned, she could have put it in a file folder
18 at the hospital and left it there and the effect would
19 be the same.

20 A. Well, as you heard in my previous
21 testimony, we did not -- we did not do some things and
22 you've heard from nurses' testimony that there was a
23 period of time before anyone sat down and talked with
24 these nurses about the incident to gain information,

1 and we regret that.
2 I didn't become involved until several
3 months after, in terms of knowing that there were
4 nursing issues, however, that does not mean that these
5 nurses would have the forethought to volunteer certain
6 things that may or may not have been meaningful for
7 them, given the fact, I'm sorry, Mr. Gomberg, this is
8 the truth, they don't deal with sudden deaths on a
9 daily basis and to anticipate the forensic-like
10 questions that may assist the organization that may
11 come to mind, I don't necessarily expect that that
12 would be in the front of people's mind when they, too,
13 have experienced a sudden tragic death.
14 Q. Right. But you'd agree with me that
15 making detailed notes and not sharing them with anybody
16 certainly doesn't help the process in terms of getting
17 to the bottom of what happened?
18 A. There are times where nurses,
19 physicians, other people do make detailed personal
20 notes for different reasons and they were waiting for
21 somebody to be questioned. You know, I can't tell you
22 what went on in their minds, Mr. Gomberg.
23 Q. No, I'm not asking you, Dr. Reeder, what
24 went on in their minds, but I guess what I'm asking you

1 is what went on in your mind in the sense that you're
2 the Head of Nursing and surely as the Head of Nursing
3 or somebody under you would have been very concerned to
4 find out whether there were nursing issues sometime
5 after October 22nd and before the stuff was sent to the
6 Coroner on January 26th, 1999.
7 A. That I agree with.
8 Q. All right. Well, I guess what I'm
9 asking you is institutionally, let's assume that it
10 didn't have to climb up to the top, which is where you
11 are, but is there somebody who should have been looking
12 at this much more promptly after the death that took
13 place on October 22nd?
14 A. Yes.
15 Q. All right.
16 A. And that did not happen.
17 Q. All right. And what institutionally has
18 been done to insure that that happens so that we're not
19 back here asking you similar questions a year from now?
20 A. I think that's a good question and I
21 would say that we are, in fact, working on a guidelines
22 policy, whatever you want to call it, that really helps
23 us manage not only sudden, unexpected deaths, but all
24 critical occurrences that may have very, you know,

1 serious unintended consequences.

2 Q. All right. Now, just to -- I think that

3 I got sidetracked. We were talking about this issue

4 of, earlier, whether the monitoring, the hourly

5 monitoring starts in emergency or starts on the floor,

6 and I'm sure the jurors are wondering about that. What

7 institutionally has been done to make sure that that

8 confusion is addressed?

9 A. Well, first of all, I think it needs to

10 start as soon as the, you know, the patient is put on a

11 monitor or as soon as therapy is initiated. And that

12 is something that we will also need to do to

13 communicate to our staff.

14 Q. Right, and has that been done yet?

15 A. I don't know.

16 Q. Now in terms of the issue of preserving

17 evidence and a less emotionally-laden way of putting it

18 is "preserving information," so let's talk about

19 preserving information. We've heard evidence in the

20 last two days about these tapes, all right, and we've

21 heard about the patient care plans, both the one that

22 apparently was recycled and the one that went home with

23 Ms. Doerksen five days later. Has any directive gone

24 out by way of your office, that's the office of Head

1 Nurse or the Chief of Nursing, to deal with those
2 forensic issues, as you've described them, and I agree
3 that's what they are.
4 A. No, it hasn't, and let me tell you why,
5 because it's my belief that as faxes, palm pilots,
6 voice mail, are tools to assist individuals to manage
7 their work efficiently, so too are these tapes that are
8 used by nurses to record, report, so too are the
9 nursing care plans that they use as, you know, pieces
10 of paper to carry around information.
11 Nurses are very busy in the course of a
12 12-hour shift and it facilitates the work of nurses and
13 I do not believe it is up to me as Chief of Nursing to
14 micromanage at the unit level the things that nurses
15 need to do to facilitate their work that needs to be
16 done as well as the communication between nurses.
17 Q. Yeah, I ---
18 A. It is simply an enabler of the work of
19 nurses.
20 Q. Okay, so I agree with that, but what I'm
21 suggesting to you is that it is up to you to
22 micromanage the preservation of information when a
23 child dies highly unexpectedly.
24 A. It's up to the organization to do a

1 better job in fully understanding the Coroner's
2 expectations in terms of evidence and any other
3 information that would be expected. I will tell you
4 that I've learned a lot about that now, things that I
5 would never have thought of before.
6 Q. All right. And is there a point person,
7 now, if I can call him or her that, who has been
8 appointed to, as you put it, micromanage the forensic
9 aspects of an unexpected death, regardless of whether
10 there's a Coroner's investigation?
11 A. Through the risk management service,
12 they are taking the lead on refining things that are
13 already in place and have served us well and really
14 refining that with input from organizational leaders
15 like myself, as well as managers.
16 Q. You see, I don't want to get into the
17 details of this, but what concerns me about risk
18 managers is that the interests of a risk manager may be
19 different than the interests of somebody who really
20 wants to find out what happened. Do you agree with
21 that?
22 A. In my experience, risk managers in
23 hospitals are very interested in knowing what happened.
24 Q. They may be interested in knowing what

1 happened, but they may not be interested in sharing
2 that information, so I'm ---
3 A. I respectfully disagree with that.
4 Q. Well, that leads me to the final area
5 that I wanted to deal with, and that is this letter
6 that was sent. I think you're aware of what we're
7 talking about, from the risk manager, and that -- in
8 any event, we may be able to deal with this fairly
9 quickly. I take it that you didn't participate in the
10 writing of the covering letter or in the preparation of
11 the answers?
12 A. No, I did not.
13 MS. BROWNE: If I may be of some assistance,
14 that's Exhibit 51(A) and 51(B) in the
15 handwritten -- if Ms. Reeder had that with
16 her, perhaps she would be able to refer to
17 it.
18 THE WITNESS: I'm familiar with it, thank
19 you.
20 MS. BROWNE: You've got it anyway.
21 MR. GOMBERG: May I have the court's
22 indulgence just for a minute? I think I'm
23 finished.
24

1 BY MR. GOMBERG:

2 Q. Now, the only other area that I -- the
3 only other question that I had relates to -- if one
4 assumes in a generic way that there's an unexpected
5 death and the Coroner's office is not involved ---

6 A. Mm-hmm.

7 Q. --- all right, for one reason or
8 another, what investigative environment do you have to
9 look at that?

10 A. Well, first of all, all unexpected
11 deaths are reviewed in a number of different ways.
12 They're reviewed by the risk management office, they're
13 reviewed on the medical or surgical side of the house
14 through M&M conferences with the appropriate or
15 respective division. They are also reviewed by the --
16 in our organizational structure, we have -- it's called
17 "clusters," clusters of patient groupings and so it
18 would be reviewed and the cluster quality improvement
19 meeting so that -- which is a multi-disciplinary group
20 that reviews the unexpected deaths and looks to making
21 improvements in patient care as well as other aspects
22 of the patient management.

23 It's also reviewed in our hospital
24 morbidity and mortality committee that reports to the

1 medical advisory committee and that's done at a fairly
2 high level and we're planning, now, on reviewing at a
3 high level unexpected deaths. Our hospital quality
4 management committee and patient care committee, as
5 well, may have occasion to review those unexpected
6 deaths.
7 Q. All right. Now, the last question that
8 I have for you relates to, and this is an outgrowth of
9 this case, you've been here from the beginning and
10 you've heard that there is very, very conflicting
11 testimony, there's a lot of it, but there's certainly
12 conflicting testimony between Dr. Schily and Nurse
13 Soriano about what was said on the telephone at roughly
14 4:05 in the morning. I take it that when there's an
15 outcome like this one, that's an area that ought to be
16 investigated, as well, isn't it?
17 A. As it relates to the conversation
18 between Ms. Soriano and Dr. Schily?
19 Q. Sure, because somebody -- somebody --
20 may be wrong about what was said, right?
21 A. Yes.
22 Q. Is that something that the hospital is
23 institutionally set up to address, because that's a
24 direct conflict between a doctor and a nurse, and it

1 does impact on the treatment, doesn't it?
2 A. It does, and unfortunately, Dr. Schily
3 is no longer with us and as you're aware, he could only
4 be here on the first day of the inquest, so I would
5 never have the opportunity to talk with him directly.
6 From where I sit, I would want to know more details
7 about the conversation and I have a number of
8 unanswered questions based on his testimony, as well.
9 You know, as you talk about conflict, it
10 can range from he said/she said to differences in
11 perceptions or recollections of the conversation. It
12 also concerns me, based on Dr. Schily's testimony, that
13 he did not ask more specific questions of Anagaile,
14 particularly because she's a novice nurse, because
15 novice nurses often time don't think to ask prodding,
16 if you will, or leading questions of physicians to get
17 them to think a little bit more in terms of what the
18 nurses are thinking about, so I would not have
19 necessarily expected that of her at the time.
20 Q. All right. But as the Head of Nursing,
21 is it an institutional problem, and this was addressed
22 very briefly but not in the context that I'm going to
23 address it, that a nurse with four or five months' of
24 experience ends up taking care of nine patients as

1 opposed to somebody with 14 or 20 years of experience?
2 Is that an institutional issue?
3 A. I think it's an institutional issue if
4 any nurse ends up taking care of nine patients for a
5 prolonged period of time, and we have certainly
6 addressed that and we were addressing it even before
7 Lisa died but the fact of the matter is that this
8 country, throughout North America, there's now a
9 nursing shortage and so until we can get ahead of the
10 power curve to stabilize our staff with experienced
11 nurses, we will have dips when we have high censuses
12 such that we don't have an adequate number of nurses to
13 look after certain groups of patients, and I don't like
14 that situation any more than you do or my nursing
15 colleagues. When we place them in that situation, that
16 causes them great moral distress.
17 Q. All right. But I guess as a matter of
18 common sense as much as anything else, that if you're
19 going to have a nurse left looking after nine patients,
20 at least one of whom was on a PCA morphine pump with no
21 oximeter, that it would be better if it was an
22 experienced nurse as opposed to a nurse that was out
23 five months?
24 A. Sometimes we don't have that luxury, Mr.

