

INQUEST INTO THE DEATH OF

L I S A S H O R E

EVIDENCE OF DR. MORTON REINGOLD

TAKEN FEBRUARY 1, 2000

BEFORE DR. JAMES CAIRNS, DEPUTY CHIEF CORONER

CORONER'S COURT, TORONTO

A P P E A R A N C E S:

Counsel for the Coroner	MARGARET BROWNE, MS.
Counsel for the Shore Family	FRANK K. GOMBERG, ESQ.
Counsel for the Hospital for Sick Children, et al	PATRICK HAWKINS, ESQ. RENEE A. KOPP, MS.
Counsel for Drs. Schily, Catre and Wright	ANNE POSNO, MS.
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1 DR. MORTON REINGOLD, SWORN

2 EXAMINATION IN-CHIEF BY MS. BROWNE:

3 Q. Dr. Reingold, I understand you are a
4 medical doctor, correct?

5 A. Yes.

6 Q. And can you just tell us where you were
7 educated, and where you practised?

8 A. I graduated from University of Toronto
9 Medical School in 1978 and subsequently I practised in
10 a private general practice in Toronto at 845 St. Clair
11 West. I have also practised emergency medicine at
12 Humber River Regional Hospital, and I was appointed a
13 Coroner in October of 1991.

14 Q. And perhaps you would just explain for
15 the benefit of the jury and anyone else what the --
16 what you do as a Coroner?

17 A. As a Coroner, I am responsible for
18 investigating deaths that obviously fall within the
19 jurisdiction of the Coroner's legislation, and the
20 investigation of the death then proceeds, and it
21 entails any number of other variables, and ultimately
22 preparing a report to the Coroner's Office as to my
23 findings and, as well, I myself do conduct inquests as
24 an Inquest Coroner.

1 Q. In fact you did one with me.

2 A. Yes.

3 Q. I understand, Dr. Reingold, that when
4 you talk about deaths that fall under the auspices of
5 the Coroner's Act, that includes a lot of deaths which
6 are mandatory to be investigated and have an inquest.
7 One is all deaths in prison, is that correct?

8 A. Correct.

9 Q. In custody.

10 A. Mm-hmm.

11 Q. All construction deaths have to be
12 investigated, and so on. There's a certain limit to
13 mandatory inquests. And this one is not a mandatory
14 inquest, correct?

15 A. Correct.

16 Q. This is discretionary. This was called
17 for to examine whatever issues came out in the inquest?

18 A. Yes.

19 Q. Tell me when you became involved. Did
20 you go to the hospital the night that Lisa died, or the
21 morning, or the day?

22 A. I was called on the morning of October
23 22nd, 1998, and my records show that, in fact, the
24 Coroner's dispatch office, which is the office that
25 calls the individual coroners to investigate a death,

1 received the call at about 8:22 in the morning, and I
2 was called at 8:38 that morning with the name and
3 hospital, et cetera, to investigate this particular
4 death.

5 Q. I should probably have added that you're
6 responsible for a certain area of Toronto, a
7 geographical area where deaths occur.

8 A. Correct. I predominantly am responsible
9 for central Toronto.

10 Q. Central Toronto, okay. And tell me what
11 you found when you got there, and what steps you took.
12 Where did you go? What did you see?

13 A. Sure. Well, I arrived at the hospital
14 shortly after receiving the call, it might have been
15 somewhere around 9:00 or 9:30 in the morning, and I
16 proceeded to the nursing station where Lisa's death had
17 -- the nursing station at the ward where Lisa's death
18 had occurred. I first met with the nursing staff at
19 the ward, and asked them to review with me the events
20 of the previous evening in terms of her stay in the
21 Emergency Department, medication she had received
22 there, and her then transfer to the ward, and what had
23 transpired over the evening hours in terms of
24 medications received, as well. I then reviewed her
25 hospital chart which was provided to me at the nursing

1 station, and after reviewing the hospital chart, I
2 proceeded to the room and where Lisa's body was still
3 remaining.

4 Q. All right, and anything further?

5 A. At that point I reviewed the -- went
6 into the room, and I saw her body which was still on
7 the hospital bed. I saw some infusion equipment that
8 was still attached to her via intravenous lines and
9 made some notes of that equipment, and then returned to
10 the nursing station to prepare some of my warrants that
11 needed to be done for my investigation.

12 Q. So the warrants that you were preparing,
13 how were the warrants used, to seize equipment, to
14 seize records, to seize whatever?

15 A. My warrants were to -- firstly, to order
16 an autopsy to be performed on Lisa, and secondly, to
17 insure that the equipment that I was aware of, mainly
18 the infusion pumps, morphine equipment, that that was
19 sequestered for the Coroner's office so that that
20 equipment could be reviewed and analyzed as indicated.

21 Q. And you said you were aware of infusion
22 pumps, or tube pumps that you became aware of?

23 A. Correct, I was aware of a IVAC pump, and
24 a PCA pump.

25 Q. At that time, were you aware of any

1 monitor?

2 A. No, I wasn't.

3 Q. All right. And what did you do with the
4 IVAC and the PCA, or what did you order done?

5 A. I ordered that they be sequestered for
6 the Coroner's office.

7 Q. And I understand, I don't think there's
8 any question about this, it's admitted by all Counsel
9 that eventually as a result of your sequestration of
10 the two pumps, they were sent off to the States to be
11 examined at a unit called ECRI; can you just tell me
12 what that stands for E-C-R-I? Do you know?

13 A. I don't know what it stands for.

14 Q. Okay.

15 MR. HAWKINS: Emergency Care Research
16 Institute, I believe.

17

18 BY MS. BROWNE:

19 Q. Thank you, Mr. Hawkins. We've heard
20 already evidence that they went there. They came back
21 and that they were examined and that they were ---

22 A. Yes.

23 Q. --- in good working order.

24 A. Yes, I received those reports.

25 Q. Apart from the sequestering of the

1 equipment and getting -- making sure it was sent away,
2 what were your next steps to -- did you do anything
3 else after that?

4 A. I ---

5 Q. On that date?

6 A. On that date, I talked to some family
7 members that were still at the ward, and informed them
8 that an autopsy was being ordered. And I think that
9 was about it after -- until I spoke to the pathologist
10 basically to alert the pathologist at Sick Kids of the
11 nature of the investigation, and what my concerns were.

12 Q. Right, and I understand that as a result
13 of the steps that you took, that eventually there was
14 an autopsy and we've had the pathologist testify.
15 We've had, or at least somebody testified for him, and
16 we've had his report entered. So you received a copy
17 of his report also?

18 A. Yes. Mm-hmm.

19 Q. Anything, any other steps that you'd
20 taken? Did you receive any correspondence, did you
21 become aware of any correspondence later on?

22 A. Later on? Yes.

23 Q. Could you tell us what -- who you
24 received letters from?

25 A. Well, in December of '98 ---

1 Q. December, right.

2 A. Dr. William Lucas, who is the Regional
3 Coroner for Toronto, contacted me about a letter he had
4 received from the family via Mr. Gomberg, the -- who
5 was acting on behalf of the family. And in that
6 letter, he advised me that there were many questions
7 that the family had and that they had areas of concern
8 that they wanted responded to, and Dr. Lucas forwarded
9 that letter to me so that I could follow up with it.

10 Q. And what follow-up steps did you take?

11 A. I arranged a meeting at the Hospital for
12 Sick Children.

13 Q. Can you tell me when and where this was
14 arranged?

15 A. Yes, that meeting occurred on March the
16 1st of 1999 at the Hospital for Sick Children in a
17 conference room, and at that meeting I attended and the
18 staff from Hospital for Sick Children who attended the
19 meeting were Cathy Seguin, Director of Surgical
20 Services, that's S-E-G-U-I-N; James Wright, Staff
21 Orthopaedic Surgeon; Marion Stevens who is a Risk
22 Manager; and Larry Roy, R-O-Y, who is the Anaesthetist-
23 in-Chief of the hospital.

24 Q. Before you arranged for this meeting to
25 -- or to answer certain questions that Dr. Lucas had

1 passed on to you, had you heard anything further about
2 a Corometric monitor or received any further
3 information for the charts?

4 A. No. My review of the -- at the time I
5 was at the hospital for my initial investigation, I did
6 not see anything in the chart indicating the use of a
7 Corometric monitor. There was no notation that I saw
8 about it, and when I discussed the events with the
9 staff at the nursing station, I was not advised of this
10 Corometric monitor. So, in fact, I had not heard of
11 the Corometric monitor up until the point I received
12 this letter.

13 Q. Did you see any Corometric monitor at
14 the hospital?

15 A. I did not. I cannot say I saw it, but I
16 also cannot say I was actually looking for it.

17 Q. All right.

18 A. Because I wasn't aware of it.

19 Q. Now, what about orders? Did you receive
20 parts of the chart at a later date, suspended orders?
21 Did you become aware of that?

22 A. I only -- if you're referring to the
23 Kidcom orders?

24 Q. Yes, I am.

25 A. I was not aware of those orders at the

1 time I reviewed the chart. I was only aware of the
2 hard copy of the chart, and whatever handwritten orders
3 were in that chart that I reviewed. I did become aware
4 of the Kidcom orders at this particular meeting.

5 Q. That's the first time you became aware?

6 A. Correct.

7 Q. All right now, let's just -- tell me
8 where this meeting was, and where it was held, and how
9 long it took, and you've already told us who attended.

10 A. Yes, I mentioned it was at the Hospital
11 for Sick Children in a conference room, the exact
12 conference room I can't tell you. And it, the meeting,
13 I believe, lasted about an hour and a half.

14 Q. And this was for the purpose of
15 answering questions that Dr. Lucas had received and
16 passed on to you?

17 A. Yes.

18 Q. Is that correct?

19 A. Yes.

20 Q. I gather these are the questions that
21 have been marked as an Exhibit and they are also --
22 there's seven panels, let me find them.

23 A. It's a letter dated December the 11th,
24 1998.

25 Q. Yes, and if I could just refer to -- if

1 you could find those panels, it's Exhibit 39, and
2 members of the jury this is -- it's also included --
3 where would it be included? I'm just looking for the
4 number, maybe you could help me, Detective Culleton
5 (sic) of the actual letters, which were made copies.

6 THE CORONER: It's my recollection that
7 perhaps it was just the blow-ups that were
8 made copies.

9
10 BY MS. BROWNE:

11 Q. It's just the -- okay, so we're going to
12 have to go through the blow-ups, then. All right. One
13 other thing; you made notes at this meeting?

