

INQUEST INTO THE DEATH OF

L I S A S H O R E

THE EVIDENCE OF DR. MARKUS SCHILY

TAKEN NOVEMBER 8th, 1999

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 Dr. M. Schily	ANNE POSNO, ESQ.

REPORTING PLUS
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1 MR. HAWKINS: Dr. Cairns, if I might
2 interject as it may assist Dr. Schily? We
3 had agreed previously to file the original
4 Hospital for Sick Children records as an
5 exhibit on consent, so it might assist Dr.
6 Schily to have the originals as opposed to
7 copies.

8 THE CORONER: Thank you, Mr. Hawkins. That
9 would appropriate if you could do so at this
10 time. We will now enter in as an exhibit the
11 original file from the Hospital for Sick
12 Kids. May I put it on the record that all
13 Counsel were in agreement that this could be
14 done through Mr. Hawkins without bringing the
15 Director of the Health Records Department
16 here. Thank you, Mr. Hawkins.

17 MR. HAWKINS: Perhaps what we can do, for
18 simplicity of reference, I have organized it
19 into two parts; the smaller part being the
20 admission of October 21, '92, and the other
21 part being the rest of the records. So
22 perhaps for simplicity, we mark the records
23 for October 21, 22 as exhibit, is it 3?

24 THE CORONER: 3.

25 MR. HAWKINS: And the other one is as

1 Exhibit 4.

2 THE CORONER: I think that would be
3 appropriate.

4

5 --- EXHIBIT NO. 3: Original Hospital for Sick Children file
6 being the admission of October 21st and
7 22nd, 1998.

8

9 --- EXHIBIT NO. 4: Original Hospital for Sick Children file
10 being the balance of records for all
11 other dates for Lisa Shore.

12

13 DR. MARKUS SCHILY, AFFIRMED:

14 EXAMINATION IN-CHIEF BY MS. BROWNE:

15 Q. May I begin by asking you, is your
16 surname Markus or is your surname Schily?

17 A. Schily. Schily. My family name is
18 Schily.

19 Q. I thought I -- thank you. Dr. Schily,
20 would you just tell us something about your background;
21 where you qualified as a doctor and what you did after
22 that, please?

23 A. I studied medicine in Germany. I
24 graduated in 1987 from Albert Ludwig University in
25 Freiburg, and after that right away I was working for

1 two and a half years in Schtettica Clinic (ph.) in
2 Dartmund (ph.) as a resident of anaesthesia. In this
3 time, I was also busy in trauma care and in intensive
4 care.

5 In 1989, I was emigrating to Israel and I
6 started my residency again as an anaesthesia resident
7 in the Soroka Medical Centre of Be'er-Sheva, which is
8 in the south of Israel. I finished my residency in
9 anaesthesia in 1995 and since then I'm a staff
10 anaesthetist in Soroka Medical Centre.

11 Shortly after that, I started a second
12 residency as an intensive care doctor, which is the
13 usual procedure now in our hospital, the usual policy,
14 to have a second residency besides anaesthesia.

15 From July 1998 until end of June 1999, I was
16 a fellow in anaesthesia in the Hospital for Sick
17 Children. I returned after that and I am now again
18 staff anaesthetist in the hospital where I was trained
19 in Be'er-Sheva, and where I'm coming now from.

20 Q. Is it your intention to practice
21 anaesthesia exclusively or ---

22 A. We are a general hospital and I will be
23 involved mainly in paediatric anaesthesia and in
24 intensive care, and, of course, everything else, what a
25 general hospital needs.

1 Q. When you were a fellow in anaesthesia at
2 Sick Children's Hospital here, did you have any
3 particular branch of studies, any area of interest?

4 A. Yes. I was very busy here in research.
5 I basically was busy in three projects. The first was
6 the watching kinetics. Dealing with watching kinetics
7 of two aesthetic, two volatile anaesthetics, Halaton
8 (ph.) and Sebuforan (ph.), and I was in all the
9 projects working together with Dr. Lerman (ph.).

10 The second project was part of a multi-centre
11 study investigating the effects of Levobubivacane
12 (ph.), which is a drug you use for epidurals and other
13 block, a more modern drug than the rather older
14 Vuvivacane (ph.). And the first study was a clinical
15 study about the so-called educated hand of a paediatric
16 anaesthetist. We were investigating in this study how
17 well a staff anaesthetist, a trained staff anaesthetist
18 is ventilating neonates, hand ventilating neonates and
19 how much he's able to sense only by his hand touch the
20 possible occlusions of a tube.