1 Gomberg.

2 Q. All right, but to get back to the

3 question, in a perfect world, you'd agree with the

4 proposition that I've put to you?

5 A. In a perfect world, but unfortunately,

6 no hospital is a perfect environment, we are behind the

7 power curve in terms of having an adequate, stable

8 staff like most every other hospital in this country is

9 right now.

10 Q. Thank you, Dr. Reeder, those are my

11 questions.

12 THE CHAIRMAN: Do the jury have questions of

13 Dr. Reeder?

14

15 CROSS-EXAMINATION BY THE JURY

16 BY JUROR #2:

17 Q. I have a number of questions and some of

18 them may be repetitive, so I apologize. If you don't

19 mind, I just need to get you to -- if you could

20 specifically address these certain areas and just -- so

21 that we know for our own information what already

22 stands as policy and whatnot in the hospital.

23 A. Okay, I'll do my best.

24 Q. Okay, now general orientation, what

1 happens with that?

2 A. General orientation is a three or four-

3 day -- yeah, a three or a four-day initial orientation

4 for nearly all nurses who are new to the organization.

5 Q. Mm-hmm.

6 A. And that covers more broad issues like

7 infection control, like the documentation that we do at

8 Sick Kids, fires, safety, disasters, these kinds of

9 things.

10 Q. It's very broad.

11 A. Yeah, very broad.

12 Q. Okay, and so then from there you go to

13 the unit level where there's a new nurse -- sorry, new

14 nurse education program through the nurse educator

15 where they have more specific to the unit?

16 A. Yes, that's correct.

17 Q. What happens there?

18 A. What happens? I think this unit, it is

19 unit-specific because our patient populations are so

20 sub-specialized and so, you know, for instance, on this

21 particular unit where they're dealing with general

22 surgery, orthopedic and ear, nose and throat and I

23 might add dental patients and oral surgery patients, as

24 well, the orientation would really focus on those

1 particular patient populations, the care of the most
2 common patients that they see, you know, within those
3 particular services, the management of those patients,
4 any particular medications that are unique to, for
5 instance, ear, nose, and throat patients, that's how --
6 or tonsillectomy or general surgery patients that have
7 had a protrusion of their intestines when they're born,
8 there are specific ways of managing those patients,
9 that would be examples of what might be included in the
10 unit level orientation.
11 Q. Okay. And then again if there's any
12 upgrading that's necessary, or any problems are
13 identified, that's at the unit level?
14 A. Yes. Through the preceptors, the nurse
15 educator as well as the resource persons, if there are
16 issues in the nurse's, sort of, transition into our
17 organization, then they would be raised and dealt with
18 through those individuals.
19 Q. Okay. That leads me to when you're
20 establishing a job evaluation ---
21 A. Yes.
22 Q. --- is that through your area that you
23 do that?
24 A. Actually, the job evaluation is

1 developed, I would say a lot of people are involved in
2 that from staff nurses themselves as represented by the
3 RN Council to the child health services manager and
4 directors who are the, basically, patient-care
5 administrators in our organization, as well as our
6 human resources department, who is really overall
7 responsible for hospital-wide performance appraisal.
8 Q. Right. Which takes me a step further,
9 when you're reviewing a person, like aside from the
10 hiring process, when you go onto a year later,
11 whatever, when you're reviewing a person and their
12 ability, how do you establish what you call --
13 establish that the nurses are following what you call a
14 lifeline ---
15 A. Lifeline learning?
16 Q. --- learning?
17 A. Well, actually, the nurses establish
18 their own objectives.
19 Q. Is it written out?
20 A. Yes, there are four parameters under
21 which nursing staff and other clinical staff are
22 evaluated. First of all, there's clinical practice,
23 then teamwork, communications is the third and fourthly
24 is lifelong learning. And some nurses will identify

1 for themselves an objective, subsumed under the large
2 category of lifelong learning, so, for instance, they
3 may engage in a self-study program, they can access on
4 the internet, they may pursue a pediatric certificate
5 course that we have developed in conjunction with
6 Ryerson University, they may attend a particular
7 specialty conference, but it's the nurses that identify
8 how they are engaging in lifelong learning.
9 Q. Okay. Now, I guess what I meant to ask
10 is do you document a plan for each nurse?
11 A. The nurses document ---
12 Q. And give them a timeframe that they work
13 to?
14 A. Actually, because we do this and, you
15 know, we regard this as an aspect of professional
16 practice and have the expectation that nurses will
17 assume the responsibility and accountability to manage
18 their lifelong learning in the way that suits them the
19 most.
20 Q. Okay, so basically self-accountability?
21 A. Self-accountability, that's one of the
22 characteristics of a professional person.
23 Q. Okay. Then, again, assessing needs if
24 there's anything that comes up then it's a unit need,

1 then again, it's (inaudible)
2 A. It's usually dealt with -- yes, it's
3 usually dealt with at the unit level and depending on
4 the level of -- or the index of seriousness, if I could
5 characterize it like that, they may include the
6 manager, as well.
7 Q. Okay.
8 A. If it's really, really serious, it gets
9 to me.
10 Q. Right, okay. Okay, now, I have some
11 other questions aside from that; you been present
12 throughout the entire inquest?
13 A. Yes, I have.
14 Q. And my question is do you find the
15 testimony of the nurses to be relevant to the internal
16 needs to re-evaluate the current level of nursing care
17 insofar as charting, working without doctors' orders,
18 accessing Kidcom, communicating between nurses, those
19 are areas that ---
20 MR. HAWKINS: I'm sorry, I missed the
21 question.
22 THE WITNESS: Could you speak up a little
23 louder?
24

1 BY JUROR #2:

2 Q. I'm sorry. What I'm asking is through
3 this inquest ---

4 A. Yes.

5 Q. --- from what I've seen, there are areas
6 that I'm asking if you have seen that need to be
7 reassessed and re-evaluated insofar as the working of
8 the unit, ward 5, charting, accessing doctors' orders,
9 things that Mr. Gomberg was suggesting.

10 A. Right.

11 Q. Did you see those as red flags that that
12 area needs to be addressed, that those nurses need to
13 be ---

14 A. Well, there -- yes, and ---

15 Q. --- and perhaps retrained on it to make
16 sure that they do in fact understand what's to be ---

17 A. Yes, they are, but they already are
18 being addressed through the number of educational
19 sessions that have been held on 5A since Lisa's death.
20 That's not to say they shouldn't be ongoing education
21 activities, I believe that they should, and I believe
22 those issues equally as well should be ongoing annual
23 education for all nursing units at Sick Kids. It's a
24 really -- it's a very humbling reminder for us all how

1 important documentation is, how important monitoring of
2 patients are. I truly have learned so much in this, as
3 well, and I have thought about my own practise as a
4 nursing leader.
5 Q. Mm-hmm, okay. Now, without addressing
6 nurses involved in this inquest ---
7 A. Mm-hmm.
8 Q. --- this is just a general question.
9 A. Sure.
10 Q. My question is there appears to be no
11 apparent line of accountability from the testimony we
12 received. It was heard that it was not considered
13 necessary to even inform a replacement nurse that an
14 alarm had been disabled on the monitor. Is this an
15 aspect of the lack of communication and accountability,
16 has that been addressed? In a case where there's ---
17 A. I think it ---
18 Q. --- such critical information ---
19 A. Yes.
20 Q. --- it was just simply not made
21 available to the nurse who was going to be in charge
22 for two-and-a-half hours.
23 A. Right. I think it was a gap in her
24 communication and I think it is a very crucial piece of

1 information to be communicated. My greatest hope is
2 that now it's a moot point because as you've seen in
3 this draft policy, the issue of turning off the alarms
4 will no longer be an issue. But I will say ---
5 Q. But the issue of accountability ---
6 A. Yes.
7 Q. --- is what I'm questioning, that this
8 particular person ---
9 A. We all share in the accountability
10 of ---
11 Q. But is there someone who is ---
12 A. I'm ultimately responsible and
13 accountable.
14 Q. No, but the nurses, are the nurses
15 accountable ---
16 A. Yes, absolutely they are.
17 Q. To who?
18 A. They are accountable, first of all, to
19 themselves as registered nurses, they're accountable to
20 the College of Nurses, they're accountable to me as
21 Chief of Nursing because my job is to maintain the
22 standard of nursing practise.
23 Q. Okay.
24 A. But again they are accountable to