14 A. I did make some notes.

15 Q. And you have them in front of you today?

16 A. Yes.

17 Q. And I would ask that perhaps you want to
18 keep those; you have a photocopy that could be made an
19 Exhibit?

20 CONSTABLE CULLETON: Exhibit 48.

21
22 --- EXHIBIT NUMBER 48: Notes of Dr. Reingold from HSC
23 meeting dated March 1, 1999

24
25 MS. BROWNE: Forty-eight? And Counsel have

1 copies?

2 MR. GOMBERG: Yes.

3 MS. BROWNE: And I have five, let's see,
4 I've got five left, but I haven't got one for
5 me, so I'll give the jury four, and I'll keep
6 one.

7

8 BY MS. BROWNE:

9 Q. Did you make these notes?

10 A. Yes, I made these notes.

11 Q. As you went through ---

12 A. Yes, with the understanding that there
13 was going to be a formal response, in any event, by the
14 Sick Kids staff which I subsequently received as well.

15 Q. All right. The letters, the questions
16 were all contained on that, those series of panels
17 beside you, and I know it's probably difficult for you
18 -- could you just look over and see if, if -- I don't
19 expect you to carry them all, but just have a look and
20 see if they're the queries that you were addressing in
21 that meeting?

22 A. Yes. Yes, this corresponds to the
23 letter.

24 Q. All right. And the response letter was
25 -- did you write that, to the Shore Family? The March

1 the 3rd letter?

2 A. No.

3 Q. Who was responsible for that?

4 A. I received a letter dated March the 3rd
5 from Marion Stevens, Risk Management, from the Hospital
6 for Sick Children.

7 Q. All right. Can you just -- we have
8 these also in blow-up, but not in ... And you
9 received these from Mr. Gomberg. If you could perhaps
10 put these letters in the front, Detective Culleton
11 (sic)?

12 A. Yes, this corresponds to the letter that
13 I have.

14 Q. And the letter is from whom?

15 A. Marion Stevens.

16 Q. And what does it say, basically, the
17 letter?

18 A. The cover letter?

19 Q. Yes.

20 A. Basically, that I can -- she's enclosing
21 a copy of the response to the questions to the letter
22 from Mr. Gomberg to the Coroner's office. They're
23 assembled -- it says:

24 "... These answers were assembled

25 following our meeting with you on March

1 the 1st, 1999. These written responses
2 were reviewed and edited by myself ..."
3 meaning Marion Stevens, Cathy Seguin,
4 Lawrence Roy, and James Wright. And then she just goes
5 on to summarize.

6 Q. All right, and then, now if you could
7 just -- you can leave them there, or put them back,
8 whatever. The jury will be able to look at them, but
9 we don't have a paper copy; maybe we could get one. In
10 the meantime, would you just tell us what went on at
11 that meeting and refresh your memory from anything that
12 you need, from either the blow-ups or the notes that
13 you made. How did it proceed? Was it you asking
14 questions, and ...

15 A. Basically, yes, I asked them all of the
16 questions that were contained in the letter because I
17 wanted to be sure that the family's questions here were
18 -- were all covered at this meeting. And I had spoken
19 to the family ahead of this and advised them that I was
20 going to meet with the staff, the hospital staff, to
21 try to at least get them some preliminary answers to
22 these questions while we were still waiting for all of
23 our autopsy and toxicological testing reports. And so,
24 basically, I went through the questions one at a time,
25 and asked them to respond to them and explain

1 themselves in terms of the various questions.

2 Q. Okay, and if you can just, looking at
3 your own handwritten notes, indicate on the first page
4 of your notes, which you made I take it as the meeting
5 progressed?

6 A. Yeah, I made some handwritten notes.

7 Q. That you received some information about
8 the Corometric monitor?

9 A. Yeah, that was one of the first topics
10 of discussion.

11 Q. And what exactly does it say in your
12 notes about what information you got?

13 A. I just -- my notes here say that it
14 monitors heart rate and respiratory rate; that the Pain
15 Service and Anaesthesia service would order this type
16 of device to be used; that the monitor was, apparently,
17 was to be applied on the ward upon arrival. And
18 apparently, I wrote here that Nurse Doerksen ---

19 Q. Why did you write that? Was that ---

20 A. I wrote here that it was to be applied
21 on the ward by Nurse Doerksen.

22 Q. Mm-hmm.

23 A. And then I wrote in brackets "not
24 documented." In other words, it's not written -- when
25 I read the chart, there was no documentation of that

1 actually being done, even though it was apparently to
2 have been done, or was done, according to the hospital
3 staff. And I've made a note that the actual Corometric
4 monitor itself is not connected to the nursing station,
5 meaning that if it alarms, it alarms locally, not by
6 any type of telemetric device to the nursing station
7 itself. And I made a note that there was no memory on
8 the device.

9 I have made a note that there was hourly
10 nursing rounds. Now, this is not necessarily
11 corresponding to the Corometric monitor. And at that
12 time (inaudible) heart rate and her respiratory rate
13 were to be documented, and this was part of the,
14 apparently, part of the PCA pump protocol, not
15 necessarily related to the Corometric monitor protocol.

16 Q. Do you know from whom you got this
17 specific information, or was it sort of a round table?

18 A. It was more or less people discussing,
19 right. I can't -- it's not specific. I can't tell you
20 that.

21 Q. But everything you recorded is
22 information you got from somebody at that table?

23 A. Exactly. That was ...

24 Q. All right. After what you've got about
25 the rounds, what's the next part? Is this the Kidcom?

1 A. Yeah, there's a note here that the
2 Anaesthesia Service had ordered vital signs Q1H,
3 meaning Q hourly, and this apparently was on Kidcom,
4 and I wrote here, "was not activated by the nurse,"
5 meaning the Kidcom order was not activated.

6 Q. Okay, did you -- do you know who told
7 you that?

8 A. No.

9 Q. Do you know why it wasn't activated?
10 Did they say?

11 A. No.

12 Q. Okay. Can you go on?

13 A. I also wrote that the -- these are just
14 some of the anaesthetic orders that were provided,
15 namely vital signs Q hourly, that a Corometric monitor
16 be used, and that a saturation monitor also be used, an
17 O2 SAT monitor. Then I wrote in brackets "they were
18 not applied," meaning that I was told that that was
19 actually not used.

20 Q. Another name for that SAT monitor is
21 oximeter?

22 A. I would think so, yes.

23 Q. The next notes you have there?

24 A. That -- that she was also to have a
25 sedation scale monitor, which is a clinical sedation

1 scale, and I wrote that that was not done. And she was
2 also to have a pain scale monitor, and that was not
3 done.

4 Q. And the next note you have?

5 A. Well, the next note then goes on to
6 question -- I made a note here, number six, which I
7 take it means I was -- a response to question number
8 six.

9 Q. And question number six, just to refresh
10 our memory. Could you just look down there, or just
11 read from your notebook?

12 A. Lisa's -- there's some notes, notations
13 about her pulse rates at various times throughout the
14 morning, early morning. Why didn't anyone take Lisa's
15 blood pressure to investigate the climb in her pulse?
16 Over 90 per minute -- over a 90-minute period rather,
17 of some 48 beats per minute in a sleeping child. If
18 Lisa's blood pressure was taken, why isn't it recorded
19 anywhere? In my response, or the response I've written
20 here is that "BP was taken initially but not again."
21 And then I wrote here, "Would have been had the Kidcom
22 orders been activated."

23 Q. The next page of your notes?

24 A. These, incidentally, are corresponding,
25 again, to -- to have the typed response in the letter

1 from Marion Stevens.

2 Q. Yes, yes. Mm-hmm.

3 A. Okay. Next, it looks like questions 7
4 and 8, response. And I've read in here that the ---

5 Q. This looks -- could you put up on the --
6 so the jury can see what shows questions 7 and 8, so
7 that they can see that?

8 A. So there's your further questions with
9 regard to the Corometric monitor.

10 Q. What is -- can you read the questions
11 out?

12 A. "... Was the monitor ever applied to
13 Lisa? If it was applied, was it removed
14 at some time before Lisa died? When?
15 If it was applied and not removed, why
16 didn't it sound an alarm when her heart
17 stopped beating? If a monitor was used,
18 then has that monitor been segregated
19 and/or looked at in order to determine
20 whether it was functioning; or if it had
21 a memory that -- or if it had a memory,
22 has that memory in some way been
23 preserved? ..."

24 Obviously, that is the concern that you
25 had vis-a-vis the PCA morphine pump. It seems to me

1 that the same concern would be appropriate in terms of
2 the Corometric monitor.

3 Q. What was said?

4 A. Then, my written notes --- I was told
5 that the monitor was on at 06:00 in the morning, and
6 apparently working. That when her -- when the -- but
7 when she was found to be lifeless in the morning, that
8 there were leads attached to the body, or patches or
9 leads on the body. And the monitor, I was told the
10 monitor was in the room. The actual monitor itself, I
11 was told was not segregated. I was told that the
12 monitor sounds if certain thresholds with respect to
13 heart rate and respiratory rate are broken.

14 And I was told that the nurse had turned
15 off an apnea control at some point after several alarms
16 had gone off, and the nurse being concerned that the
17 child wasn't getting sleep because of the false --
18 because of the alarms going off. And I was told that
19 the physician was not consulted with respect to turning
20 off that particular control.

21 Q. And that was the information you
22 received about those specific questions that you
23 referred to?

24 A. Yes.

25 Q. And I take it that you used that

1 information to respond, to make sure a response was
2 sent back to the family with regard to that.

3 A. Well, the -- I spoke to Mrs. Shore after
4 that meeting and told her some of the information I had
5 and also some of the concerns that I had, as obviously
6 the family did, with respect to this monitor, and the
7 Kidcom orders, and so on. And actually the
8 investigation was still being pursued.

9 Q. The next matter you get to in your notes
10 is number, I think, nine?

11 A. Nine.

12 Q. And could you just -- is nine up there,
13 beside you?

14 A. Yes.

15 Q. Would you read it so that the jury can
16 hear it?

17 A. The post-mortem added nurse's note at
18 9:00 a.m. indicates that:

19 "... A doctor was made aware of the
20 change in Lisa's respiratory rate.
21 There was no notation that a doctor was
22 told of the very dramatic change in her
23 heart rate. Would you please find out
24 why that was not dealt with at all, or
25 at least was not recorded in the nurse's

1 note? ..."

2 Q. And you tried to find out why?

3 A. Yes.

4 Q. And what were you told?

5 A. It appeared there was some controversy.

6 The -- I have noted here that the doctor was advised,
7 or M.D. I wrote "was advised of the vital signs." This
8 is a nurse's recollection only. Heart rate -- in fact,
9 the heart rate was not documented anywhere, this change
10 of heart rate. And I was told that the doctor who
11 apparently was involved in this dialogue had no
12 recollection of this heart rate, or dramatic -- or this
13 change in heart rate.