21 Q. Were you also involved during your term
22 at the hospital with the pain management clinic?

23 A. It is policy, I think even now, it was
24 and it is policy that pain fellows at Sick Kids, they
25 are covering the pain service. Normally this is in

1 weekly shifts, and I was involved in that.

2 Q. Can you just give us a brief description
3 of the pain management clinic and the pain service?
4 What does it entail?

5 A. You will certainly hear more about it
6 later. Pain service, first of all, there are two major
7 parts; it's the acute pain and the dealing with a
8 chronic pain. The pain fellows, they are mainly taking
9 care of acute pain service, and they might have chance
10 here and there being involved in the chronic pain
11 service, as well.

12 The hospital has about three pain nurses,
13 which are very dedicated in helping the pain fellows
14 together with a pain staff, anaesthetist, who is doing
15 this work mainly, and training the pain fellow. Of
16 course, all the pain fellows, they have experience.
17 They come as senior anaesthetists from abroad mainly,
18 and they have experience in pain service and pain
19 treatment.

20 Q. How many pain fellows were there with
21 you in the time that you ---

22 A. Anaesthesia fellows, they're called.
23 They are only a pain fellow for these shifts.

24 Q. Oh, I see. I see.

25 A. Yeah. They come from -- they are called

1 during this week the responsible fellow for pain
2 service. So we were -- I roughly guess we were about
3 ten people in this year. It varies from year to year
4 slightly, the number of fellows in anaesthesia.

5 Q. When you were on shift, would you be the
6 only pain fellow -- in the shift in the pain
7 maintenance unit, would you be the only one on or would
8 there be others with you?

9 A. I would be the only fellow, that's true,
10 but there would be the staff anaesthetist, who would
11 back up and who would discuss, if needed, problems with
12 me.

13 Q. And would there be always one of the
14 pain nurses or would it be left to the general duty
15 nurses?

16 A. No. Morning rounds would be performed
17 together with the pain nurse, who has a huge experience
18 and -- yes.

19 Q. So I take it from what you're saying,
20 you didn't perform -- when you were on shift as a pain
21 fellow, you didn't perform your duties in any one area,
22 but you circulated through the hospital where you were
23 needed; is that right?

24 A. When I was in pain service?

25 Q. Yes.

1 A. I was doing my rounds.

2 Q. In the morning.

3 A. And I would go in the night whenever
4 it's needed. Besides that, there are those regular
5 shifts I forgot to mention, that, of course, a fellow
6 in anaesthesia is doing the normal on-calls, and for
7 these on-calls, the anaesthetist will take over for the
8 time where he's on call, so from half past 5:00 until
9 the next morning he will be responsible also for the
10 pain. So this is a little bit confusing.

11 The pain fellow has the full week. The other
12 fellows, if their on-call is falling in this week, they
13 will take over from half past 5:00 to the next morning,
14 pain service. Is this answering your question?

15 Q. You're helping. Can you tell me, you
16 were on duty on the night that Lisa came in and Lisa
17 died; is that correct?

18 A. Yes, I was on.

19 Q. Will you have to look at any notes to
20 refresh your memory as to your involvement? We have a
21 file here as Mr. Hawkins has put in. There's a file
22 that is from the Hospital for Sick Children relating to
23 her last hospitalization. Could you just have a look
24 at that? That would be exhibit, sorry?

25 THE CORONER'S CONSTABLE: 3 and 4. 3.

1 MS. BROWNE: 3. Exhibit 3, Constable
2 Culleton, would you just ---
3

4 BY MS. BROWNE:

5 Q. What shift were you working on the night
6 of October the 21st and the 22nd of 1998? And you can
7 look through anything there that will refresh your
8 memory.

9 A. I was there. I remember that I was the
10 fellow on-call, so I was responsible for whatever is
11 going on if needed for calls considering pain, and also
12 if it's needed to help out in the OR, which is going
13 together.

14 Q. And were you called that night?

15 A. I was first busy in the OR giving
16 anaesthesia and at -- I have to mention that I got
17 already from the pain nurse during the day, I don't
18 recall the time, but she told me that Lisa Shore, a
19 patient which was known to the hospital, might come to
20 the emergency in case that it is needed, and I got a
21 letter with the summary of her problems.