1 themselves first and foremost.
2 Q. Which doesn't necessarily work all the
3 time?
4 A. No, it doesn't, but I think tragic
5 incidents like this give us the opportunity and I can
6 say in no uncertain terms that all of my nursing
7 colleagues that have listened and sat through this
8 inquest have experienced terrific reminders and it has
9 hit home, and in no question it has hit home, in terms
10 of what it means to be accountable and responsible for
11 the decisions they make and the actions they take, and
12 equally responsible for the decisions that they don't
13 make or the actions that they fail to take. And that
14 starts with me, that's been reminded to me.
15 Q. We heard testimony that ward 5AB was
16 selected to receive patients admitted by pain service
17 department because of the level of expertise ---
18 A. Yes.
19 Q. --- in the nursing care for children on
20 PCA pumps and morphine?
21 A. Yes.
22 Q. Again, does the testimony you've heard,
23 does that not wave red flags to you for your need to
24 evaluate the nursing care provided on ward 5 to not --

1 I'm not talking universal at the hospital, I'm not
2 trying to suggest for a moment that there's a need
3 anywhere else, but I believe what we've heard here does
4 clearly indicate that perhaps ward 5 should be
5 reassessed.
6 A. Mm-hmm.
7 Q. Is there anything being taken ---
8 A. Well, I guess my personal opinion as
9 Chief of Nursing is I have a high level of confidence
10 in all of the nurses on 5A. I think all of the nurses
11 there have taken this extremely seriously from a
12 professional perspective as in a professional practice
13 perspective, but equally in terms of what it means to
14 be a nurse. I know they have all been -- their lives
15 have changed, particularly those of Ruth and Anagaile.
16 If they choose to remain to be nurses, I am very
17 confident that they will be better nurses because they
18 have learned from this in spades and I, too, have had a
19 practice-changing experience and it was a very hard
20 thing to live with for a very long time, but I can tell
21 you, it changed the way I practice and I'm a better
22 registered nurse because of that.
23 Q. Okay. So there's nothing insofar as
24 the hospital doing an assessment and doing a re-

1 evaluation (inaudible)

2 A. I am confident of the collective ability
3 of my nursing colleagues on 5A that this is the best
4 place for patients with chronic pain to be managed.

5 Q. Have you changed the format of the
6 printed flow chart to itemize the different elements
7 that need to be charted?

8 A. Have I changed the printed format to the
9 flow chart in order to ---

10 Q. To itemize the elements that need to be
11 charted?

12 A. Such as the patient's serial -- the
13 serial number on the monitor?

14 Q. Yes, the different monitors, the reading
15 of monitors.

16 A. You know, I have not done that, I have
17 not done that and I suspect that the, you know, the two
18 committees or task force that have been struck will be
19 doing that if they have not already done that. I can't
20 tell you that, though, personally myself.

21 Q. Have you held a review class of the
22 orientation session at Kidcom to ensure there's a
23 comprehensive working knowledge of Kidcom and the need
24 to access orders to effectively care for a child. Have

1 you ---

2 A. Can you break that down? That was a

3 really long question.

4 Q. Have you held a review of the actual

5 orientation session?

6 A. Mm-hmm.

7 Q. Have you reviewed that orientation

8 session to see if there's flaws there in what's being

9 taught, because as you, yourself, I believe, pointed

10 out it's a very -- you know there's documents ---

11 A. Yes. I have not reviewed that

12 personally, but it is my expectation that that will be

13 done as a recommendation from the task force that was

14 struck around Kidcom that we referred to before.

15 Q. Okay.

16 A. And if they don't, I will certainly

17 recommend that.

18 Q. Were you aware of the practice of nurses

19 on ward 5AB on a 12-hour shift accumulating their break

20 time as one single break?

21 A. As what?

22 Q. Accumulating their break time into one

23 single break?

24 A. I was not aware of that, and again that

1 is -- I guess I would view that as decisions that need
2 to be discussed on the administrative side of the child
3 health services, but in the end, different units may
4 manage their breaks as well as their lunches, dinners
5 or whatever in different ways. It depends on ---
6 Q. Again, they're self-accountable.
7 A. Well, self-accountability, but also it
8 may differ from unit to unit, depending on their
9 patient population, the rapid turnover of patients,
10 whether or not they are managing, you know, critical
11 care patients or medically fragile patients, so there
12 are lots of things that go in to that and my preference
13 would be for those decisions to be reviewed and managed
14 at the unit level as part of nurses' accountability for
15 not only the quality of worklife where they work, but,
16 you know, managing their work setting to facilitate
17 patient care, but your point is well taken, okay.
18 Q. Were you aware of the practice that the
19 nurses on a 12-hour shift were foregoing their breaks?
20 A. I beg your pardon?
21 Q. Foregoing their breaks?
22 A. Were going on breaks? Yes ---
23 Q. I mean foregoing, saying I won't take a
24 break, I'm busy, I can't do it.

1 A. Oh, boy, am I aware of that one. Many
2 nurses have told me, have complained about their
3 inability when we're very busy not to get breaks. I'm
4 told by our occupational health physician that some
5 nurses are experiencing adverse consequences because
6 they can't take breaks and dinner and that is an
7 ongoing issue that we continue to address, but again it
8 gets back to getting ahead of the power curve in terms
9 of attaining and maintaining a stable experienced
10 nursing staff. I don't like it when I don't get breaks
11 and it's even worse when staff nurses who are working
12 12-hour shifts don't get breaks. That's abominable.
13 Q. It seems awfully odd that you would
14 expect a person to last 12 hours and still be an ---
15 A. I don't expect someone to last 12 hours
16 without breaks.
17 Q. It seems totally unacceptable.
18 A. Well, it is unacceptable, I agree.
19 Q. Insofar as staffing on ward 5AB, there
20 are two night nurses and a constant care nurse. Is ---
21 A. There were that evening.
22 Q. Right. And what changes have been made?
23 A. I believe that changes have been made
24 overall to the ratio of nurses to patients on 5A, 5A in

1 particular. I think that, you know, as a general
2 policy there were usually more nurses on days, on the
3 long day shift than there are on the long evening
4 shift, but again if by virtue of the patient acuity,
5 that is, the level of complexity or illness of patients
6 as well as the number of patients, they may need to
7 call in other staff.
8 Q. Okay. Have patients been instructed on
9 how to report vital signs and pertinent information in
10 telephone reporting to doctors?
11 MR. GOMBERG: "Nurses" I think she means.
12 THE WITNESS: Yeah, have nurses been
13 instructed.
14
15 BY JUROR #2:
16 Q. Yeah, to doctors. Have nurses been
17 instructed on the format of reporting of vital
18 statistics from nurse to doctor and all pertinent
19 information so that there is a clear transfer of
20 information ensuring doctors are prepared to make
21 proper assessments? Has that been advanced, has that
22 been ---
23 A. I have a two-part response to that.
24 First of all, I don't know if that very specific thing

1 has been addressed, but at the same time, those kinds
2 of communications go both ways. The onus for
3 communicating detailed information such as vital signs
4 isn't solely on the registered nurses. If there are
5 issues, I would expect and I think our Chief of Surgery
6 and Chief of Pediatrics would also expect that
7 physicians would continue to ask the appropriate
8 questions to elicit the information they need to make
9 an informed judgment about the patient's condition, so
10 again it's two-way communication.
11 Q. Now, one last question. No, I don't, I
12 have more. I'm sorry, I have a few more, I missed a
13 page. Nurse Soriano clearly gave evidence that to this
14 day as a nurse preceptor she still does not comprehend
15 the accessing of Kidcom orders.
16 A. Yes.
17 Q. There appears to be a need for further
18 training before Nurse Soriano perpetuates her
19 knowledge.
20 A. Yes.
21 Q. Has that been addressed?
22 A. No, because she has not very recently
23 been involved in patient care. However, I agree with
24 you and we will certainly make sure that Anagaile does,

1 in fact, have a refresher in the Kidcom.

2 Q. Okay. Just a couple more, I'm sorry to

3 take your time.

4 A. No, that's okay.

5 Q. Getting to the draft ---

6 A. Yes.

7 THE CORONER: We should have had you ask the

8 questions first, it would have made the

9 lawyers redundant.

10 JUROR #5: I'm so sorry.

11 MR. GOMBERG: She's far better than we are.

12

13 BY JUROR #5:

14 Q. You said that this draft is anticipated

15 to be implemented soon. Is that mandated to be

16 implemented in the next quarter, the next two quarters?