14 Q. Over on the side there, I can't read
15 your writing.

16 A. I'm sorry.

17 Q. Over on the side there, in your notes,
18 you've got ---

19 A. 04:00?

20 Q. Your writing is terrible.

21 A. Yes.

22 Q. 04:00?

23 A. 04:00

24 THE CORONER: He is a doctor, after all.

25 THE WITNESS: 04:00.

1

2

BY MS. BROWNE:

3

Q. All right.

4

A. Which I take it, I was told, was roughly when this -- I take it this is probably when that change occurred, but I would have to look up to confirm that.

8

Q. Is there anything more with regard to the answer for number -- for question number nine?

9

10

A. No.

11

Q. And can you just, I wonder, Detective Culleton (sic), could you give him the board that shows answer number nine? The jury -- unfortunately, we just don't have this on paper.

12

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15

A. Mm-hmm.

16

Q. Hold on just a second there, and we'll put it up, and then you can read the answer to number nine that was eventually sent to the Shores. Can you just read from that so that the jury can follow along?

17

18

19

20

A. I can read it from mine.

21

Q. Yeah.

22

A. It's the same thing. The nurse called the pain service fellow and has documented that the pains that the "pain service aware." She recollected that she reported Lisa's respiratory rate, heart rate

23

24

25

1 and sedation level at 02:50 hours. She has documented
2 that she took away the PCA pump by removing the hand-
3 held device. This hand-held device allows the patient
4 to signal the PCA pump to administer additional drug.

5 Q. All right. Now, the next note that you
6 have?

7 A. Well, this actually -- sorry, this looks
8 like it is actually, sorry, on my next page, is a
9 continuation of number nine. I've written, "Nurse
10 paged M.D. 02:50. Claims M.D. not return." I guess
11 it's "call not returned. Disconnected PCA pump."

12 Q. Right. Next, the next question?

13 A. Number 14.

14 Q. 14? Can we just see question 14, then?

15 A. The Flow Sheet in the Emergency
16 Department indicates that Lisa received ---

17 MR. GOMBERG: Mr. Coroner, just to be of
18 some assistance, since the jurors don't have
19 it, I wonder if there's some way that we can
20 put the blow-ups closer to them, seeing as
21 though Dr. Reingold is not referring to the
22 blow-ups in any event.

23 THE CORONER: That would be very useful,
24 thank you.

25 THE WITNESS: Okay, number 14.

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BY MS. BROWNE:

Q. Question number 14. Don't read it too quickly, because some of us don't have it here.

A. Okay. The Flow Sheet in the Emergency Department indicates that Lisa received 10.2 milligrams of morphine, which ---

Q. Too fast, you're too fast. Slow down, and speak up.

A. The Flow Sheet in the Emergency Department indicates that Lisa received 10.2 milligrams of morphine, which was absorbed from the PCA pump. This was in addition to the two boluses of morphine that she received at 2 milligrams each, a total of 4 milligrams. As such, Lisa received 14.2 milligrams of morphine in 90 minutes. However, the Death Summary written by Dr. James Wright states that, "She was transferred to the ward having received a total of 11.5 milligrams over an approximately three-hour period." Why the discrepancy?

Q. Right, and your discussion revealed?

A. I was told that in the Emergency Department, she did receive an IV bolus of 2 milligrams times two, equalling 4 milligram total. And then on the PCA pump, she received 1.5 milligrams times 7 which

1 worked out to 10.5 milligrams, giving a 14.5 milligram
2 total infusion, for a total dose.

3 Q. And that was part of the answer that was
4 sent back to the Shores, that ---

5 A. I'd have to refer to the -- yes, the
6 written response from the hospital says that morphine,
7 14.5 milligrams, is the actual total dose Lisa
8 received. And then it goes on to explain the
9 parameters of how it was given in terms of the boluses
10 and then the PCA pump.

11 Q. I'm afraid we're going to have to ask
12 you, Detective Culleton (sic), to come over here and
13 grab the answer here, number 14? Sorry about this.
14 You have the answer there with you. You have the
15 letter.

16 A. I don't need the bristol boards. Yeah.

17 Q. So you can read while Detective Culleton
18 shows this to the jury.

19 A. I can read it if you'd like?

20 Q. You can read it more slowly.

21 A. Number 14?

22 Q. Yes.

23 A. Okay.

24 "... Morphine, 14.5 milligrams is the
25 actual total dose Lisa received. This

1 includes the 10.5 milligrams from the
2 PCA pump and two boluses, two bolus
3 doses of two milligrams each, four
4 milligrams total bolus. Lisa did not
5 receive any morphine on the unit 5A.
6 Dr. Wright has agreed that the total
7 amount of morphine was 14.5 milligrams.

8 Dr. Wright agrees that the morphine
9 which Lisa received was in the Emergency
10 Department prior to the admission to the
11 unit ..."

12 Q. And I -- on your own notes here,
13 underneath the 14.5 total, what's the next line? I
14 cannot read that.

15 A. I wrote, "Dose, 26 minutes, not to
16 exceed 20 milligrams over ---

17 MR. GOMBERG: "Two hours."

18 THE WITNESS: "Two hours."

19
20 BY MS. BROWNE:

21 Q. So that's ---

22 A. Thank you.

23 Q. So that's the way the PCA worked, that's
24 how it was programmed, the PCA?

25 A. I believe so, yes.

1 Q. All right. Now 15? What's the next
2 question, 15?

3 A. Question 15:

4 "... Why was the doctor's response to a
5 diminished rate of respiration to remove
6 the PCA when she hadn't received any
7 hits in several hours, and was asleep.
8 Why weren't other issues considered, to
9 explain a diminished rate of
10 respiration? ..."

11 Q. And ---

12 A. I've written, and I've just written
13 here, "nurse already disconnected machine at 02:00,
14 roughly 02:00 hours," and that was the only response I
15 received at that point in time, so there was not ---

16 Q. And so that -- what is the answer to
17 number 15 on the board?

18 A. On the written response from the
19 hospital for questions, and they describe this as a
20 response to 15 and 16:

21 "... The physician from the Pain Service
22 said that he asked if the vital signs
23 were normal and was told they were. He
24 said to remove the PCA pump to ensure
25 Lisa did not administer any additional

1 morphine, and was told it had already
2 been removed. He said that he would
3 have come in to assess Lisa if he had
4 felt it was necessary. He also said he
5 told the nurse to call back if
6 concerned, and he did not have any
7 further calls that night ..."

8 Q. Just, now, if you could look at your
9 notes, because you read out what you had recorded in
10 your notes with regard to 15, and combined it with 16?
11 15's supposed ---

12 A. Yes.

13 Q. --- to be the nurse already disconnected
14 the monitor ---

15 A. At roughly 02:00.

16 Q. At roughly 02:00, and then what do you
17 say?

18 A. At 16 I've written:

19 "... Dr. Schily, Marcus, the Anaesthesia
20 fellow, not aware of heart rate ..."

21 I take it, that was -- he was not at the
22 meeting, but I take it that was a response that someone
23 told me that was basically what his response to that
24 issue was.

25 Q. So somebody at that meeting, one of

1 those persons there, told you that from what they knew,
2 Dr. Schily had not been aware of the heart rate at all?

3 A. Was not aware of the heart rate issue.

4 Q. And the last little ---

5 A. "Respiratory rate less than 11, call
6 M.D." That might have been his instruction, I -- to
7 call if the respiratory rate dropped below 11.

8 Q. Where did you get that information?

9 A. Again, it would have been someone at the
10 meeting would have told me. That might have been one
11 of the parameters that the Anaesthesia fellow would
12 have indicated.

13 Q. All right. Anything further you can
14 recollect at that meeting?

15 A. No.

16 Q. And the results of that meeting -- you
17 can put them back, Detective Culleton (sic). We'll try
18 to get a paper copy at the next break. As a result --
19 after that meeting occurred, what was your next
20 involvement, Dr. Reingold?

21 A. Basically, just following up on the
22 reports that I was receiving in terms of the autopsy
23 report, the toxicology, and ultimately the equipment
24 which had been sent off for analysis.

25 Q. Okay, what do you -- how do you follow

1 up?

2 A. I received the autopsy report and the
3 toxicology reports as they become available.

4 Q. And did you forward them to anybody
5 after that, or did you keep them, or, did they go back
6 to Dr. Lucas, or ...

7 A. Well, they -- there was an ongoing
8 correspondence obviously between the family and through
9 -- in the Coroner's office and ultimately the family
10 was provided with the autopsy report and the toxicology
11 report through the Coroner's office. I myself -- it
12 was actually arranged through a meeting at the
13 Coroner's office.

14 Q. And you were at the meeting, and the
15 family was at the meeting?

16 A. No, actually that was Dr. Cairns.

17 Q. Dr. Cairns. So by this point, it had
18 passed on to someone else?

19 A. Yes.

20 Q. And that concluded your involvement?

21 A. At that point, yes.

22 Q. You were the investigating Coroner at
23 the time?

24 A. That's right.

25 Q. But when it was marked for inquest, it

1 was ---

2 A. Well, at this point, it had become
3 apparent that it -- it was becoming very difficult
4 management-wise, in terms of also various parameters
5 here with the hospital, and the family, and lawyer and
6 so on, and it became apparent to me that it best be
7 handled by someone senior at the Coroner's office.

8 Q. Dr. Cairns being a little senior to you?

9 MR. GOMBERG: He's got more gray hair.

10 MS. BROWNE: Okay, thank you very much, Dr.
11 Reingold, but stay there, I'm sure that we'll
12 have more questions for you.

13 THE CORONER: Mr. Krkachovski.

14 MR. KRKACHOVSKI: Thank you, Mr. Coroner.

15

16 CROSS-EXAMINATION BY MR. KRKACHOVSKI:

17 Q. Dr. Reingold, if I can just take you
18 back to the beginning, sir; who specifically notified
19 you on the morning of October the 22nd?

20 A. The specific person?

21 Q. Do you know?

22 A. No. It could be looked up, but, I mean,
23 it was a dispatch attendant at the Coroner's office.

24 Q. From the Coroner's office?

25 A. Yes.

1 Q. And do you have any recollection as to
2 what you were told?

3 A. Specifically, no. But my recollection,
4 exact words, no, but my recollection would have been
5 that a child had died on the ward, and everything was
6 still at the ward in terms of her body, and the
7 hospital chart, et cetera and that would have been
8 about it, probably.