22 Later on -- do you want me to go into
23 the things which ---

24 Q. Yes. I was going to ask. Later on you
25 were on-call; is that right?

1 A. Yeah, from the moment where the regular
2 fellows would go home, I stayed, so normally the normal
3 work shifts end at half past 5:00, so I was going on
4 with the procedures in the OR and later on in the night
5 I got a call from the emergency.

6 Q. Where do you spend the time when you're
7 on-call waiting for a call? Where are you?

8 A. The normal policy is that the fellow on-
9 call will, as needed, work in the hospital, and if he
10 were to stay longer than 12:00 being involved in the
11 OR, in giving anaesthesia or in the hospital -- sorry,
12 giving anaesthesia, then the next day he will get off.

13 So, for example, if I would have worked in the OR
14 until 1:00, I wouldn't have to work then the next day
15 in the OR.

16 The pain service, if I would have to
17 take care between 12:00 or whenever, pain service, this
18 wouldn't infringe my work the next day.

19 Q. On that particular night, do you recall
20 when you heard about Lisa coming into the Emergency
21 Department at Sick Children's?

22 A. To my best recollection, I didn't write
23 the exact time down, but it must have been sometime
24 after 10:00 in the evening.

25 Q. And you were still at the hospital then?

1 A. Oh, yes. I was in the eye surgery room
2 when I got paged from the Emergency.

3 Q. After 10:00?

4 A. Yes.

5 Q. And is there anything in the records
6 before you that indicate that you made an entry when
7 you were called and ---

8 A. There's actually -- I recall that the
9 nurse from the emergency made an entry. I don't find
10 it now, but she was writing that she contacted the pain
11 fellow.

12 Q. Where would that be in the notes? Would
13 that be in the nurses' notes or the emergency record?

14 A. I have it. I have it here.

15 Q. Oh, good. May I just see what page
16 you're looking at?

17 A. It should be -- there's 15 and this is
18 14, so this is the emergency nurse notes we call ...

19 Q. Okay.

20 A. And here you will find ---

21 Q. I'm just going to try to get to where
22 you're ---

23 MS. BROWNE: If I may just refer Counsel to
24 -- we have a differently numbered brief, and
25 it starts at page 3 of the medical records

1 that we have, the Emergency Nursing Record.

2
3 BY MS. BROWNE:

4 Q. If you could just, again, please, Dr.
5 Schily, indicate? The first page of that Emergency
6 Nursing Record, who fills that out?

7 A. Well, definitely not me. I think it --
8 it's signed down by the nurse. It says "Triage Nurse
9 signature."

10 Q. And could you recognize the signature of
11 that person, that nurse?

12 A. No, no.

13 Q. You don't recognize it?

14 A. I don't, no.

15 Q. It looks like the first letter is "R"
16 and then there's an "F" for the last name. And could
17 you just read out for the jury what it says with the --
18 next to the arrow?

19 A. It's written, "On pain meds for right
20 leg pain from knee down." There's a sign for
21 "increased pain since last p.m." And there's an arrow,
22 "Ongoing problem." And then below that there's the
23 mark indicated for body weight. Her respiratory rate
24 was 20 and the pulse was 92 and the temperature was 37.

25 Q. And can you just tell me whether or not

1 the medications are listed? Medications the patient
2 was on.

3 A. Well, yes. In upper is current
4 medications. It's written, "Amitriptyline, 75
5 milligrams. Time last taken, last p.m."

6 Q. That would have been, to your
7 understanding, the day before, October the 21st?

8 A. Well, I guess. I can't refer to that
9 exactly ---

10 Q. You can't, okay. All right. Go on.

11 A. --- but this is what I -- and
12 Gabapentin, 1,400 milligrams, last time taken at 22:20,
13 and Carbamazepine, 400 milligrams at 7:00. 19, sorry.
14 19:00.

15 Q. So it looked as if she had that day,
16 according to my reading, she'd already had her dosage
17 of Gabapentin, Carbamazepine. I'm sorry, I'm
18 pronouncing this badly, at 7:00, and she had a dosage
19 of Gabapentin at about 10:20; is that correct in my
20 reading?

21 A. This is exactly what's written here.

22 Q. And according to what I'm looking at,
23 she hasn't had her Amitriptyline, the sedating one,
24 since the day before?