17 A. It's not mandated.

18 Q. The fiscal year?

19 A. But rather I would like to -- I would

20 like to have this implemented ---

21 Q. I guess my question more clearly would

22 be ---

23 A. How soon?

24 Q. --- in fact, will it?

1 A. Will it be implemented?
2 Q. Yes.
3 A. Absolutely. When it's implemented, my
4 hope is within the next month or less, but I cannot
5 guarantee that because, again, when we implement new
6 policies like that, we seek wide input, wide feedback,
7 so that we as an organization don't miss anything.
8 Q. Once this piece is implemented and again
9 I'm getting back to the accountability issue ---
10 A. Mm-hmm.
11 Q. --- we've heard a lot of testimony about
12 protocol, nursing not being done to protocol, clinical
13 judgment being used in place of protocol and I'm just
14 curious, once this piece is implemented, if an incident
15 happens and it's found that these guidelines were not
16 strictly adhered to, what would the ramifications be?
17 A. Well, first of all, I would hope that an
18 incident like this never happens again.
19 Q. Of course.
20 A. Part of our response as an organization
21 is developing these additional guidelines so staff have
22 even more detailed knowledge and guidelines to pursue
23 that. My expectation is once any guideline is
24 implemented that they would be followed and if they're

1 not, then we need to explore why it has not been
2 followed.
3 Q. However, and please correct me if I'm
4 wrong, there doesn't appear to be consequence and I'm
5 not asking if there has been consequence presented, I'm
6 just saying what ensures that the efforts of the
7 Hospital for Sick Children and the Committee ---
8 A. I didn't get that last part. What
9 ensures ---
10 Q. What ensures that all the work that you
11 people are going through to implement this, what
12 ensures that they will even be read? After the
13 training ---
14 A. Mm-hmm.
15 Q. --- and six years down the road from
16 now?
17 A. Well, I think there are a number of
18 things that we can do. First of all, I can articulate
19 my expectation of all nurses and I can do that in a
20 number of different ways and I will. I can articulate
21 my expectations to the clinical practice leaders, the
22 nurse educators, the advance practice nurses, the RP's,
23 as well as the child health service managers to make
24 sure that every nurse does, in fact, see this policy as

1 well and read it and understand that it's our
2 expectation as an organization that it's followed.
3 Now, if it's not followed and it will
4 happen because nothing works 100 percent, always, then
5 I think that it's our responsibility to assist the
6 nurse to understand why that happened, what were the
7 circumstances surrounding this, there may be a reason,
8 you know, and to discuss this with the nurse and if
9 we're not satisfied that there was sufficient reason,
10 then we need to have a further discussion as far as --
11 to help them reflect on that and to learn from that so
12 it doesn't happen again. At the end of that
13 conversation, I articulate my expectations, as I always
14 do, in terms of what it means to be an accountable and
15 responsible, professional nurse.
16 Q. And one last question.
17 A. And if it comes to me, they don't like
18 coming to my office most of the time, I'm told, but I
19 think it's an important conversation to have so that
20 me, in my role as Chief of Nursing, can assist nurses
21 to learn and improve their practice rather than
22 punishing them for making a human error or a mistake.
23 Q. And I have one last question and I would
24 ask that you don't take offence, but it's just that

1 I've noted, it appears from your testimony that while a
2 number of areas are being addressed through drafts and
3 discussions and committee, a lot of areas have not been
4 addressed in the past year and a half, and most have
5 not been finalized.
6 A. Yes.
7 Q. Is there not a sense of urgency at the
8 hospital to (inaudible)
9 A. I have a great sense of urgency and I
10 think my colleagues in the administrative and executive
11 also have a great sense of urgency and I can tell you,
12 when I have some time after the inquest, I will
13 continue to engage in this process through my
14 leadership through the people that report to me. This
15 is an absolute must for our organization and we're
16 committed to doing it, not only for our organization
17 but so that we can share this with other pediatric
18 institutions across Canada.
19 Q. Thank you.
20 A. You're welcome.
21 THE CORONER: Do any other jury members have
22 questions?
23
24 BY JUROR #4:

1 Q. Yes, Nurse Reeder, when were called into
2 this situation?
3 A. When was I called into this situation?
4 Q. Would it be part of an investigation or
5 how did you arrive on the scene?
6 A. I never arrived on the scene, but I was
7 notified by one of the nurse practitioners on the pain
8 service that there had been a death on the pain service
9 and that it involved the morphine pumps and it wasn't
10 until several months after, I think specifically it was
11 the end of February, that I was made aware that there
12 were nursing practice issues as part of this
13 investigation.
14 Q. And there was no investigation done two,
15 three days after October the 22nd?
16 A. I have as much information as you do and
17 I think ---
18 Q. Does that seem odd?
19 A. Yes, it does. Yes, it does, and that is
20 one of the areas that we have already recognized as an
21 organization we need to improve. There were
22 preliminary things being done, as you've heard, to
23 secure, you know, most of the equipment, the
24 anaesthesia service had an immediate that day meeting

1 about trying to figure out what happened from their
2 perspective, so things were starting immediately, but I
3 don't think we took it far enough soon enough. And we
4 know that now.
5 Q. Did you have an opportunity to look over
6 the flow chart?
7 A. Yes, I have.
8 Q. Along with the doctor's orders?
9 A. Yes, I have.
10 Q. Could I ask you what your thoughts are
11 about why the doctor's orders weren't followed on the
12 flow chart?
13 A. Well, can I address each one of them
14 separately? I have evaluated the flow chart and
15 because I'm not an expert in pediatric nursing
16 practise, I did seek consultation from some of my
17 nursing colleagues, and as an overall, it didn't meet
18 my expectation, but I think that you have heard both
19 Anagaile and Ruth say that in retrospect and from now
20 on they will do things differently, so I think they
21 acknowledge that error in judgment, as well. And it
22 would be my expectation going forward that all nurses
23 would do a better job in terms of what and how they
24 document on the flow chart.

1 Secondly, I have heard their testimony
2 about the doctor's orders and these two nurses have
3 been forthright from the beginning in terms of, you
4 know, coming, you know, you heard Ruth share with --
5 share that she talked with Mary that morning about --
6 questioning her own self, why she turned on (sic) the
7 apnea alarm; she could have not told Mary that at all,
8 but she did. I think that both of them have been
9 forthright on the witness stand ---
10 Q. No, I'm not questioning the fact that
11 they weren't forthright ---
12 A. Yes. I think it was an oversight on
13 their part, number one, in missing the line that said
14 "See Kidcom orders."
15 Q. So that was wrong?
16 A. I think it was an oversight and I think
17 it was an error in human -- I think it was a human
18 error with tragic consequences, that's what I think.
19 Q. But it was wrong?
20 A. It was wrong?
21 Q. In not ---
22 A. "Wrong" implies to me that they did
23 something deliberately; it was an error in -- it was an
24 error of omission, it was a human error with tragic

1 consequences.

2 Q. With all the evidence that you've heard,
3 would it be your opinion that the nurses did everything
4 possible in the care of Lisa to have possibly prevented
5 her death?

6 A. I don't know if they could have
7 prevented her death. In retrospect, as we look back,
8 as we all look back, they could have provided not --
9 more close monitoring in terms of the blood pressure,
10 in terms of the pain and sedation scale, that's not a
11 question in their mind or my mind.

12 Q. Well, it certainly is in ours.

13 A. I beg your pardon?

14 Q. It certainly is in ours.

15 A. Well, you're asking my opinion as, you
16 know, Chief of Nursing at the hospital. And they
17 didn't meet my expectations. I think in retrospect
18 they clearly see that they made errors in judgment and
19 errors in omission. Because we still don't have a
20 cause of death, it's very difficult for me and I hope
21 it's very difficult for anyone else to draw a cause and
22 effect relationship between the errors in judgment that
23 these nurses made and Lisa's very tragic outcome. I
24 cannot do that in good conscience at all because,

1 again, there's no cause of death that we have heard
2 throughout this inquest. There are ideas about the
3 cause of death, but there's no cause of death. And I
4 can't imagine what that's like for Mr. and Mrs. Shore
5 to live with that and deal with that.
6 Q. And I have one more question.
7 A. Okay.
8 Q. I may be out of line ---
9 THE CORONER: Make sure it's a question,
10 number one, and go slowly with it so that I
11 can stop you in mid-sentence in case it is.
12 MR. HAWKINS: Maybe you should write it
13 down.
14
15 BY JUROR #4:
16 Q. In addressing the Shore family, you had
17 mentioned that you were terribly sorry, "we failed you
18 as an institution."
19 A. Yes, we did.
20 Q. Can you explain how or why? Like, you
21 failed them as an institution.
22 A. We did. There were gaps in our
23 communications between physicians and nurses, the
24 nurses certainly didn't meet our expectations with

1 respect to monitoring and documentation and timely --
2 timely review of the Kidcom orders, but there is also a
3 gap in the Kidcom system that we have now corrected, so
4 that didn't trigger in their minds to look at the
5 Kidcom orders.
6 I think there were significant gaps in
7 the communication between Dr. Schily and the unit. Dr.
8 Schily, knowing that this was the first and unique and
9 unusual case and the first time the anaesthesia service
10 had admitted a patient to that unit, he should have
11 done -- I believe he should have had a phone call or
12 gone up to that unit and as the physician, because this
13 was an unusual out of the normal pattern of cases that
14 nurses attend to on 5A. So, yes, we as an organization
15 take responsibility for failing Lisa, for failing her
16 family.
17 Q. Thank you very much.
18 A. You're welcome.
19
20 BY JUROR #5:
21 Q. You said you failed. Did you include
22 the doctors?
23 A. I did.
24 Q. Did you include the doctors?

1 A. Did I include the doctors?
2 Q. Yes.
3 A. I commented about Dr. Schily, you
4 certainly heard Doctor Wright.
5 Q. Thank you.
6 THE CORONER: Any other questions from the
7 jury?
8 JUROR #1: Yes, sir.
9
10 BY JUROR #1:
11 Q. I'm still having a problem with clinical
12 judgment. Is there any exception to clinical judgment,
13 are there any limitations or exceptions where clinical
14 judgment cannot be exercised?
15 A. I guess exceptions to -- an exception to
16 clinical judgment is the fact it is not 100 percent
17 accurate in every situation. It is part of the
18 collective of skills and things nurses use to manage
19 patient care and anticipate untoward consequences.
20 Q. I understand that, Doctor, but I'm
21 asking you, we use this general, broad term so
22 frequently here, of clinical judgment.
23 A. Right.
24 Q. Are there instances where clinical

1 judgment cannot be exercised?