9 Q. All right. And somehow you knew to go
10 to Ward 5A. Is that information that was relayed to
11 you during the phone call, or did you go somewhere in
12 the hospital?

13 A. No, I would have been told also the
14 ward.

15 Q. All right. To your knowledge, was any
16 instruction given to the hospital before your arrival
17 regarding the removal of equipment or anything they
18 should do specifically, pending your arrival?

19 A. No, not to my knowledge.

20 Q. And have you learned as to whether at
21 the time the hospital had an internal protocol in terms
22 of how to deal with sudden, unexpected deaths?

23 A. I'm sorry? Can you repeat that
24 question?

25 Q. Were you aware at the time if the

1 hospital had a protocol as to how to deal with
2 unexpected deaths?

3 A. I was -- I can't say I know their
4 protocol. I can only say that most hospitals, or all
5 hospitals that I go to as an investigating Coroner,
6 know that when there is an unexpected death, especially
7 if there is unexplained circumstances, that the body
8 and any relating equipment is not to be touched until
9 such time as the Coroner releases it.

10 Q. But I gather you haven't seen anything
11 specific from Sick Kids in that respect?

12 A. No, nor any hospital. I've never
13 reviewed their protocols.

14 Q. All right. And, similarly, do you know
15 whether at the time Sick Kids had a protocol in place
16 for dealing with the Coroner's office?

17 A. A protocol with dealing with the
18 Coroner's office?

19 Q. As distinct from handling a situation of
20 an unexpected death, was there a separate protocol in
21 how to deal with the Coroner's office?

22 A. I can't tell you I'm aware of any such
23 protocol.

24 Q. Now you mentioned that when you arrived
25 at the hospital, you went to the nursing station on

1 Ward 5A, and you met with the nursing staff. Do you
2 recall who you met with specifically?

3 A. No, I don't, not the names.

4 Q. Do you have any notes that were made
5 that day?

6 A. The actual notes from that day I don't
7 have, because they are then transcribed into a -- my
8 Coroner's investigation report which I do have,
9 obviously, which is my -- which is referred to as a
10 Form 3 investigation at the Coroner's office.

11 Q. Do we have that, Mr. Coroner?

12 THE CORONER: Certainly.

13 MS. BROWNE: I think he said, "Do we have
14 that?" I don't think we do.

15 MR. HAWKINS: I don't think we do.

16 THE CORONER: I'm sorry.

17 MS. BROWNE: I think, can we have it? May
18 we have it?

19 MR. GOMBERG: You're definitely getting old.

20 THE CORONER: No, I don't think it has been
21 included in the ---

22 MR. GOMBERG: I don't think I've seen it.

23 THE CORONER: --- in the list of material.
24 But I see that Dr. Reingold has it in front
25 of him. I thought your question was, "May

1 you have it?" And the answer is yes.

2 MR. KRKACHOVSKI: Ms. Browne is looking into

3 that. I'd also like to have whatever notes

4 Dr. Reingold made. I've got a notation that

5 he made some notes regarding the IV equipment

6 in response to Ms. Browne's questioning, so

7 I'd like to see whatever notes you have quite

8 apart from the reports.

9 MS. BROWNE: I think I've got these.

10 MR. KRKACHOVSKI: You've got those?

11 MS. BROWNE: They notes that he was

12 referring to, I think, are what's now gone in

13 as Exhibit 48.

14 THE WITNESS: Okay. Here is my Form 3

15 investigation.

16 MS. BROWNE: How many pages is it?

17 THE WITNESS: One page, because of the rest

18 of it is the autopsy and toxicology reports.

19 MS. BROWNE: Okay, so it's just one paper,

20 which page?

21 THE WITNESS: This one right here.

22 MS. BROWNE: This one here. All right, I

23 wonder if we could prevail upon ---

24 THE WITNESS: I'll just mention, though,

25 that the handwritten notes at the bottom are

1 later notes made just regarding picking up of
2 equipment and so on.

3 MS. BROWNE: You could explain that to us,
4 if we can just get some copies made.

5 THE WITNESS: Okay.

6 MS. BROWNE: Could we prevail upon you?
7 It's just the top page.

8 MR. HAWKINS: Maybe we should take five
9 minutes while copies are made so that Counsel
10 can read it.

11 THE CORONER: That's fine, we'll recess for
12 five minutes.

13
14 --- A BRIEF RECESS

15
16 MS. BROWNE: Thanks, Mr. Coroner, we now
17 have, I can give you this -- all Counsel have
18 a copy of the Coroner's investigation report,
19 Form 3. Is that a copy of your statement?

20 THE WITNESS: Yes.

21 MS. BROWNE: May that be the copy marked as
22 the next Exhibit, and I have copies for the
23 jury.

24 THE CORONER: Thank you.

25 CONSTABLE CULLETON: Exhibit 49.

1 MS. BROWNE: 49? I think I've got enough.

2

3 --- EXHIBIT NO. 49: Copy of Coroner's
4 investigation statement, Form
5 3, dated March 1, 1999

6

7 THE CORONER: Sorry.

8 MR. KRKACHOVSKI: Thank you, Mr. Coroner.

9

10 BY MR. KRKACHOVSKI:

11 Q. All right, Dr. Reingold, we now have
12 your investigation statement. Now, I note there's a
13 date near the top left-hand portion of it. It reads
14 "99/3/11." How do we read that date?

15 A. That's November -- sorry, the 11th day
16 of March, 1999.

17 Q. All right. Is that when this document
18 was prepared?

19 A. That's the date of printing of this
20 document.

21 Q. All right. Were you working from notes
22 to prepare this document?

23 A. Yes.

24 Q. What happened to the notes?

25 A. Those notes would have been transcribed

1 directly to here, and then they're just handwritten
2 notes, verbatim, would have been -- those verbatim
3 notes, handwritten notes would have been destroyed.

4 Q. Now, and correct me if I'm wrong; having
5 reviewed the document, I don't see any individual --
6 staff members, I should say, having been identified as
7 to with whom you met on the morning of October the
8 22nd. Am I right?

9 A. That's the staff members at the Hospital
10 for Sick Children meeting? Or the ---

11 Q. Yes.

12 A. --- one that occurred on March the 1st,
13 1999?

14 Q. No, no, no.

15 A. No.

16 Q. When you first attended on the morning
17 of October the 22nd ---

18 A. Yes.

19 Q. My question that started all of this
20 was, who did you meet with?

21 A. Okay, and you're right. My notes, the
22 original rough notes and this typewritten note do not
23 indicate exactly which nurses I met with, the names.

24 Q. Now, to the extent that it's
25 significant, I just want to ask you about a couple of

1 notations on here, for the jury's benefit. About a
2 third of the way down, there's a couple of notations.
3 Death factor 7, 10, by what means 5. Can you tell us
4 what those mean?

5 A. By what means "5," is a category,
6 undetermined, which means at the time of preparing this
7 statement, I had not yet -- was not able to classify
8 this within the five categories the Coroner uses to
9 classify deaths. So I'd left it as undetermined until
10 such time as either an inquest or a Paediatric Review
11 Committee came to some conclusion that would further
12 classify it.

13 Q. I just, because I want to make sure that
14 I'm reading your handwriting correctly, can you just
15 review the handwritten notes that are at the bottom of
16 the page?

17 A. "Refer to the Paediatric" -- these were
18 handwritten notes for myself. These were done at a
19 later point in time.

20 Q. Yes.

21 A. And, because this is just a copy, this
22 is not an original. The original form would be some --
23 at the Coroner's office itself, the Form 3 statement
24 that I'd sent in. I wrote:

25 "... Referred to Paediatric Review

1 Committee March 18, 1999 for review on
2 April 13, 1999. Mrs. Shore advised by
3 Louise, Dr. Cairns office, of that
4 meeting ..."

5 Q. And then below that?

6 A. "... PCA pump picked up with Sergeant
7 Evans on 25th of March, 1999, and
8 delivered by Sergeant Evans to Dr.
9 Cairns ..."

10 Q. And then above those notations, towards
11 the left-hand side of the page, what ---

12 A. That was just some notes I've copied on
13 for the purposes of today's meeting, in fact, just the
14 time -- the morgue death sheet, when the call was
15 received and dispatched.

16 Q. I see. All right, and 8:22 is when the
17 office got the call?

18 A. Yes.

19 Q. And 8:38 is your dispatch?

20 A. Yes.

21 Q. Now there's another notation in a box on
22 the extreme left-hand side. I can't quite make it out.
23 What does that say?

24 A. That was just the -- I wrote down the --
25 my appointment as a Coroner, assuming I was going to be

1 asked that question, so I would be able to give the
2 right answer.

3 MR. GOMBERG: But is it your final answer?
4

5 BY MR. KRKACHOVSKI:

6 Q. There is a -- I don't want to belabour
7 that point, there's no mention of a Corometric monitor
8 on this investigation statement.

9 A. That's correct.

10 Q. And I think you said you first learned
11 of the monitor, was it when you met in March of '99?

12 A. I learned of the monitor when -- or at
13 least the question of the monitor when I received Mr.
14 Gomberg's letter.

15 Q. And in terms of any information from the
16 hospital, it wasn't until the March, '99 meeting, I
17 gather?

18 A. When the -- when the actual full
19 information about the monitor came out, in terms of
20 what it looked like, how it operated, et cetera, et
21 cetera.

22 Q. Now, if we can go back to where we left
23 off in terms of the chronology. And I'm sorry if I've
24 asked you this already, are you able to remember any of
25 the staff that you spoke to on the morning of the 22nd?

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A. By name?

Q. Yes.

A. No.

Q. All right. In terms of their position, do you know if you spoke to the two nurses who were on duty at the time of Lisa's death?

A. I couldn't tell you that. Again, I'd asked to speak to the nursing staff involved, and some nurses sat down with me, and reviewed the chart with me. I don't know their exact positions, whether they were head nurses, or ...

Q. Do you know if they were nurses as opposed to doctors, for example?

A. They were nurses.

Q. Did you speak to a doctor that morning?

A. I don't recall speaking to a doctor that morning.

Q. Did you ask to speak to the nurses who were on duty at the time Lisa died?

A. I believe -- I don't recall that, no. I believe I asked to speak to nurses who could help me review the chart.

Q. How was it determined who should be speaking with you?

A. That -- I left it to them to determine

1 who would best be able to answer my questions.