25 A. This is what's written here, yes.

1 Q. Yes. Okay. I just want to make sure
2 that I was getting it. Now, the next page that you
3 have there, it's numbered 4 in our records, can you
4 tell me what this is? It looks like two different
5 handwritings.

6 A. Well, it's the clinical observations and
7 the treatment and investigations and it looks like the
8 writings of a nurse, of the emergency nurse, and she's
9 -- do you want me to go through?

10 Q. No, I just wanted -- it looks as if one
11 is at 22:20, which would be ---

12 A. This is the time of admittance, I guess.

13 Q. Admittance. And for those of us that
14 don't know, that's 10:20 p.m. for those of us not on
15 the 24-hour clock?

16 A. Yes.

17 Q. And that's in one handwriting. Would
18 this have occurred before you were involved in Lisa's
19 treatment? Would these two entries on this page be
20 something that you read later?

21 A. That is very difficult for me to answer,
22 since there's things I don't recall. It's a long time
23 ago, and -- but I guess -- I think it sounds logical
24 that these things were at least partly written. At
25 least the first part looks like written before.

1 Q. And if it was written before, would you
2 have read that before you got involved in her
3 treatment?

4 A. I don't recall if I was reading that. I
5 got a report from the nurse, this I recall.

6 Q. Okay. And then I see that in the second
7 entry in a different hand, 23:50, which is 11:50 p.m.,
8 there's a notation of "pulse 88."

9 A. That's correct.

10 Q. Respiration, I believe. Is that "R" for
11 respiration?

12 A. Yes, this was.

13 Q. 16?

14 A. Yes.

15 Q. And there's no blood pressure mark?

16 A. There's no blood pressure mark.

17 Q. All right. But it says that, "Seen by
18 pain fellow." That's about one, two, three, four,
19 five, six lines into the second notation. I can't read
20 the first part. "PAP?" Is that PAP? Can you read it?

21 A. Which line, sorry?

22 Q. It's the second hand on that page.

23 A. Yes.

24 Q. One, two, three, four -- the sixth line
25 down it says -- that looks like initials, then it says,

1 "Seen by pain fellow."

2 A. Yeah. I wondered also what it means. I
3 can't tell you what ---

4 Q. Do you recollect seeing the child, Lisa?
5 Do you recollect seeing her?

6 A. Oh, yes.

7 Q. All right. Well, can you remember when
8 you saw her? This might help us with this.

9 A. Right away after I was called. It took
10 about ten minutes until I could go down, and it must
11 have been somewhere -- it must have been between
12 quarter past 10:00 to 11:00, somewhere in there. I
13 don't recollect an exact time.

14 Q. What was her condition when you saw her?

15 A. Lisa was moaning, was very -- making
16 noises of pain and sort of moving on the bed with her
17 leg slightly up, so far as I remember. Her mother and
18 her father were present at that time in the room, and
19 she was answering my questions and she looked like
20 being in severe pain.

21 Q. And what did you do?

22 A. Well I, first of all, approached her and
23 introduced myself. I started to ask them about the --
24 how severe is the pain; how long it's ongoing; what
25 nature of the pain is, and I was told that the pain

1 kept her from sleeping, that the pain started to be
2 stronger, especially if I recollect it right, after she
3 got some physiotherapy, and that she -- it was like a
4 stabbing, very, very strong pain.

5 Q. Was this in her leg area or was it all
6 over her?

7 A. It was basically in her leg area, so far
8 as I remember.

9 Q. Were you able to ask her questions and
10 receive answers as well as the information you got from
11 her parents?

12 A. So far as I remember, I got answers of
13 her, perhaps sometimes with a slight delay. I have to
14 admit, that's a long time and I don't -- I know that I
15 talked to the parents.

16 Q. What did you decide that should be done
17 for her? What could be done?

18 A. After discussing the treatments, after
19 listening to what the parents told me about the
20 treatments and success of treatments of the past, and
21 after also hearing that she's on the medication and
22 that this medication doesn't seem in this situation to
23 help, I decided that -- and it was also a decision
24 already made before to admit her, as the first thing,
25 which meant to find a bed for her, since anaesthesia

1 can't admit and for this reason we asked orthopaedics
2 to help us, and ---

3 Q. Any particular reason that you asked
4 orthopaedics to help you? Was it ---

5 A. She had an orthopaedic problem in the
6 past and she was known by orthopaedics.

7 Q. All right. And did you -- what happened
8 when you asked orthopaedics to admit her?

9 A. So far as I recollect, they already were
10 informed and were involved, but I'm not hundred percent
11 sure about that, if it happened after I came or if this
12 was done before already.