2 A. Well, I think, you know, the one example

3 that we have come to be so familiar with here is the

4 importance of complete monitoring of patients who are

5 on PCA pumps.

6 Q. So are you saying, then, that clinical

7 judgment cannot be exercised in monitoring? Is that

8 what you're saying?

9 A. I think it needs to be if in -- if there

10 are cases where appropriate monitoring is not ordered

11 or if patients are on an unusual medication such that

12 nurses may be concerned about the patient's response to

13 medication, then it is important for them to exercise

14 their clinical judgment to put those patients on

15 monitors, to do vital signs more frequently, as you

16 heard Pauline Matthews testify ---

17 Q. Yes, we're talking about clinical

18 judgments that nurses can bring forward.

19 A. Yes.

20 Q. I'm asking you if there are clinical

21 judgments ---

22 A. I gave you ---

23 Q. --- limitations on those clinical

24 judgments?

1 A. Yes, mm-hmm. I gave you the example of
2 the monitoring situation that we have learned about
3 during this inquest.
4 Q. Are you saying then that there is no
5 exception to monitoring?
6 A. I'm saying that my expectation is that
7 nurses will follow monitoring protocols and if they
8 don't, then we need to explore with them before making
9 judgments about what happened and why they didn't
10 follow that.
11 Q. I understand that's your expectation,
12 just as proper charting is your expectation, just as
13 taking vital signs is your expectation, just as though
14 you've expressed many expectations today. But I'm not
15 asking you about an expectation.
16 A. Mm-hmm.
17 Q. I'm asking you if there are limitations
18 in areas where a nurse simply is not allowed to use
19 clinical judgment?
20 A. Yes, there are.
21 Q. Could you tell me what they are, please?
22 A. Well, unless a nurse is permitted by
23 virtue of the Registered Health Profession Act, as an
24 example, they are not allowed to exercise their

1 clinical judgment in prescribing medications for
2 invasive treatments.
3 Q. Anything else?
4 A. Monitoring, again, will change as a
5 result of this inquest and so unless there are very
6 unusual circumstances, clinical judgment with respect
7 to following the monitor guidelines will be minimal and
8 following the guidelines I expect will be followed.
9 Q. So the only exception to a nurse using
10 clinical judgment, then, is prescribing medication?
11 A. Now, I think there are others but I
12 can't, you know, I -- another one would be performing
13 surgery on a patient, they're not qualified to do that.
14 Some nurses are put in situations where they actually
15 might have to do that, but that's very unusual,
16 extraordinary circumstances. I'm just giving you two
17 examples that come to my mind.
18 Q. So there really aren't many areas where
19 a nurse can't use her clinical judgment?
20 A. If I thought about it, there are
21 probably more, but that pertains ---
22 Q. It sounds to me like a nurse can do
23 almost anything, except surgery and not prescribe
24 medicine.

1 A. Well, if you read the Registered Health
2 Professions Act, it is interpreted very broadly, but it
3 is also discussed within their scope of practice that's
4 outlined.
5 Q. Well, I'm asking you as Chief of Nursing
6 because I don't have access to that document.
7 A. Yes. No, I gave you examples, there are
8 definitely more but this is a little stressful and I'm
9 having a hard time pulling more examples out of my
10 head.
11 Q. You claim that you can speak to the
12 veracity of these nurses. How can you do that if you
13 weren't involved in this until February, many months
14 after the incident? How can you sit there and say that
15 you can speak to the absolute truth, honesty and
16 veracity of these nurses when we've had such
17 conflicting testimony and so many errors made? I mean,
18 I don't understand that.
19 A. Well, all of us are called to judge
20 other individuals and in my capacity of Chief of
21 Nursing with my professional values that are widely
22 shared by most registered nurses at Sick Kids, I have
23 also gotten to know these two individuals throughout
24 the course of this inquest and it's in my professional

1 judgment and in my years of experience that I do
2 believe they are telling the truth.
3 Q. Now, you were saying that monitors are
4 an adjunct ---
5 A. Yes.
6 Q. --- to nurses doing monitoring?
7 A. Yes.
8 Q. If a nurse doesn't do an hourly
9 monitoring, okay, a nurse is in a situation where she's
10 doing hourly monitoring ---
11 A. Mm-hmm.
12 Q. --- and she doesn't have the benefit of
13 an oximeter, perhaps, or a monitor, what happens if
14 something critical or something dangerous occurs to the
15 patient between her hourly visits?
16 A. But that can happen regardless of
17 whether or not a patient is on the monitor.
18 Q. No, we're speaking about patients that
19 are on morphine, so let's make that exception, then.
20 Opiate patients, let's just put it that way.
21 A. Okay.
22 Q. We're not talking about a patient that's
23 about to be discharged and (inaudible). What occurs,
24 then, if a patient is being monitored hourly ---

1 A. Mm-hmm.

2 Q. --- and they're on the PCA pump, if

3 there's no oximeter or heart alarm or Corometric and so

4 on? It means that there is a danger area, doesn't it?

5 A. Yes, but there are always dangers for

6 patients who come to hospital.

7 Q. But isn't it our job here to minimize

8 these dangers?

9 A. It absolutely is, ma'am, and that's what

10 we're doing by putting together these monitoring

11 guidelines, that's what we continue to do by educating

12 staff, that's what we will continue to do by meeting

13 with the Coroner afterwards and I know for certain that

14 my physician colleagues that are here today and

15 (inaudible) physicians will also move that forward with

16 physician colleagues, as well.

17 Q. I'll see if I have anything else,

18 because this will be my last opportunity to speak with

19 you, won't it?

20 A. I don't know.

21 THE CORONER: Yes.

22 JUROR #1: Is that correct? Yes, my friend

23 would like to ask a question.

24

1 BY JUROR #2:

2 Q. Yes, because there is a such an area of

3 concern with us with the clinical judgment, you said

4 that the medical health practitioner act (sic)

5 defines ---

6 A. I'm sorry?

7 Q. You said the medical health practitioner

8 act (sic) defines clinical judgment?

9 A. Registered Health ----

10 MR. HAWKINS: Regulated Health Professions

11 Act.

12 MR. GOMBERG: Regulated Health Professions

13 Act.

14 THE WITNESS: Regulated Health Professions

15 Act. Thank you, Mr. Gomberg.

16

17 BY JUROR #2:

18 Q. Is there any chance of getting just a

19 take-out of that one part?

20 A. I beg your pardon?

21 Q. Is there any chance of us getting just a

22 copy of the one part?

23 MR. HAWKINS: I don't think she intended to

24 say that it's defined in the Act. What the

1 Act defines is what nurses by law can and
2 cannot do and that's in the Regulated Health
3 Professions Act and in the Nursing Act. If
4 you'd like a copy, I could get them.
5 THE CORONER: I don't honestly think it's
6 going to be of any assistance to you in this
7 situation.
8 MR. GOMBERG: If you're having insomnia some
9 night, you should read it.
10
11 BY JUROR #1:
12 Q. Yes, I think on one of these -- one of
13 the directives, I don't have it in front of me, it
14 spoke about sedation scale.
15 A. Yes.
16 Q. It didn't speak about -- so that would
17 be the arousal scale, would it? If an opiate ---
18 A. Yes.
19 Q. --- kid is on a monitor now, do they
20 automatically get the sedation scale, is that in your
21 draft?
22 A. Yes, I believe it is. It would be more
23 -- not so much the electronic monitoring guidelines,
24 but the guidelines that are being revised for the

1 administration of not only morphine, but other opioids
2 and other highly toxic drugs.
3 THE CORONER: Perhaps I can help the jury
4 member. The PCA protocol that was in place
5 at the time that Lisa died, that there had to
6 be hourly monitoring of pulse, blood
7 pressure, respirations, pain scale, sedation
8 scale had not been changed. What is going to
9 be added to those are some additional items
10 such as a Corometric monitor just must be
11 used and an oximeter must be used. At the
12 time of Lisa's death, all of those were
13 mandatory so it wasn't a matter of clinical
14 judgment; if they were ordered, they had to
15 be done unless there was a reason where they
16 couldn't be done.
17 In addition to those, there will be an
18 oximeter on every patient and a Corometric
19 monitor on every patient, I think is a
20 reflection of the evidence to date, and there
21 may be other things coming and Mr. Hawkins,
22 correct me if I'm wrong on that.
23 MR. HAWKINS: Yes, unless I misheard you,
24 you said the apnea and oxygen saturation were

1 mandatory, those were discretionary based on
2 physician's order and we know there was an
3 order here at the ---
4 THE CORONER: At the time of Lisa's death,
5 whether the patient went on a Corometric
6 monitor or an oximeter, were at that time at
7 the discretion of the physician.
8 MR. HAWKINS: Yes.
9 THE CORONER: The other parts in terms of
10 pain scale and sedation scale were a
11 mandatory part of the protocol.
12 MR. HAWKINS: Right.
13 THE CORONER: It is my understanding that
14 the new protocol does include that there will
15 be an oximeter on every patient on a PCA pump
16 and there'll be a Corometric monitor on every
17 patient on a PCA pump.
18 MR. HAWKINS: Yes, it's slightly broader
19 than just PCA pump, it's all parenteral
20 opioids which includes some other methods
21 other than PCA pump giving morphine.
22 THE CORONER: All right, in addition to
23 other medications which will come under the
24 same guidelines.