2 Q. I'm sorry, were you dealing with one
3 person, or several?

4 A. There was two or three nurses, in fact,
5 who went through the chart with me that morning.

6 Q. Okay. You get to the nurses' station.
7 Are you greeted by the nurses that you're ultimately
8 dealing with?

9 A. Not necessarily. There's -- could be a
10 ward clerk or nurses at the nursing station.

11 Q. All right. And is the first thing you
12 do, go over the chart?

13 A. In any particular case, or with this ...

14 Q. No, I'm talking about on the morning of
15 the 22nd. Is the first thing you did after getting to
16 the nurses station, being greeted by the nurses, take
17 the time to review the chart?

18 A. Yes. That was the first -- I asked them
19 if I could review the chart, and if some of the nurses
20 who were involved could help me to review the
21 information on the chart to clarify the orders and the
22 events which had occurred over the night.

23 Q. And how long did that take
24 approximately?

25 A. I'd say that probably took me about half

1 an hour.

2 Q. All right. And you then go into Lisa's
3 room?

4 A. Yes.

5 Q. For the first time?

6 A. Yes.

7 Q. All right. Now had someone been, I'll
8 use the word "stationed" outside of Lisa's room, to
9 make sure that it was as it should be?

10 A. I don't recall there being a person
11 stationed outside of there.

12 Q. Was anyone inside the room when you got
13 there?

14 A. I don't recall there being anybody in
15 the room when I got there.

16 Q. Was anything said to you as to whether
17 anything had been removed from the room?

18 A. No.

19 Q. I gather Lisa was still attached to the
20 IV?

21 A. Yes.

22 Q. Now, how did you go about determining
23 what should be seized?

24 A. I determined what should be seized based
25 on what I'd read in the chart, and what my inclination

1 was as a Coroner, and the information I'd gleaned from
2 the chart as to what the probable problems would be in
3 this case in terms of what the potential causes of
4 death would be.

5 Q. Now the chart indicates that Lisa had
6 been disconnected, or at least the pump had been taken
7 away from her, a number of hours before her death. Is
8 there a reason you decided to seize the pump?

9 A. I decided to seize the pump because my
10 feeling was that there was a high probability that this
11 was going to be a toxicological problem, and since the
12 pump was obviously central to administering drugs, that
13 would be a relevant thing to seize.

14 Q. I gather there was no suggestion that it
15 was going to be an equipment monitoring problem at that
16 time?

17 A. I couldn't say that at that point in
18 time.

19 Q. Well, was there any suggestion that
20 equipment might be involved, that is to say, monitoring
21 equipment?

22 A. I was not advised of any monitoring
23 equipment, and I was not aware of that.

24 Q. Did you take the time to look about the
25 room and see what was in there?

1 A. I would say that I looked, I looked at
2 the body, I looked at what was connected to the body in
3 terms of lines and briefly looked around the room. I
4 mean, I didn't -- I can't say that I looked, you know,
5 extensively, under, you know, in shelves and, you know,
6 elsewhere, in areas that I normally wouldn't be
7 interested in.

8 Q. Did you note any patches on Lisa's
9 chest?

10 A. I recall there being patches on her
11 chest.

12 Q. Were there leads attached to the
13 patches?

14 A. I don't recall.

15 Q. Do you recall any -- I'm sorry. And I
16 gather from your evidence you didn't take note as to
17 whether there was a monitor in the room or not?

18 A. I can't say if there was a monitor in
19 the room because I didn't -- I can't say I saw it, but
20 nor was I specifically looking for this. If you're
21 referring to the Corometric monitor, I can't say I was
22 looking for it. I wasn't aware of it, of its existence
23 at that point in time.

24 Q. Do you normally take an inventory of
25 what's in the room?

1 A. A formal inventory?

2 Q. Yes.

3 A. No. No, I wouldn't take a formal
4 inventory.

5 Q. I assume you rely on the chart for that?

6 A. Well, I rely on staff that I speak to in
7 terms of what equipment is relevant to a particular
8 case, what I read in the chart, and then walking into a
9 room, I see basically what appears to be in the room in
10 terms of the basic equipment.

11 Q. Well, I'm just trying to understand
12 because the evidence of the nursing staff is that there
13 was a Corometric monitor in the room.

14 A. Mm-hmm.

15 Q. And I'm trying to understand if that's
16 in fact the case, why you didn't seize it?

17 A. I didn't seize it because I didn't -- I
18 wasn't aware of its existence. I didn't see it and I
19 wasn't aware it was even being -- I was not aware that
20 it was attached to her, or had been even ordered
21 attached to her. If I had been, then obviously that
22 might have been a relevant thing to seize.

23 Q. Or that it had been an issue, I gather?

24 A. Right. I wasn't aware it was an issue.

25 Q. How long were you in the hospital in

1 total that morning?

2 A. Probably between an hour, an hour and a
3 half.

4 Q. So far as you know, did any of the
5 people you spoke with go away to consult with the
6 nurses who were on duty to find out what happened?

7 A. I can't tell you that.

8 Q. Am I right that when you left the
9 hospital, you had seized or were about to seize
10 whatever you were told had anything to do with Lisa's
11 care through the night in the way of equipment?

12 A. Yes.

13 Q. Now, I just want to turn to your notes
14 that you made regarding the meeting of March the 1st,
15 1999. First of all, dealing with the people who were
16 in attendance, how was it determined who was going to
17 be present at the meeting from the hospital's end?

18 A. I spoke to the Risk Management staff
19 member, Marion Stevens, and she had basically arranged
20 the meeting, and invited these people to attend the
21 meeting, thinking that they would be the relevant
22 people to respond to these questions.

23 Q. Did you know ahead of time who was going
24 to be present?

25 A. I had -- I was told that there would be

1 people from Anaesthesia and Orthopaedics there. Beyond
2 that, I wasn't aware of the specifics, though.

3 Q. Not by name?

4 A. No.

5 Q. All right. And I gather the list of
6 people on page one is comprehensive; in other words,
7 there was those four people and you?

8 A. That's right.

9 Q. All right. And you would agree with me
10 that none of the people who looked after Lisa that
11 night were involved in the meeting?

12 A. They were not -- they did not attend the
13 meeting.

14 Q. Was there a reason for that?

15 A. I can't tell you the reason for that.

16 Q. And, specifically, do you know why
17 neither of the nurses attended the meeting?

18 A. I don't know.

19 Q. Do you know why Dr. Schily did not
20 attend the meeting?

21 A. No.

22 Q. Did you think it important that they be
23 there, the nurses and Dr. Schily?

24 A. I didn't order that anybody in
25 particular be there. I left it to the Risk Management

1 person to invite the relevant people to the meeting,
2 and I, from what I understood, there was some, perhaps,
3 some reluctance on certain -- on the part of certain
4 people to attend the meeting, and I -- it was not my --
5 again, it was not for me to order certain people to
6 attend the meeting. I asked them to have the relevant
7 people attend the meeting, and these are the people who
8 attended.

9 Q. You would agree with me that in terms of
10 the information that you were given at the meeting, it
11 would have been second and possibly third-hand
12 information?

13 A. Absolutely.

14 Q. And during the course of the meeting and
15 answering the questions posed by Mr. Gomberg, were the
16 individuals from the hospital referring to any notes or
17 documents or pieces of paper?

18 A. Yes, they had -- they had chart
19 material, I believe, at the meeting, and notes.

20 Q. You say chart material. Are you talking
21 about Lisa's chart?

22 A. I would believe so. I can't say exactly
23 if they had the complete chart or some nursing notes
24 and orders.

25 Q. Quite apart from what Lisa's chart may

1 contain, did they have any notes from either Nurse
2 Doerksen or Nurse Soriano at this meeting?

3 A. I believe they would have had those
4 notes. I can't say for sure that they did, but I
5 believe they did, and in view of the fact that when
6 questions were asked regarding certain things that were
7 done with respect to nursing care, they referred to
8 notes, and I would -- to answer those questions, so I
9 would assume that those were the nursing notes.

10 Q. Did you ask for copies of the notes?

11 A. The actual chart notes, do you mean,
12 or ---

13 Q. No, I'm not talking about Lisa's chart,
14 hospital chart. I'm talking about copies of any other
15 pieces of paper that these four individuals were
16 referring to in answering your questions, or Mr.
17 Gomberg's ---

18 A. I did not ask for their own personal
19 notes, no.

20 Q. Apart from Lisa's chart and Mr.
21 Gomberg's letter, I assume, had you received any other
22 documentation by the time of this meeting in March of
23 '99? From the hospital, that is.

24 A. No.

25 Q. And was any explanation or indication

1 given to you as to why the monitor was being mentioned
2 for the first time four or five months after Lisa's
3 death?

4 A. Did I have an explanation as to why that
5 was the first ---

6 Q. Yes.

7 A. --- I was hearing about it? No.

8 Q. Did you raise that with them? Why was I
9 not told about the monitor back on October the 22nd?

10 A. Well, that, you know, clearly that was
11 an area of concern, and it was an area of controversy,
12 insofar as there was some debate about the monitor in
13 terms of -- again, I was not told about it, when I
14 asked to be advised of relevant -- of the relevant
15 events which had occurred and the equipment that was
16 being used. And there was no good answer for that
17 question.

18 Q. Now just turning the page, in the middle
19 of the second page, you told Ms. Browne that you were
20 told that this particular piece of equipment, the
21 Corometric monitor, had no memory, unlike the PCA pump.

22 A. Mm-hmm.

23 Q. Yes?

24 A. I was told there was no memory, yes.

25 Q. All right. So, in other words, unlike

1 the PCA pump, you can't go into the piece of equipment
2 and figure out when it was on and when it was off, and
3 when the alarm may have been disconnected, for example.

4 A. I would assume that's what that means.

5 Q. All right. You would agree with me that
6 makes charting all the more important in terms of the
7 use of a Corometric monitor? That is to say, the
8 nurses ought to have made a note as to when that
9 equipment was used and when an alarm may have been
10 disabled.

11 A. I think that's reasonable.

12 Q. You note that a pulse oximeter had been
13 ordered but not applied, about two-thirds of the way
14 down.

15 A. Mm-hmm.

16 Q. Was any explanation given for that, as
17 to why it had not been applied?

18 A. My recollection is that a lot of the
19 things that were not done, were not done because the
20 Kidcom orders were not carried out.

21 Q. Anything beyond that with respect to the
22 pulse oximeter, in terms of why it was not applied?

23 A. Not that I'm aware of, no.

24 Q. Now, I note there is no indication in
25 your notes regarding the March 1st meeting.

1 A. I'm sorry?

2 Q. There's no indication in your notes of
3 the March 1st meeting that the monitor was completely
4 turned off at the time of the arrest, or that there was
5 no alarm when the leads were taken off.