13 Q. Okay.

14 A. I can't answer that.

15 Q. All right. After you asked for her to
16 admitted, what recommendations or prescriptions did you
17 make for her treatment?

18 A. Well, basically there were two
19 possibilities of treating this. She had had, as
20 already mentioned, not a spinal block, but an epidural
21 block in the past, which is slightly different in the
22 way you do it and in the way of -- an epidural,
23 basically, is like for a labour, a procedure where the
24 catheter is not puncturing the dura, which is covering
25 the CSF. The spinal would go directly into the spinal

1 interfacial place. So she had an epidural in the past.

2 Q. Yes?

3 A. Which gave her pain relief for a very
4 brief time. Not too much, as I understood, and I
5 understood by that time that the pain even a little bit
6 increased later. Lisa's mother reported that she
7 thinks that this was basically because the treatment
8 was not an ongoing one, but a single shot epidural,
9 which means one administration of a drug, as a bolus
10 and not as an infusion.

11 It was the middle of the night and trying
12 again a block might have been difficult, and I felt
13 that this subject should at least be discussed with
14 those people in the chronic pain involved with Lisa.

15 I involved my staff, who was the anaesthesia
16 staff, and she came to the emergency and I discussed
17 then these ways, ideas of treating her and we decided
18 to treat her with a PCA, which is a Patient-Controlled
19 Anaesthesia and to run this PCA machine with morphine
20 as a treatment, as a solution for the overnight
21 admittance, for the admittance, until she will see her
22 pain doctor for the chronic pain.

23 Q. We'll hear more about this PCA machine
24 later from somebody who's more conversant, but
25 essentially, what is it, a needle with -- just what is

1 it?

2 A. The PCA machine has a different task.
3 It's basically a little tiny computer which allows to
4 handle the administration of morphine in a way that the
5 patient has more control over the administration of
6 morphine.

7 In the past the patients were dependent on a
8 nurse and a doctor's order and sometimes had to wait
9 hours until someone would be able to come and to give
10 this pain treatment, and so the idea was if you block
11 the administration for certain times, we call it in
12 doctor's language, a "lockout time," then you prevent
13 basically severe side effects, and as a matter of fact,
14 there are publications existing which say that using
15 this machine you might reduce side effects, and you
16 have a better pain control, and you even might have a
17 reduced use of narcotics, in some cases. So, you need
18 less, over the whole time, less narcotics. This
19 machine has different things to dial in.

20 Q. Yes.

21 A. You dial in the amount the machine is
22 administering. No, sorry. You first of all choose the
23 mode the machine is working on. There are different
24 modes. One is the PCA mode, which I choose here, and
25 therefore I will only refer to that.

1 Q. Right. Go ahead.

2 A. The PCA mode means that the patient is
3 having a button in his hand. He's pushing it and by
4 pushing it, the pump is starting to infuse a tiny
5 amount of the drug. Very important for this is to
6 mention that from the infusion pump, there's going a
7 line to the infusion, and this line has -- it's a
8 special line. It's not a normal infusion line. This
9 is a line which has a back-off valve, so one flow valve
10 so that if you attach this to a running infusion that
11 the morphine can't run up the infusion, but only go
12 down to the patient, which is very, very important
13 since there have been unfortunately in the past
14 problems with this, and it's solved with using this
15 line.

16 Q. Can you just tell me how old are people
17 before they're able to use this kind of thing? How old
18 are children?

19 A. That depends on the child. Some
20 children never will be able to handle it, those who are
21 mentally retarded or whatever, and this already
22 indicates that you need a child who is cooperative,
23 understanding and as a matter of fact, you need not
24 only a child who is cooperative, you need parents who
25 understand and who are helping you managing the pain

1 with this machine.

2 Q. Okay. You were ---

3 A. So basically if we look at children, I
4 would say you can start thinking about it around the
5 school age. Children become more understanding and
6 more cooperative in this age. Some children later,
7 some earlier. With 11 years a child should be able.
8 There are exceptions where at 11 years you can't do it,
9 but Lisa was definitely very cooperative and
10 understanding.