1 MR. HAWKINS: Correct.
2 THE CORONER: Is that fair enough?
3 MR. HAWKINS: Yes.
4 MR. KRKACHOVSKI: Maybe I'm misunder-
5 standing, Mr. Coroner. I had thought that
6 the change since Lisa's death was that a
7 pulse oximeter was mandatory but I haven't
8 heard that a Corometric monitor is also
9 mandatory. Am I wrong on that?
10 MR. HAWKINS: No, that -- I don't think I
11 said that.
12 MR. KRKACHOVSKI: No, no, you didn't.
13 THE CORONER: I did, so perhaps I'm
14 confused.
15 MR. HAWKINS: I don't mean to, but at the
16 time, as the protocol which you have as an
17 exhibit, oximetry monitoring and apnea or
18 Corometric monitoring were discretionary
19 based on physician decision.
20 JUROR #2: But I believe what she's
21 referring to is that in the testimony the
22 nurses gave, they said that in the absence of
23 accessing the orders, they used their
24 clinical judgment in the monitoring.

1 MR. HAWKINS: Yes.
2 JUROR #2: So that's, I believe, the first
3 question.
4 MR. HAWKINS: Okay.
5 THE WITNESS: That's correct, and that is an
6 example of good clinical judgment used by the
7 nurses in the absence of the doctor's orders.
8 MR. KRKACHOVSKI: Sorry, can we address my
9 problem, Mr. Coroner, because I don't want to
10 mislead the jury when I make my submissions.
11 Am I wrong in my understanding that a
12 Corometric monitor is still optional, it's
13 just the pulse oximeter that's mandatory when
14 we're dealing with the PCA pump?
15 MR. HAWKINS: Yes, that's my ---
16 THE CORONER: As of today.
17 MR. HAWKINS: I believe as of today, and I
18 believe that's what Jennifer had testified
19 to.
20 THE CORONER: Perhaps I can help the jury.
21 Dr. Reeder, you're indicating that in the
22 absence of orders on this particular night,
23 the nurses could use their judgment. The
24 patient was on a PCA pump and it's my

1 understanding at that time there was a
2 mandatory protocol that had to be followed by
3 the nurse?
4 THE WITNESS: Mm-hmm.
5 THE CORONER: And that while the nurse could
6 use judgment as to whether to put on a
7 Corometric monitor or whether to put an
8 oximeter on that night, the nurse, according
9 to the protocol, was not allowed to use
10 clinical judgment in taking blood pressure,
11 sedation scales or pain scales.
12 THE WITNESS: I would agree with that, yes.
13 THE CORONER: I don't know if that helps the
14 jury in that regard.
15
16 BY JUROR #5:
17 Q. Will you be having some mock practice
18 about inquests further on?
19 A. We may even hold a mock inquest.
20 Q. In six months, you know, like ---
21 A. No, we are actually planning to have
22 nursing grand rounds to talk about this inquest, use it
23 as an opportunity to educate nurses and physicians
24 about the process of a Coroner's inquest, as well as

1 address the issues of securing evidence and all the
2 things that, you know, we have learned about all these
3 many weeks. I think that given the prominence of this
4 within the organization right now, there is a high
5 level of readiness for staff to learn about this and
6 I'm very -- we're planning on that, believe me.
7 Q. That will be good.
8
9 BY JUROR #1:
10 Q. Yes, couldn't you have spoken with Dr.
11 Schily while Dr. Schily was still here in Toronto and
12 still a pain fellow at the hospital? You're
13 complaining today about not having the opportunity to
14 speak with him because he's no longer -- so he's
15 returned from whence he came, but could you not have
16 spoken with Dr. Schily when Dr. Schily was here and
17 practising at the hospital?
18 A. Well, I'm not sure if I complained about
19 that, but I stated that I didn't have that opportunity;
20 number one, I never even met Dr. Schily until he was
21 here. I did not know that Dr. Schily was a member of
22 the pain management team and by the time ---
23 Q. Well, why didn't you know all these
24 things?

1 A. Why didn't I know that?
2 Q. If this is a concern to you ---
3 A. Well ---
4 Q. --- as the Director of Nursing?
5 A. Chief of Nursing.
6 Q. Chief of Nursing.
7 A. On of the things is, again, that this
8 wasn't discussed with me in detail until the end of
9 February when it was first brought to my attention that
10 there were nursing issues around Lisa's death.
11 Q. Who brought it to your attention?
12 A. I think the first person was Marion
13 Stevens from risk management. As far as speaking to
14 Dr. Schily, you know, I never met the man until he was
15 here that morning and then, you know, I didn't know
16 what he was going to testify about, I didn't know what
17 he was going to say and he was -- he left here fairly
18 quickly afterwards, and I just didn't have that
19 opportunity.
20 Q. Yes, well, nor have we, the jury, apart
21 from ---
22 A. I appreciate that.
23 Q. --- that day.
24 A. I appreciate that.

1 Q. Are you saying that now you don't have
2 enough -- adequate nurses in the hospital to safely
3 cover the care of the patients?
4 A. I'm saying that we are much improved
5 over where we were at the time of Lisa's death and even
6 where we were last year at the time. There are certain
7 areas where we are still recruiting for nurses; for
8 example, the neo-natal intensive care unit and we're
9 not there yet, but we are in a much better situation
10 than we were a year ago.
11 Q. And Diane asked you about a line of
12 accountability.
13 A. Yes.
14 Q. It seems to me that when one -- when a
15 nurse gets a phone call from another nurse instructing
16 her to do this or stating an admission is coming, it
17 seems to me if notations were made on charts or
18 somewhere, that we would have the chain of
19 responsibility ongoing, so that in a situation like
20 this, one person upon another can't just say I don't
21 remember the nurse I spoke with, I don't remember their
22 name.
23 Don't you think it would be a good
24 situation for even the doctor, when he's calling, to

1 the nurse to say that he's put Kidcom orders on in
2 emergency, for him to get the name of the nurse or a
3 number, name, number, whatever, some means of
4 identification and punch that into the Kidcom or
5 something like that, and then she notes that she spoke
6 with Dr. Schily or Dr. Smith and so on all the way
7 along when instances of responsibility are being passed
8 from one person to another, that these things aren't
9 notated?

10 A. I think -- I hear what you're saying,
11 but I don't necessarily agree with that because if
12 there was, first of all, the little pieces of paper,
13 the reports in people's pockets, the tape that you
14 heard of, are all ways that nurses and physicians use
15 to manage their work, you know, interns, when they're
16 on, or residents at night, they have their cheat sheet
17 and that's what they use to guide them through, you
18 know, the responsibilities they have to look after
19 patients. I think if everyone stopped every moment
20 that they communicate with another person to document
21 it ---

22 Q. Well, that's not what I'm suggesting at
23 all. I'm suggesting that when it occurs when a level
24 of responsibility is being passed from one person to

1 the other, this is no longer my responsibility ---
2 A. Right.
3 Q. --- now it becomes your responsibility
4 A. Right.
5 Q. So I would document your name.
6 A. Mm-hmm.
7 Q. And you will document mine, perhaps.
8 A. Right, right. Again, I hear what you're
9 saying, but, you know, that's not a traditional
10 practice in medicine or nursing that I'm aware of, with
11 the exception of the hand-off note at the end of shifts
12 when a resident or fellow will hand off or an attending
13 physician will hand off to another attending when
14 they're transferring the service of a child, that's
15 formally documented in the progress notes, but the day-
16 to-day, hourly kinds of things are more forms of
17 informal communication.
18 Q. I'm not talking about really day-to-day,
19 I'm talking about levels of responsibility ---
20 A. Yeah.
21 Q. --- incidences that occurred in that
22 room that night when the heart rate went up, when she
23 was suffering, I believe someone said, tachycardia and
24 I just ---

1 A. Well, I will tell you that we will
2 reconsider that in the context of not only this but how
3 we manage levels of responsibility and communication
4 within our organization. Would someone please make a
5 note of that?
6 Q. And does the hospital have telephone
7 records, recording every outgoing call?
8 A. I believe we do, but I'm not sure. That
9 would be within the purview of the communications
10 department, so I ...
11 Q. Okay, and did you bring with you today
12 the disciplinary sheet that Mr. Hawkins promised us?
13 A. I beg your pardon?
14 MR. HAWKINS: I'm sorry?
15 JUROR #1: Weren't you going to produce a
16 sheet on discipline for the jurors?
17 MR. HAWKINS: I don't -- my look of surprise
18 on my face conveys that if I did, I forgot,
19 and I apologize. I'm -- I'm not -- I don't
20 know what you're addressing. I had brought
21 Kidcom stuff and confidentiality policies
22 which you'd asked for, that was all that I'd
23 had on my list. Was there something else,
24 Dr. Cairns? I don't ...

1 JUROR #5: We were asking -- someone said --
2 one of the witnesses said there's a general
3 disciplinary policy and nurses sign that for
4 confidentiality. It was with regard to
5 confidentiality of the patient.
6 MR. HAWKINS: The nurses -- in the Kidcom
7 system, which is one of the things I was
8 going to mark when Dr. Reeder was done, there
9 is a confidentiality -- well, there is a -- I
10 think it's called the Kidcom Regulations that
11 includes confidentiality that the nurses
12 sign, and I have that.
13 JUROR #5: And does that also state the
14 disciplinary measures that occur when the
15 confidentiality is broken? I think we talked
16 about that.
17 THE CORONER: I'll have to interrupt. The
18 issues of discipline you will not be able to
19 make recommendations on, so we will not be
20 providing to you internal disciplinary
21 matters, not that they're not important, but
22 the parameters of a Coroner's inquest do not
23 allow us to speak to issues of discipline or
24 for you to make recommendations regarding

1 changing of discipline.