6 A. Mm-hmm.

7 Q. Was there any discussion like that from
8 the hospital or with the hospital staff?

9 A. We talked about it, and my recollection
10 is that there -- nobody was aware of an alarm going
11 off. Nobody heard an alarm go off.

12 Q. At the time of the resuscitation?

13 A. Right.

14 Q. Right.

15 A. Or prior to the resuscitation.

16 Q. And correct me if I'm wrong, I didn't
17 see that in your notes.

18 A. That's right.

19 Q. Are you just going from memories?

20 A. Yes.

21 Q. All right. So your memory is that
22 someone mentioned there was no alarm during the
23 resuscitation?

24 A. Mm-hmm.

25 Q. Yes?

1 A. That's right.

2 Q. And did they specifically indicate that
3 the monitor at some point had been turned off
4 completely?

5 A. There -- I don't recall being turned off
6 completely, no, I don't recall that ever being spoken
7 about. There was, I think we talked about earlier,
8 about one part of an alarm being turned off because of
9 the false alarms.

10 Q. That would be the apnea alarm?

11 A. Yes.

12 Q. But did no one draw an inference that
13 when, during the resuscitation, the leads were taken
14 off and the machine did not alarm, the entire unit must
15 have been turned off?

16 A. We didn't -- I don't recall us saying
17 that. That would be, obviously, a good question.

18 THE CORONER: For the record, Mr.
19 Krkachovski, I think that information came to
20 light some time between the inquest
21 adjourning in November, and re-starting in
22 January, following issues about the
23 Corometric monitor and potential wave
24 patterns being present at the time of Lisa's
25 cardiac arrest. I think that information,

1 the Paediatric Review Committee and the
2 agreed statement that was read out at the re-
3 commencement of this inquest with regard to
4 if a monitor was in the room at the time of
5 the arrest, and if it was attached to Lisa,
6 then it was definitely switched off. I think
7 that really, the first time that that became
8 perhaps the more obvious issue was at that
9 time, and not at this early stage.

10
11 BY MR. KRKACHOVSKI:

12 Q. I recognize that fully, Mr. Coroner. I
13 simply ask whether there was a discussion at the early
14 stage in March of 1999 as to when the leads were taken
15 off Lisa, why didn't this piece of equipment alarm as
16 it should have.

17 A. Yeah, no one at the meeting could
18 provide an answer to that.

19 Q. That's all I have. Thank you very much,
20 Doctor.

21 THE CORONER: Ms. Crain?

22 MS. CRAIN: No questions, Mr. Coroner.

23 THE CORONER: Mr. Hawkins?

24
25 CROSS-EXAMINATION BY MR. HAWKINS:

1 Q. Dr. Reingold, just going back I guess to
2 the beginning, we note from the chart that Lisa was
3 officially pronounced dead at 7:52.

4 A. Mm-hmm.

5 Q. And then you were called, or the
6 Coroner's office was called, at 8:22?

7 A. Yes.

8 Q. And that's certainly promptly and within
9 the requirements of the Coroner's Act for notifying
10 your office?

11 A. Mm-hmm.

12 Q. Yes it is?

13 A. I would think so.

14 Q. Okay. And that day when you attended at
15 the hospital, the only notes we have are the summary
16 you made in March of '99?

17 A. Mm-hmm.

18 Q. And that doesn't include details of who
19 you talked to and what you asked them and what you
20 looked at, that sort of detail. You didn't go into
21 that in your notes?

22 A. Mm-hmm. That's right.

23 Q. And then I take it when you talk about
24 the events of that day, or what happened at the
25 hospital, are you going on sort of a combination of

1 your general practice plus your memory of what happened
2 that day?

3 A. Well, my memory of the day, mostly. I
4 mean, I know I have a pretty good recollection of what
5 transpired that morning in terms of going to the
6 hospital. I recall meeting in the nursing station,
7 going into a room, reviewing the equipment, and
8 returning and preparing my documents.

9 Q. Okay, and we -- well, I guess we've
10 heard evidence that there was a Corometric monitor in
11 the room following the arrest. Can you say with
12 certainty whether that monitor was or was not in the
13 room when you attended?

14 A. No.

15 Q. It may have been there, but you simply
16 -- well, it may have been there?

17 A. It's possible.

18 Q. And that day, I understand, you reviewed
19 the chart, but you didn't officially seize the chart or
20 request a copy of it?

21 A. On that date, I did not seize the chart.

22 Q. And we know that this wasn't done
23 specifically by you, but I assume you're aware that the
24 actual request for a copy of the chart was sent by Dr.
25 Lucas on the 17th of December?

1 A. Yes.

2 Q. And in response to that request, the
3 hospital provided a copy of the chart?

4 A. Yes.

5 Q. And we've heard, or we've learned a lot
6 about suspended Kidcom orders. I understand that the
7 original chart that was provided to the Coroner's
8 office in December contained some computerized orders
9 but just not all of them?

10 A. I can't say that for a fact. I'm not
11 sure what part of the Kidcom orders were provided.

12 Q. Okay. But do you recall that some part
13 of the Kidcom orders were provided in December?

14 A. I didn't review the chart at that point.
15 Dr. Lucas did.

16 Q. Okay. So that -- so Dr. Lucas was
17 handling that part of it?

18 A. He would have received the chart
19 directly here in the Coroner's office and would have
20 reviewed it.

21 Q. And then subsequently in January, and I
22 don't think there's any issue about this, but the
23 hospital provided the complete Kidcom orders?

24 A. I don't know.

25 Q. And, as far as you were aware, was that

1 the hospital volunteering that information?

2 A. Again, I don't know. I believe Dr.
3 Lucas at that point was handling the transferring of
4 the medical records, the seizing of the medical
5 records.

6 Q. Okay. But you're not aware that there
7 was another request generated out of the Coroner's
8 office, but, for those extra charts, that it was simply
9 Sick Kids that provided them to the Coroner's office?

10 A. I don't know.

11 Q. Okay. And then you met at the hospital
12 with various people on the 1st of March?

13 A. Yes.

14 Q. I understand that between October 22nd
15 and the 1st of March, you did not separately ask to
16 meet with any of the staff, or any of the ---

17 A. No.

18 Q. --- people at the hospital?

19 A. That's correct.

20 Q. Okay, so that was -- and that meeting
21 was sort of arranged or set up by the hospital?

22 A. At my request, yes.

23 Q. Okay. And that meeting was set up
24 shortly after you made the request to meet with the
25 hospital in February sometime, I assume, if it was the

1 1st of March?

2 A. I can't say the exact date I put the
3 request in, but the meeting occurred on March the 1st.

4 Q. Okay, and you don't recall that there
5 was any significant delay on the hospital's part from
6 after you asked for the meeting that it was set up?

7 A. I don't recall a significant delay.

8 Q. And then following the meeting on March
9 1st, you received the letter from the hospital, and
10 that was sent to you on March 3rd?

11 A. Yes.

12 Q. And that letter substantially confirmed
13 what you were told at the meeting on March 1st.

14 A. Yes.

15 Q. And as I understand that, as I
16 understand it, and this is Ms. Stevens' recollection
17 and my own recollection, that at that time you
18 requested that the hospital provide the response to
19 you, and that you would handle disseminating that
20 information to the family. That was the Coroner's ---

21 A. Yes.

22 Q. That was your responsibility to
23 disseminate that?

24 A. Yes.

25 Q. And then subsequently we spoke, and you

1 gave me permission to have the hospital send a copy
2 directly to the family.

3 A. Mm-hmm.

4 Q. That's right?

5 A. I believe that's right.

6 Q. And the family, I understand, after they
7 got the copy of the letter, wrote to the Coroner's
8 office, and this time it was to Dr. Young with a series
9 of further questions?

10 A. Mm-hmm.

11 Q. And you're aware of those further
12 questions?

13 A. I don't have that letter in front of me.

14 Q. Okay, this was a letter of March 17,
15 1999 that went to the -- that went to Dr. Young, the
16 Chief Coroner, and I gather you were copied on that?

17 A. Mm-hmm. It says so.

18 Q. Do you remember receiving that?

19 A. I don't recall this letter, but it does
20 say it was cc'd to me, so I assume I received it.

21 Q. Okay, and that letter asks -- or in that
22 letter the family is asking for some clarification of
23 information contained ---

24 A. In the original letter.

25 Q. --- in the hospital's response.

1 A. Right.

2 Q. And would it surprise you that the
3 hospital never actually got that letter of March 17th
4 until just prior to the inquest, about six or seven
5 months later?

6 A. Would it surprise me that the hospital
7 didn't receive this letter?

8 Q. Yeah, you're not aware of when the
9 hospital got that or not?

10 A. No, I'm not aware of whether the
11 hospital received the letter or not.

12 Q. Okay. But certainly it's not directed
13 to the hospital, and if it was to be sent to the
14 hospital, it would have to come from the Coroner's
15 office.

16 A. Well, yeah, it's addressed, as you
17 pointed out, to Dr. Young.

18 Q. Okay. Perhaps that can be the next
19 Exhibit since we've talked to Dr. Reingold about that.

20 THE CORONER: Thank you.

21 CONSTABLE CULLETON: Exhibit 50.

22

23 --- EXHIBIT NO. 50: Letter to Dr. James Young, Chief
24 Coroner, from Sharon Shore, dated
25 March 17, 1999

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MR. HAWKINS: Sorry, just one moment, Dr. Cairns.

THE CORONER: That's fine, thank you.

BY MR. HAWKINS:

Q. And after you received the letter from the hospital with the answers to the questions on the 3rd of March, after that letter was received by the hospital, I understand that they didn't subsequently contact the hospital to ask them to clarify anything that's in there, and ask for further information?

A. I did not.

Q. Okay. And this is the investigation in this case, I guess, two of the sort of the more important pieces of information in the investigation, the post-mortem report, at the time that you have your meeting with the hospital and the response is delivered, the post-mortem report and the toxicology reports are not even available at that time.

A. I'd have to look at the dates to see.

Q. Well, the dates that I have, is the toxicology is March 8, 1999.

A. Okay.

Q. And the pathology is March 15, '99.

1 A. Okay, so there -- so you're right then.

2 Q. And that seems like a long time but I
3 take it that that's a factor of the sort of complexity
4 of the case and the amount of testing and re-testing
5 that needed to be done?

6 A. Unfortunately, yes, that's the turn
7 around time. That type of turn around time is not
8 unusual. A complex case can take a considerable length
9 of time to examine.