11 Q. And did you, indeed, set this up, this
12 PCA up?

13 A. Yes.

14 Q. In the Emergency?

15 A. We didn't have this machine in the
16 Emergency. I went personally up and brought a machine
17 from the recovery room, and I brought also the special
18 line and the syringe pump, which are all designated for
19 this machine, and I explained the function of the
20 machine to the emergency nurses, although I have to
21 mention that we had a very good emergency nurse which
22 were familiar with pain treatment.

23 Q. And her name? Do you remember her name?

24 A. This was Pauline.

25 Q. Pauline Matthews?

1 A. I'm sorry, I don't remember her family
2 name.

3 Q. Okay. You don't know.

4 A. But Pauline.

5 Q. All right.

6 A. And so I dialled in, first of all, the
7 amount in cc or millilitres the machine is with every
8 push which is allowed to administer infusing, and I
9 dialled in here, sorry, 1.5 cc, and, of course, you
10 have to choose the amount. You have to say how much
11 drug in milligrams you put in your volume, since
12 otherwise, since the machine is sensing only volume,
13 the machine can't -- is not measuring concentration,
14 okay? Do you have any -- is that clear? The machine
15 is infusing, and is infusing per volume.

16 So I decided, and this is normal policy, that
17 you normally take one milligram per one cc, so I
18 dialled in 1.5 cc, which means the same, equivalent,
19 like, 1.5 milligrams of morphine for every allowed
20 push. And then we come to the next step. I dialled in
21 a lockout interval and I choose -- I was choosing six
22 minutes, which is more or less standard in our
23 department, especially if you start a PCA, you want to
24 not have too long of a lockout interval, since
25 otherwise the patient never will come up to a pain

1 relief which will be sufficient.

2 And as a third parameter I dialled in a total
3 dose limit, a factor which is basically meant to
4 prevent if someone else is coming and starting to push
5 the button. It's sort of giving an extreme limit of
6 over two hours how much this patient can receive. This
7 is actually the factor which is the most less helpful
8 in pain treatment. In fact, it's very often more
9 disturbing than helping, since people tend to put this
10 too low down and as a result, the patient is not
11 getting the medication.

12 Q. Did you record these instructions
13 anywhere in the chart that you have?

14 A. Yes. I discussed it and recorded it
15 with handwriting in the emergency chart, which
16 should ---

17 Q. Let's just see if we can match that up.

18 A. Yes, I have it on page number 36.

19 Q. At page 36 of the hospital chart?

20 A. The hospital chart.

21 Q. Page 7 in the Counsel's brief. So, 36.

22 Just indicate what's on that page.

23 A. Okay. And we have the sticker of the
24 patient on the right side.

25 Q. Yes.

1 A. And then I was writing on the left side
2 the date, 21 of October, '98. Beside that I wrote, "10
3 milligrams morphine. Incremental doses, 2 milligrams
4 IV." It was meant -- I forgot to mention, before you
5 start a PCA, you basically want to give the patient
6 quickly relief of a strong, acute pain. This was an
7 acute pain on chronic pain, so you wanted to give him a
8 relief and not wait a long time, and therefore, I told
9 the nurse, we will inject manually some morphine. And
10 this is what is written here, "Incremental doses, 2
11 milligram IV, until pain-free."

12 Q. I just heard from Mr. Gomberg that he
13 has this particular one enlarged. I thought we could
14 put it on the easel and the jury could follow it along.

15 THE CORONER: This is an enlargement of this
16 particular page?

17 MS. BROWNE: Yes, it's page 36 in the
18 hospital chart.

19 THE CORONER: Do any Counsel have any
20 objection to this? I think it would, from my
21 point of view, be very helpful. I shouldn't
22 speak for you, but I think it might be very
23 helpful if you could actually see what we're
24 talking about as we're going along, so,
25 unless Counsel have any objection, I will put

1 this in as the next exhibit.

2 And this is referring to, I think,
3 Doctor, the orders that you wrote in the
4 Emergency Department that night, and those
5 were the orders that were going to be
6 followed for Lisa's treatment from then until
7 she was seen by her PN doctors the next
8 morning? Is that a correct summary?