2 JUROR #1: Yes, I understand that, but I

3 must have misunderstood that we would be

4 getting that. Obviously I misunderstood we

5 would be getting that document.

6

7 BY JUROR #1:

8 Q. So would you say that the care that Lisa

9 received that night was not adequate?

10 A. I would say that the care Lisa received

11 that night was not adequate.

12 Q. Not adequate care, because some of the

13 nurses and nursing educators feel that her care was,

14 indeed, adequate ---

15 A. From the perspective ---

16 Q. --- when they've been asked that

17 question.

18 A. I understand that.

19 Q. Yes.

20 A. From the perspective that there was

21 incomplete monitoring and subsequent incomplete

22 documentation and from the perspective that there was

23 incomplete communication by Dr. Schily in the

24 conversation that he had with Anagaile, that there was

1 incomplete communication on the part of Dr. Schily with
2 respect to providing more detailed information about
3 Lisa's condition, about the multiple medications ---
4 Q. He provided everything on the orders.
5 A. He did.
6 Q. Which were not accessed, everything was
7 there.
8 A. I know.
9 Q. Everything.
10 A. And with respect to the gaps in
11 Kidcom ---
12 Q. And even on the emergency, he said in
13 his testimony, "I did more than that. I said 'See
14 Kidcom orders.'" And he wrote that on his emergency
15 orders.
16 A. That's true.
17 Q. And he said, "I did more than that."
18 A. So all these things together I would say
19 yes, there was substandard care.
20 Q. And as Mr. Gomberg said a little while
21 ago, there were three prompts. I don't think you
22 agreed with the prompts, but whatever they were, they
23 were opportunities for the nurses to get the orders and
24 there were further prompts to that, because nurses know

1 generally that you cannot treat a patient without
2 orders unless you use this clinical judgment.
3 A. Mm-hmm, that's correct.
4 Q. And, golly, it's a good thing there
5 weren't -- I mean, if there were medications -- if I
6 was being treated by a nurse on pure, sheer clinical
7 judgment, I would find that very frightening ---
8 A. Well ---
9 Q. --- because perhaps the doctor has
10 ordered medications for me and I'm not getting them
11 because a nurse is deciding on her clinical judgment
12 what she's going to treat me, how she's going to
13 monitor me and so on.
14 A. I hear what you're saying.
15 Q. I find that very frightening.
16 A. Well, I hear what you're saying, but it
17 happens, it happens all the time.
18 Q. It happens all the time that nurses
19 don't follow orders?
20 A. May I finish? May I finish?
21 Q. Yes.
22 THE CORONER: The witness may finish.
23 THE WITNESS: It does happen all the time in
24 circumstances where physicians have not

1 arrived, where they have not met the patient,
2 when patients are in obvious need of care and
3 that could be patients coming into the
4 emergency room, for instance, having a heart
5 attack, they will get them into a room, give
6 them oxygen, set them up right away, start
7 taking their vital signs and assess the
8 patient until the doctor comes very quickly.
9 We must do that; that is our obligation to
10 the patient.
11 I've had circumstances in the operating
12 room, my own experience, where patients
13 arrive to the operating room bleeding and in
14 shock, where we have not waited for the
15 surgeon to come, but we have begun to prepare
16 that patient for surgery. So, yes, there are
17 times that nurses will exercise their
18 clinical judgment to begin to care for that
19 patient whether or not there are doctor's
20 orders.
21
22 BY JUROR #1:
23 Q. Yes, she begins to care for that
24 patient, but surely in your scenario, they don't wait

1 for hours and hours ---
2 A. No, they don't.
3 Q. --- and still not access orders.
4 A. They don't.
5 Q. Or not phone a doctor or not call a
6 supervisor? I think those are all my questions.
7 A. Thank you.
8 THE CORONER: Ms. Browne.
9 MS. BROWNE: Are you going to get to me or
10 what? When I said I'd pass, I meant I'd pass
11 until the end.
12 THE CORONER: That's why I just mentioned
13 your name. I knew that you had been left
14 out.
15 MS. BROWNE: Thank you. Do you have, Mr.
16 Hawkins, another copy of the CV of Dr.
17 Reeder?
18 THE CORONER: Excuse me, Ms. Browne, the
19 witness would like a ten-minute break.
20 MS. BROWNE: Oh, I'm sorry, Doctor.
21 THE CORONER: So we'll recess for ten
22 minutes.
23
24 --- A BRIEF RECESS

1

2 THE CORONER: Ms. Browne?

3 MS. BROWNE: Thank you very much.

4

5 CROSS-EXAMINATION BY MS. BROWNE:

6 Q. I got this from Mr. Hawkins, it's a copy

7 of the CV of Dr. Reeder and I've only got one, but it's

8 better than nothing for the jury to look on. It's one

9 of the heavier ones, we've had one that was 32 pages

10 long; yours is 18 and I just wanted to ask you a little

11 bit about it, if you don't mind? I note that, with

12 interest, that you've done most of your work in the

13 past in the army, right?

14 A. Yes.

15 Q. So you're a retired colonel?

16 A. I'm a retired colonel, that's right.

17 Q. In the United States Army?

18 A. That's correct.

19 Q. Are you Canadian?

20 A. No.

21 Q. Are you still American?

22 A. Yes.

23 Q. Is there any reason that you came up

24 here? I mean, we'd like to hear it's because of our

1 wonderful system, but you tell us the truth.
2 A. I was looking for a new leadership
3 position when I was preparing to retire from the army
4 nurse core and I heard about this new leadership
5 position that the Hospital for Sick Children created
6 through a colleague of mine at Duke University and she
7 sent me the job description, telling me it had my name
8 on it and she was right, so I called up Sick Kids and
9 they recruited me.
10 Q. I was just wondering if the years of
11 being in an army and being sort of answerable to the
12 one immediately on top of you, isn't that the way it
13 works, that made you want to be in a leadership
14 position?
15 A. I would not enact some of the kinds of
16 leadership styles that I saw in the army nurse core.
17 However, I've said this many times, I've been all I can
18 be in the army and so it was time for yet another
19 direction for my nursing career.
20 Q. Okay. I've been reading through your CV
21 which you did a lot of work in bioethics and ethics?
22 A. I have, yes.
23 Q. And what's bioethics (sic) deal with?
24 A. Bioethics -- I don't know if it is a

1 synonymous term with "clinical ethics," but it is the
2 study and exploration of ethical issues and in this
3 case, in health care, but for me clinical ethics really
4 is, for me, I studied, provided consultation, wrote and
5 effected some of my research on clinical ethics, on an
6 aspect of clinical ethics.
7 Q. It's just when I saw "bioethics" I was
8 thinking about the decisions that I hear are going to
9 have to be made about whether or not we clone people
10 and so on and so forth.
11 A. That's exactly what it's about. It
12 ranges a wide area of ---
13 Q. You also indicated, I guess, in answer
14 to -- I think it was Mr. Krkachovski, that you were not
15 an expert in pediatric clinical nursing?
16 A. No, I'm not.
17 Q. What is your expertise? I look and see
18 a word like ---
19 A. Perioperative nursing.
20 Q. --- perioperative -- yes, can you
21 explain that to me?
22 A. Well, that's a contemporary term for
23 operating room nurse and that is the care of patients
24 before, during and after surgery, but primarily

1 focusing on the intraoperative phase of surgery.
2 Q. So that the "peri" comes from Latin.
3 A. Yes.
4 Q. "Being all around," assisting.
5 A. Yes
6 Q. All around the operation part?
7 A. Mm-hmm.
8 Q. Okay. And you've indicated as I've
9 gathered from all the questions that other Counsel have
10 put to you that this is an ongoing process, the
11 hospital's response to Lisa's death and to this inquest
12 is still going on?
13 A. Absolutely.
14 Q. And after this inquest is finished, you
15 intend to go back with further suggestions?
16 A. Yes.
17 Q. And I take it a lot of the suggestions
18 will be along the lines that we've heard you already
19 answered the jurors questions about some things are not
20 going to be the subject of clinical judgment, some
21 things are going to be followed all around?
22 A. You know, it's a bit pressuring for me
23 to say absolutes here right now, but certainly these
24 are areas where we will go back and continue to discuss

1 them, you know, in an interdisciplinary way so that
2 we're all in common agreement with how we need to
3 proceed forward, but ...
4 Q. Your testimony has been extremely useful
5 as far as indicating what a professional is and what a
6 professional does and what professional must pay
7 attention to with regard to the nursing staff.
8 A. Mm-hmm.
9 Q. It's also true, though, that there are
10 rules binding professionals.
11 A. Yes.
12 Q. If I do something wrong, I get the law
13 society on my (inaudible).
14 A. I can't even comment on the law society.
15 Q. Well, believe you me, they're there.
16 And I understand the need for self-accountability and I
17 don't mean to in any way denigrate that all.
18 A. Mm-hmm.
19 Q. That has come out clear in your evidence
20 that the first thing a person must do is be self-
21 accountable?
22 A. Mm-hmm.
23 Q. But there also must be other people to
24 whom that person is accountable? Agreed?