10 Q. Okay. Thank you, those are my
11 questions.

12 THE CORONER: Mr. Gomberg?

13

14 CROSS-EXAMINATION BY MR. GOMBERG:

15 Q. Dr. Reingold, I want to thank you for
16 coming. You and I have spoken on the phone, but I've
17 never met you before today. I just have a few
18 questions which may betray my ignorance about the way
19 the Coroner's office interfaces with the hospital.
20 First of all, I take it that there are three issues
21 that are critical in doing a Coroner's investigation
22 with regard to a death in the hospital. Number one,
23 the chart; number two, the equipment; and number three,
24 the body. Right?

25 A. Correct.

1 Q. It seems reasonable?

2 A. Yes.

3 Q. There's no issue, you've got the body.
4 Which leaves us with the chart and the equipment.

5 A. Mm-hmm.

6 Q. All right. Now I take it since you
7 weren't part of the team that was working on Lisa
8 either before she died or just after she died, in an
9 effort -- that's wrong wording -- when they were trying
10 to resuscitate her, you're relying on the hospital with
11 regard to number one, the chart; and number two the
12 equipment?

13 A. Correct.

14 Q. So if you showed up there and the body
15 wasn't there, that would be a walking advertisement for
16 a problem, right?

17 A. Yes.

18 Q. You'd go looking for the body?

19 A. Yes.

20 Q. And that happens from time to time, but
21 it's fairly rare, isn't it?

22 A. Yes.

23 Q. All right. So you're left, then, with
24 the chart and the equipment, and I suppose -- let's
25 forget about Coroner's warrants and all of that fancy

1 jargon. What you expect when you show up to a world-
2 class institution like the Hospital for Sick Children
3 is that they're going to hand you voluntarily the
4 chart, right?

5 A. Correct.

6 Q. Right. And that the chart doesn't mean
7 the technical chart, as it may be defined in the Public
8 Hospitals Act, or in the regulations to the Public
9 Hospitals Act, but the chart is the chart as these five
10 members of the jury are sitting here, and as they as
11 lay people would assume the chart to be, right?

12 A. Yes.

13 Q. All right. In other words, you're not
14 going there with all this medical education to try and
15 analyze what might be in the chart, you want everything
16 that has to do with the treatment of the child in the
17 hospital, right?

18 A. Correct.

19 Q. Right. And I suppose that given the
20 fact that the child wasn't in the hospital for very
21 long, namely from late in the evening on October 21st
22 until she passed away just after 7:00 on October 22nd,
23 asking for the chart meant asking, in your mind, for
24 every piece of paper, every piece of paper including
25 the toilet paper, if it was relevant. Right?

1 A. Fair enough.

2 Q. All right. And you were relying on the
3 hospital to determine what was relevant?

4 A. Yes.

5 Q. Now, would it surprise you to know that
6 there was a nurse in the hospital roughly at the time
7 that you were in the hospital, who had actually treated
8 the patient and who printed out orders by way of a
9 nursing care plan, that were not made available to you.
10 Would that surprise you?

11 A. She printed up orders from the Kidcom?
12 Is that what you're saying, or ---

13 Q. She printed up orders that were
14 suspended on the Kidcom, but she got those very orders
15 -- or those very orders came to her attention by way of
16 a nursing care plan that printed up sometime at around
17 8:00 or 8:30 in the morning.

18 A. After the death?

19 Q. Right. Would that surprise you?

20 A. It would surprise me.

21 Q. It would surprise you because you were
22 never given that piece of paper, right?

23 A. Correct.

24 Q. Right. Would it surprise that five days
25 later, that nurse went into the computer, on October

1 27th, the Kidcom computer, and printed up those nursing
2 care plan orders, including the Kidcom, and took them
3 home, where she sealed them in an envelope for four
4 hours -- for four months, and eventually gave them to
5 her lawyer and didn't give them to you?

6 A. Yes.

7 Q. All right. That would more than
8 surprise you, wouldn't it?

9 A. Yes.

10 Q. That would shock you out of your mind,
11 as a Coroner, wouldn't it?

12 A. It would disturb me.

13 Q. It would disturb you a lot, right?

14 A. Yes.

15 Q. Because it comes close to obstructing an
16 investigation, doesn't it?

17 A. It would interfere with my
18 investigation.

19 Q. Well it would seriously undermine and
20 impair any effective investigation that you might want?

21 A. Mm-hmm.

22 Q. Right?

23 A. Yes.

24 Q. Because your investigation is only as
25 good as the information that you have.

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A. Correct.

Q. All right. And you were missing the chart?

A. Yes.

Q. All right, or at least the part of the chart that would have dealt with the Kidcom orders, right?

A. Right.

Q. All right. Now, I suppose that you don't make nice distinctions between whether that part of the chart that you were missing is part of the chart, or part of the nursing care plan. You don't care about that, do you?

A. It's all part of the chart.

Q. It's all part of the chart, and that when you want the chart, you want every piece of paper.

A. Correct.

Q. All right. Now, let's just talk about the equipment for a minute. I take it that, to shorten this up a little bit, the approach with regard to the equipment is exactly the same as your approach with regard to the chart, right?

A. Yes.

Q. All right, so, for example, when you went in there, you had no reason to expect that a

1 Corometric monitor had anything to do with the price of
2 tea in China, right?

3 A. Correct.

4 Q. All right. And if you did think that a
5 Corometric monitor had anything to do with anything, I
6 suppose that what you would have done is you would have
7 sequestered it?

8 A. Correct.

9 Q. All right. And nobody volunteered to
10 you that a Corometric monitor had anything to do with
11 anything, right?

12 A. That's right.

13 Q. All right. Your assumption, up until
14 you found out differently, probably on March the 1st or
15 around then, was that a Corometric monitor was a non-
16 issue.

17 A. That's correct.

18 Q. It was a phantom; it had nothing to do
19 with anything, right?

20 A. Yes.

21 Q. It had no more bearing on this case than
22 the cleaning equipment in the basement of the hospital,
23 right?

24 A. Right.

25 Q. Now, with regard to nurses cooperating

1 in the hospital, cooperating with an investigation,
2 certainly you'd agree that notes made by nurses one day
3 or two days or three days later, all right, would be
4 very helpful to you in terms of your investigation,
5 right?

6 A. True.

7 Q. Certainly they'd be a lot more helpful
8 to you as part of your investigation than they are
9 going into two sealed envelopes where they're buried
10 for three or four months until they go to their lawyer,
11 right?

12 A. Yes.

13 Q. And I take it that it doesn't say
14 anywhere in the Public Hospitals Act or in the
15 Coroner's Act that hospitals shouldn't volunteer
16 information to a Coroner and say, hey, you might have
17 missed this, or you might not have asked for this. You
18 should know about this, this, and this when you come to
19 do the investigation, right?

20 A. Right.

21 Q. All right, and just to get back to the
22 point that I made a few minutes ago, it's surprising
23 isn't it, that here we are, sitting in January of the
24 year 2000 with a jury and the Deputy Chief Coroner of
25 the Province, and as we sit here, we're finding out

1 information that you should have, and could have, if
2 you'd been made aware of it, gotten soon after the
3 death on October 22nd, 1998. That's surprising, to say
4 the least?

5 A. Yes.

6 Q. All right. In fact, it's disturbing,
7 right?

8 A. Yes.

9 Q. In fact, it's very disturbing, right?

10 A. Yes.

11 Q. In fact, you've never seen anything like
12 that in your career up to now, have you?

13 A. Not exactly, no.

14 Q. And certainly, it's much less than you'd
15 expect from a world-class institution like the Hospital
16 for Sick Children?

17 A. It's a fair statement.

18 Q. Those are my questions.

19 THE CORONER: Does the jury have questions
20 for Dr. Reingold?

21 JUROR #1: Could we have a few minutes?

22 THE CORONER: Yes, we can recess for 15
23 minutes.

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25 --- A BRIEF RECESS

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MS. BROWNE: Just before the jury asks their questions, I just want to raise one little matter that came up, if I might?

THE CORONER: Thank you, yes.

RE-EXAMINATION BY MS. BROWNE:

Q. Dr. Reingold, I just wanted to know, do you have any notes of when you exactly arrived at the hospital specifically that day of the death?

A. I don't have a specific time written down anywhere. I do recall proceeding to the hospital after receiving the call from dispatch, so I would assume I would have gotten there within approximately an hours' time, so I would think, as I said earlier, I think, about 9:30, probably around ---

Q. Could it have been after 10:00?

Q. After 10:00, I don't think so. Maybe close -- maybe 10:00 at the latest, but it was, I know, my recollection would have been more between 9:30, around 9:30.

MR. GOMBERG: Can I help with this, because I know what you're driving at. We had a discussion outside the courtroom. There's an

1 issue about whether or not the two nurses --
2 that's Nurses Doerksen and Soriano -- were
3 physically in the hospital, or whether they
4 had gone home when Dr. Reingold arrived. And
5 just to shorten this up, so we don't have to
6 start calling witnesses on that point, Mr.
7 Hawkins has told me that his information is
8 that the two nurses had gone home that
9 morning, and I'm prepared to live with that
10 assurance from Mr. Hawkins, because it seems
11 crazy to be parading witnesses in one way or
12 the other on that particular point. So I
13 think that's what Ms. Browne was driving at,
14 and if that helps, then we can move on.

15 THE CORONER: I appreciate your assistance.

16 Is that fine with you, Mr. Hawkins?

17 MR. HAWKINS: That's satisfactory, cause
18 certainly the -- the suggestion seemed to be
19 that those nurses were still there when Dr.
20 Reingold arrived, which ...

21 THE CORONER: We'll accept that Dr.
22 Reingold, when he got to the hospital, the
23 two nurses who were on overnight had already
24 gone home.

25 MR. GOMBERG: They'd probably gone.

1 THE CORONER: They'd probably gone.

2 MR. GOMBERG: All right? I think that's the
3 best that we can do.

4 THE CORONER: Thank you. Does the jury have
5 questions?

6 MR. HAWKINS: I have a couple of questions,
7 just following out of Mr. Gomberg's
8 questions.

9 THE CORONER: Yes.

10

11 RE-EXAMINATION BY MR. HAWKINS:

12 Q. Doctor, Mr. Gomberg asked you a number
13 of questions about cooperating with the Coroner's
14 office and obstructing or interfering. I take it in
15 the course of your work as a Coroner, at least
16 periodically, and perhaps more frequently than
17 periodically, people inadvertently don't provide you
18 with all of the information that you need?

19 A. It's -- it occurs.

20 Q. And certainly a part of that is or can
21 be the unfamiliarity that people, and particularly
22 individuals who are involved in deaths and who have
23 never been involved in deaths before, have with the
24 processes of your office and what's required of them?

25 A. It's possible.

1 Q. And certainly we've heard a lot about
2 the disclosures to the Coroner's office. You have no
3 information that any of those disclosure issues were
4 anything but inadvertent?