9 THE WITNESS: This page, you see on here
10 it's basically the page I was writing for the
11 Emergency Department, and, of course, would
12 have to be part of the general chart going
13 with Lisa to the ward. There are more pages,
14 which we soon will talk about, which are
15 covering the real orders, but so far as I
16 recollect, in the emergency they don't use
17 the computerized system and therefore, you
18 have to write the things with handwriting.

19 And in the wards you basically will
20 write in the computer your orders.

21
22 --- EXHIBIT NO. 5: Enlargement of Page 36 of the hospital
23 records, being Dr. Schily's orders.
24
25

1 BY MS. BROWNE:

2 Q. Yes. We're going to get to that, Dr.
3 Schily, but, first of all, I wonder, could you -- for
4 the benefit of the jury there's a pointer somewhere.

5 THE CORONER: I'm just wondering, Ms.
6 Browne. It's 11:00 a.m. This is quite an
7 important piece of evidence, and perhaps it
8 would be a reasonable time to take a 20-
9 minute morning recess?

10 MS. BROWNE: Yes, of course.

11 THE CORONER: Recess for 20 minutes. I
12 indicated earlier to caution the jury that at
13 recess you should not speak with anyone
14 except yourselves. We'll recess for 20
15 minutes.

16
17 --- A BRIEF RECESS

18
19 DR. MARKUS SCHILY, RESUMED:

20 CONTINUED EXAMINATION IN-CHIEF BY MS. BROWNE:

21 Q. I wonder, could you possibly just come
22 over to what has been marked as exhibit, I believe it
23 is ---

24 THE CORONER: Number 5.

25 MS. BROWNE: Thank you very much.

1

2 (When Dr. Schily is speaking at the easel, he has his
3 back to the microphone and the quality of the sound
4 reproduction is very poor, hence "inaudible" notations
5 during his testimony)

6

7

BY MS. BROWNE:

8

Q. And perhaps point out with the pointer
9 what you were telling us before. On the left there you
10 have the date, right? Okay, would you explain what is
11 then written next to that?

12

A. Okay. Here is written "10 milligrams
13 morphine, in incremental doses, 2 milligram IV until
14 pain-free." Pain score, this means about 5.

15

Q. On a scale of what? About 5 is at a
16 scale of ---

17

A. That is a scale of 1 to 10.

18

Q. What is 1 and what is 10?

19

A. 1 would mean no pain. 0 or 1, this is
20 different. It doesn't measure so much. And 10 would
21 be the worst pain you ever could imagine. This is the
22 way we normally explain the pain score to our patients.

23

Q. And the number 5, you've got number 5.
24 That comes from the patient herself; is that right?

25

A. The pain score is normally, in these
26 situations, assessed if we have a cooperating patient,
27 by the patient. There are different pain scores, which

1 are done by the nursing staff, which in this case, this
2 is -- we believe that pain is something subjective.

3 Only can someone who is experiencing the pain
4 say how strong the pain is. So 5 would be still in
5 pain, still reasonable pain, but a pain you can better
6 cope and a 10 would be a pain you couldn't actually
7 bear.

8 Q. All right. Can you continue then with
9 the next line, which has a little arrow?

10 A. Okay. That arrow, first of all,
11 indicates on the word which I read like "done." And
12 beside there we have "IV line," intravenous line, "PCA
13 device." Patient-controlled analgesia device, which is
14 the machine I was talking about. Then we have an arrow
15 under that. "See KidCom orders." KidCom is spelled K-
16 I-D-C-O-M. This is a short name for our computer
17 system in the Hospital for Sick Children.

18 Our computer system in the Hospital for Sick
19 Children, we are -- put in all our pain orders and
20 prescriptions through the computer system, which is
21 hospital-wide, with some exceptions. One of the
22 exceptions is emergency. They have it there, but the
23 things you do or you prescribe, you have to write down.
24 This is what I was told by them.

25 Q. All right. We'll hear a bit more about

1 KidCom later, but can you just tell me what the orders
2 were?

3 A. This is my signature, and I was writing
4 on the right-hand side, and here I was referring to my
5 orders, and it's written, "50 milligram, MG, morphine
6 in 50 cc saline." And there is a sign for equals. "1
7 milligram equals 1 cc." This is referring to what I
8 explained to you, that we have to say what sort of
9 concentration we're running our machine on.

10 Under that I was indicating, "bolus, double
11 point, 1.5 milligram." I always write my orders in
12 milligram and not in cc, to repeat basically my
13 concentration.