1 A. Yes.

2 Q. And that a professional must be
3 responsible and accountable to the persons in their
4 field?

5 A. Yes.

6 Q. And that would include superiors at the
7 hospital such as yourself?

8 A. Yes.

9 Q. And your colleagues and so on and so
10 forth?

11 A. Yes.

12 Q. I don't think I have anything more.
13 Thank you.

14 A. You're welcome.

15

16 CROSS-EXAMINATION BY THE CORONER:

17 Q. I've got just one question, Dr. Reeder.
18 You've indicated that this is still an ongoing
19 process. Can I take it from that, that obviously
20 within a day or so this jury are going to be retiring
21 to consider a verdict and whatever their verdict and
22 recommendations, can I assume that the hospital for
23 Sick Kids or someone like yourself and other members
24 are going to look at these recommendations very

1 seriously and implement those that are reasonable and
2 those that are practical, that the part of your
3 finishing process to response at the hospital to Lisa's
4 death will be awaiting what this jury feel your
5 response should be. Is that a fair comment?
6 A. You have my promise that we will
7 certainly review all the recommendations that are made
8 by the jury and continue to refine the things that
9 we've already started, as well as other recommendations
10 that are made, we will certainly consider.
11 Q. Thank you, Dr. Reeder.
12 JUROR #1: May I ask one more question, sir,
13 when the others finish?
14 THE CORONER: Yes.
15 JUROR #1: Is there time now, or ...
16 THE CORONER: Yes, everyone else is
17 finished.
18
19 RE-EXAMINATION BY THE JURY:
20 BY JUROR #1:
21 Q. During the course of this inquest, we've
22 heard -- we've had many surprises, almost daily.
23 A. Me, too.
24 Q. And we've learned new things almost

1 daily and we were some way into the questions -- to the
2 inquest until we began learning about assessment notes
3 that the nurses may write after the shift, until we
4 learned about patient care summaries, until we learned
5 about recording as an exchange from one nurse to
6 another on a shift, until we learned about the Kidcom
7 system that had been recorded for six months but we had
8 just learned of it and so unfortunately that evidence
9 was lost.
10 I want to ask you now because I have
11 never really seen even a mock chart. I mean, I've seen
12 a part of a chart, but I want to ask you now if we have
13 seen every single thing, item, that would be in a chart
14 and be related to Lisa's care, if we have seen
15 everything, if there's anything that hasn't come up
16 that we may have missed, been privy to.
17 A. Okay, and does the jury have an exact
18 duplicate of the patient chart that was finally
19 consolidated by the Coroner's ---
20 THE CORONER: Yes, they do.
21
22 BY JUROR #1:
23 Q. But there would be other things in a
24 normal chart, wouldn't there? There would be, like,

1 lab notes ---

2 A. Oh, yeah, I mean ---

3 Q. I mean a full and complete chart. I

4 mean, we've begun to learn what a chart, what is

5 included in a chart as we've gone along. Is there

6 anything now that we left that we don't know about?

7 A. As far as the patient's chart, to the

8 best of my knowledge ---

9 Q. And storage of information and so on and

10 so forth, is there anything you can think of? Can you

11 assure this jury that we have every piece of

12 information that is available? I know we've missed

13 some, but ...

14 A. As you have been surprised, I have been

15 surprised at some things, but not all things. What I

16 have learned is that the jury and some of the attorneys

17 have placed great importance on several things that we

18 would not consider to be important at all, because they

19 are just day-to-day things that we do in the course of

20 providing patient care, and so it's not that we didn't

21 think about those things, what we didn't think about

22 those things because the importance that you place them

23 now retrospectively is not a part of our thinking in

24 terms of knowing what is appropriate, what would be

1 helpful in the context of a Coroner's investigation.
2 Now, we certainly have a better idea of
3 that, but I believe on behalf of the organization I can
4 give you my best assurance, but I cannot provide 100
5 percent certainty, because even I don't -- cannot tell
6 you sitting here in my leadership role, I don't use
7 patient charts every day, I don't review them by myself
8 every day, that's not -- that isn't my level, and so it
9 would be inappropriate for me to say with 100 percent
10 certainty I can assure that you have everything in
11 those patient charts. My hope is that you do. That's
12 the best I can say.
13 THE CORONER: Thank you, Dr. Reeder.
14 THE WITNESS: That's it?
15 THE CORONER: That's fine, thank you.
16 MR. HAWKINS: A couple of things, Dr.
17 Cairns, before we close ---
18 THE CORONER: Yes, please.
19 MR. HAWKINS: --- for the day. The jury had
20 asked about the -- and maybe there was some
21 misunderstanding of what was asked about the
22 Kidcom policy. What I have are the two, sort
23 of, Kidcom agreements that were signed by
24 Nurses Doerksen and Soriano, along with the

1 regulations on access to Kidcom, user
2 identification and confidentiality, which I
3 can file as an exhibit.
4 THE CORONER: That would be the next
5 exhibit, then.
6 CONSTABLE CULLETON: Exhibit 69.
7
8 EXHIBIT NO. 69: Kidcom confidentiality
9 agreements signed by Nurses
10 Doerksen and Soriano
11
12 MR. HAWKINS: The next thing which I would
13 just propose to file collectively as an
14 exhibit, the jury had also asked for the
15 training manuals which were delivered to me
16 today for the Kidcom. This is in three
17 packages; the physician training manual, a
18 nursing handout binder and then a nursing
19 training manual.
20 MR. GOMBERG: Okay, I don't have any
21 objection to it, but I haven't seen it, but
22 it's fine by me.
23 MR. HAWKINS: These arrived halfway through
24 the afternoon.

1 MR. GOMBERG: No, I'm not complaining, I'm
2 just saying I haven't seen it and quite
3 frankly, I don't really feel like reading it
4 tonight, so good luck to the jury.
5 THE CORONER: You can put those collectively
6 as the next exhibit, (A), (B), and (C), if
7 you like.
8 CONSTABLE CULLETON: That will be Exhibit
9 70, (A), (B) and (C).
10
11 EXHIBIT NO. 70: (A) Kidcom in-patient
12 training binder
13 (B) Kidcom physician training
14 binder
15 (C) Kidcom current
16 instructor's nurse training
17 binder
18
19 THE CORONER: I should comment at this time,
20 ladies and gentleman of the jury, we have, I
21 think, been sitting for a total of 15 days.
22 There are some questions that have been
23 answered, hopefully, to your satisfaction.
24 There are others that, unfortunately, you

1 will have to make the decision on.
2 I have reviewed with my staff and I have
3 also discussed this with all the Counsel in
4 the room: is there any other witnesses that
5 can be brought before you that can help you
6 in any further way possible? And the answer
7 I've got from both my own perspective and the
8 others, you have heard a number of names
9 mentioned. Those people have been checked
10 out, they have nothing that they can add or
11 subtract that will assist you in sorting out
12 some of the conflicts that still will remain
13 at the end of the evidence.
14 I did poll all Counsel this afternoon in
15 that regard, they're all in agreement with me
16 that the calling of further witnesses will
17 not do anything to assist you in the role
18 that you have, so that with that in mind,
19 this will end the witness part of the
20 inquest.
21 You can and it will be, hopefully, part
22 of your recommendations, and it's already
23 been discussed in terms of both delays in the
24 initiation of this investigation by some

1 people from my office and by interaction with
2 Sick Kids, if this had been done in November,
3 some of those people may be available and
4 that will certainly -- should form part of
5 your investigation, but I really don't see
6 any point in my dragging another seven
7 witnesses who will not really be able to help
8 you in answering your questions and coming to
9 further recommendations, but I did want to
10 put that on the record that I have tried to
11 identify them and that I think I can speak
12 for all Counsel, they don't need to stand up,
13 but that they really don't think there's
14 anything further that can be gained from
15 that.
16 So it's my intention now to adjourn
17 until 11:00 a.m. tomorrow morning, at which
18 time we will start closing addresses. There
19 will be a meeting at 9:00 a.m. of Counsel so
20 that they can discuss those recommendations
21 that they may feel that they are all in
22 agreement with and therefore shorten some of
23 their addresses.
24 So it is the intention that you will get

1 closing addresses from all Counsel tomorrow
2 and a summation by myself; that should be
3 able to be completed by tomorrow and then you
4 will be free to deliberate on your verdict.
5 I'm not sure how long your verdict is going
6 to take, but unlike a criminal jury, you will
7 not be sequestered, you can come in and do a
8 normal working day of 10:00 to 4:00 or 9:30
9 to 4:30, whatever you feel is necessary and
10 you may take as many days as you feel are
11 necessary and you may take as many days as
12 you feel are necessary, as well. There will
13 be no pressure on you in that regard. So,
14 Constable, we'll adjourn until 11:00 a.m.
15 tomorrow morning with a meeting at 9:00 a.m.
16 for all Counsel.
17
18 --- ADJOURNED.
19
20
21
22
23
24

1 THIS IS TO CERTIFY that the foregoing
2 is a true and accurate transcription of
3 my recordings and notes, to the best of
4 my skill and ability.
5
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8
9
10 Barbara A. Pollard
11 Certified Court Reporter
12
13
14
15 Photostatic copies of this transcript are not certified and
16 have not been paid for unless they bear the original
17 signature of Barbara Pollard, and accordingly are in direct
18 violation of Ontario Regulation 587/91, Courts of Justice
19 Act, January 1, 1990.