5 A. I -- that -- I would say that's correct.

6 Q. And you certainly have no information to
7 suggest that any of those disclosure issues were
8 intentional on the part of the hospital or the
9 individuals involved?

10 A. On my -- on the day that I did my
11 investigation?

12 Q. Well, from -- on the day that you did
13 your investigation.

14 A. I have no reason to believe that
15 anything was done intentionally ---

16 Q. Okay, thank you.

17 A. --- on that morning.

18 THE CORONER: Does the Jury have questions?

19 JUROR #2: The one question that we had, I'm
20 not sure if we can ask or not, but it is in
21 line with what Mr. Gomberg and Ms. Browne
22 were pursuing, is ---

23 THE CORONER: Go ahead and try.

24
25 CROSS-EXAMINATION BY THE JURY

1 BY JUROR #2:

2 Q. Okay. We felt that we have an audience
3 full of nurses, including the nurses who were attending
4 to Lisa that night, And we were just curious if your
5 recollection -- if you could look out and see if any of
6 the nurses you spoke with are actually here.

7 A. I wouldn't be able to do that, no.

8 Q. Okay, now my other question. You
9 actually addressed it. What I was wondering is if the
10 Hospital for Sick Children, in the event of a
11 questionable death, if they have a protocol that they
12 follow, and you said that you weren't sure about
13 protocol that they had. But I guess what I'm curious
14 about is when you go to investigate a death, is there a
15 format that's usually followed insofar as the room
16 sealed, or information is made available. And, just
17 for the sake of my notes, I had written down that
18 hospitals know the body and all involved equipment not
19 to be touched until released by yourself, the Coroner.

20 A. Mm-hmm.

21 Q. Do you find that every hospital tends to
22 adhere to the same code of ethics?

23 A. I would say yes, that ---

24 Q. So you have certain expectations when
25 you go that there'll be certain things available to

1 you?

2 A. Absolutely, yes.

3

4 BY JUROR #5:

5 Q. How many years' experience do you have
6 as an investigator, sir?

7 A. As a ---

8 Q. Coroner investigator?

9 A. I was appointed in 1991.

10 Q. Do you think you did a good job in this
11 case?

12 A. I think I did the best I could with the
13 information I had.

14 Q. Thank you.

15 A. You're welcome.

16 THE CORONER: Any other questions from the
17 jury?

18

19 BY JUROR #1:

20 Q. Yes, if the testimony showed that indeed
21 one or both of the nurses were at the hospital at 10:00
22 a.m. that morning, would that alter anything that has
23 occurred here just now? Because we said we weren't
24 going to waste any more time regarding the fact that
25 the nurses that attended to Lisa were or were not at

1 the meeting, since there was no names shown on your
2 list.

3 A. Mm-hmm. The specific nurses names
4 weren't requested, yes.

5 Q. And if the testimony were to show, and
6 Mr. Gomberg said that he will accept that those nurses
7 were not there at the time that you were there, that
8 they had already gone home ---

9 A. Mm-hmm.

10 Q. --- so that it would save the court
11 time.

12 A. Yes.

13 Q. But if the testimony shows that they
14 were indeed in the hospital still at 10:00 a.m., could
15 we go back to this?

16 THE CORONER: If they were in the
17 hospital ---

18 JUROR #1: Yes.

19 THE CORONER: --- and were in some way
20 refusing to meet with the Coroner, or the
21 Coroner had asked to meet with them, then I
22 think it would be relevant. If you will
23 leave that with me, perhaps I can talk to
24 Counsel after and try and reassure you one
25 way or the other on that matter.

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BY JUROR #1:

Q. Okay, because Coroner, didn't you say that you would like to meet with the nurses that cared for Lisa that ---

A. Normally, that would be the practice, is to go to the nursing station and ask to speak to the people relevant in the care of the decedent.

Q. Yes, that's the practice, but wasn't that your request?

A. Yes.

Q. Yes.

A. To speak to the nurses involved.

Q. So that's why it's important to me ---

A. Sure.

Q. --- to find out about this. And I have one other question. While you were there, you looked at some papers, didn't you?

A. At the chart.

Q. You looked at the chart. Would that be the Flow Chart?

A. I'm sorry?

Q. Would that be the Flow -- or, sorry, you looked at the ---

A. Hospital chart.

1 Q. --- hospital chart. And it contained
2 several documents?

3 A. It would have -- yes, that's correct.

4 Q. And did you look at the Flow Sheet?

5 A. I don't know what you mean by the Flow
6 Sheet.

7 Q. The Flow Sheet, the record of care given
8 to -- throughout the evening.

9 A. Yes, I would assume ---

10 Q. The treatment and so on. Would you have
11 looked at that?

12 A. I would have seen that. That was a hard
13 copy.

14 Q. And when you left, would you have taken
15 a copy of that with you?

16 A. Not on that day, no.

17 Q. You took nothing with you?

18 A. That's correct.

19 Q. Just your notes.

20 A. That's right.

21 Q. I wonder if I could ask you one more
22 question, sir?

23 A. Sure.

24 Q. Can you recollect having looked at this
25 Flow Chart?

1 A. I can't tell you specifically that piece
2 of paper was something I saw, but if it was part of the
3 chart that day, I would have seen it.

4 Q. Well, it's right behind you.

5 A. No, I, I see it.

6 Q. Can you recall if you reviewed that,
7 that morning?

8 A. Again, I can only tell you that if it
9 was part of the hospital chart, I would have seen it
10 that morning.

11 Q. You would have seen that?

12 A. I can't tell you now, on this particular
13 date, that I remember that piece of paper out of all
14 the rest of the papers in the chart.

15 Q. But you know that you would have
16 reviewed it?

17 A. Presumably, if it was in the chart and
18 part of the hard copy of the chart, I would have seen
19 it that morning, because I reviewed the entire chart.

20 Q. Well, you did mention the heart, the
21 increased heart rate and ---

22 A. That would have been something ---

23 Q. Would that have come from the Flow
24 Sheet?

25 A. --- coming out of the meeting with the

1 hospital, when we were talking about the monitors, I
2 believe.

3 Q. Yes, that would have come later.

4 A. Mm-hmm.

5 Q. Okay, I wonder, if looking at that Flow
6 Sheet now, if you could tell me if the same information
7 is on that Flow Sheet today as was on that Flow Sheet
8 at 8:30 or 9:00 when you looked at it, when you arrived
9 at the hospital that morning?

10 A. Are you asking me if it's been changed
11 in some way?

12 Q. Well, that would be your
13 characterization of what I'm asking, but ...

14 A. Well, I can't tell you that. The only
15 way I could tell you that clearly would be if I had
16 copied, photocopied the exact, the original at that
17 date and then brought it here and compared it to this
18 what you're showing me now.

19 Q. And is that typical, that when a Coroner
20 first begins his investigation on a case, that he comes
21 away without any documents?

22 A. It depends.

23 Q. Patient care, the treatment plan?

24 A. It depends on the situation and what the
25 concerns are. In this particular case, the autopsy is

1 done at the Hospital for Sick Children by a forensic
2 pathologist that is used by the Coroner's office, and
3 insofar as he uses the chart, and the chart goes
4 directly to his office from the nursing station, it's
5 not common for me to photocopy a chart at Sick Kids
6 immediately, unless I have some concerns about things
7 going and disappearing, or what have you.

8 Q. Mm-hmm. I would think that any
9 Coroner's investigation is a concern. Thank you very
10 much.

11 A. Yeah, sure.

12 Q. Thank you.

13 THE CORONER: Any further questions for Dr.
14 Reingold? Thank you Dr. Reingold. I
15 understand, ladies and gentlemen of the jury,
16 that tomorrow morning at 9:30 we are going to
17 move to the Hospital for Sick Kids for a
18 demonstration of how the Kidcom operates.
19 Mr. Hawkins, perhaps you have some comments
20 that you might like add as to where we should
21 meet, et cetera?

22 MR. HAWKINS: Perhaps we can recess and
23 confirm that and then we will give that
24 information to the jury and to Counsel.

25 MS. BROWNE: In the meantime, if you don't

1 mind my interrupting, I just want to say that
2 I have a paper copy now of all those boards,
3 and I've got two that can go in as an
4 Exhibit. There's the question dated December
5 the 11th and the answers dated March the 3rd,
6 and I've got enough copies for all the jury
7 members so they don't have to drag the boards
8 around.

9 THE CORONER: Mr. Hawkins, how long of a
10 recess do you need?

11 MR. HAWKINS: Well, just hold one moment and
12 perhaps we can ---

13 CONSTABLE CULLETON: 51(A) and (B).

14 MS. BROWNE: 51(A) and (B)?

15 THE CORONER: Thank you.

16 MS. BROWNE: And I have lots of copies here,
17 so take one and pass them that way.

18
19 --- EXHIBIT NO. 51(A): Letter of questions dated
20 December 11, 1998, from Mr.
21 Gomberg to Dr. Lucas

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23 --- EXHIBIT NO. 51(B): Response to questions letter,
24 dated March 3, 1999, from HSC
25 to Dr. Reingold

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MR. GOMBERG: Dr. Cairns, I don't think that he was suggesting that we re-convene to get that information. I think that if we just adjourn for the day, and keep ---

MR. HAWKINS: I didn't have precise instructions, I'm sorry, but I've now clarified that where people should meet is the Rotunda, which is in the old building, which is the entrance off University Avenue, the main entrance off University. There is that circular driveway just north of Elm, south of Gerrard, off University on the east side. You go in the main entrance and there's the Rotunda sign there you will find the demonstration for 10:00.

THE CORONER: That's fine, thank you.

DR. REEDER: Excuse me. We'd like to encourage people to either walk, take a taxi or the subway because at that time of the morning, parking is really limited.

MR. HAWKINS: Or park here, and walk over.

THE CORONER: So it will be the jury, obviously we will have the court reporter. This is not going to be purely just to view

1 something. We will actually allow testimony,
2 so that the media will also be allowed, but I
3 don't know how big the room is, and
4 hopefully, we can have some cooperation that
5 unnecessary spectators do not come for that
6 particular part, so that we can enable the
7 main participants and the media who are here
8 in a public forum to attend. So we'll
9 adjourn until 9:30 in the Rotunda at the
10 Hospital for Sick Kids tomorrow morning.

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14 --- ADJOURNED.

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18 THIS IS TO CERTIFY that the foregoing
19 is a true and accurate transcription
20 of my recordings and notes, to the
21 best of my skill and ability.
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29 Barbara A. Pollard
30 Certified Court Reporter
31
32

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