14 Q. Yes.

15 A. Of course, the machine is reading it in
16 cc or is performing the order in cc, but I write the
17 orders in milligrams, since the nurse will be again
18 aware of the fact how much milligrams I want to give.
19 "Lockout interval." This was the lockout interval.
20 This is what I've told you, the interval that the
21 machine is not administering any drug. Even if the
22 patient pushes the button, there's nothing running.
23 "Lockout interval, double point, six minutes. Point
24 total dose, (inaudible) 20 milligrams in two hours."

25 We normally talk about two hours total dose,

1 and put also divided by one and say a one hour total
2 dose and we stretch it over a period of two hours. The
3 reason behind this is because many times initially the
4 patient needs more and the second hour already he is
5 settled with the pain relief (inaudible).

6 Under there again is my signature and my
7 name, Dr. Schily. There are two arrows here on the
8 left side and it's written "Done," and an arrow. Then
9 an arrow, "Set up by Dr. Schily." It looks like a
10 signature. It's not a signature which is familiar to
11 me, but certainly it's a nurse.

12 Q. Up on the top right-hand corner beneath
13 the black bar, there's two lines. Could you just --
14 just below the black bar. Yes.

15 A. Yes. Okay.

16 Q. Could you just tell me what those are?

17 A. This is not my handwriting, first of
18 all, definitely not my handwriting. An arrow, it shows
19 that -- this is the way the nurses are interpreting or
20 showing that these things are done, so here it's
21 written, "2 milligrams morphine given, 23:50." So, ten
22 to 12:00.

23 Another arrow under that, "2 milligrams
24 morphine given at 00:40." Is that correct?

25 THE CORONER: Right.

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BY MS. BROWNE:

Q. Mm-hmm. And does this mean through this pump?

A. No, this is referring, since I am -- this is referring to my first order, to the first part of the order giving manually a single bolus to speed up the pain relief.

Q. So Lisa received a shot of morphine before she was put on the pump and ---

A. Exactly. And also to my best recollection, while she was on the pump in the very beginning to speed up things, since lockout intervals sometimes prevent you from reaching a level that a patient is better coping with the pain, and you might want to speed up the titration of the drug.

Q. Now, can you just tell us, if you can, your writing appears where? Point to it with -- your writing is where? Just the two signatures?

A. Okay. This is my handwriting. This is my handwriting, too. This is not my handwriting, so, these arrows and these explanations, and this is also not my handwriting. This is, so far as I know, not my handwriting.

Q. So ---

1 A. It looks very similar, but if you look
2 very carefully at the morphine, and my morphine will be
3 different, and also the word "given," it's different.
4 Unfortunately, it's not signed here.

5 Q. So that where you have the little
6 arrows, either to this way or down the way, those were
7 entered by whom?

8 A. Those were, to my best understanding,
9 entered by the nurse.

10 Q. And would that have been entered in your
11 presence or after you had gone?

12 A. I don't recollect.

13 Q. You don't recollect. And do you know
14 what nurse was it who entered these things?

15 A. Well, I was working together at that
16 time with Pauline.

17 Q. Pauline Matthews, all right. All right,
18 thank you. Perhaps you could just leave that pointer.
19 We have some more stuff for you.

20 You mentioned, Dr. Schily, something called
21 KidCom, and we're going to hear about that later, but
22 just indicate to us briefly, what is that short for,
23 KidCom, and how does it work?

24 A. That's a difficult question. Where it's
25 coming from, I don't know. "Kid" is certainly

1 referring to Hospital for Sick Children. "Kid" means
2 kid. And "Com," sorry.

3 Q. No, that's all right.

4 A. I don't have a very logical explanation.
5 "Com" means certainly the computer system.

6 Q. Seems like a normal condensation.

7 A. A condensation and a familiar name for
8 every fellow in the Hospital for Sick Children.

9 Q. How long has this computer system been
10 working, do you know? Was it there before you came?

11 A. It was existing before I was there. I
12 can't tell exactly how long. In the time I was there,
13 there were some places in the hospital, as I was
14 already outlining before, which were not yet involved.
15 So far as I know, Intensive Care just right now, I'm
16 not a hundred percent sure, but I heard a rumour it's
17 now also having KidCom. And Emergency had a KidCom,
18 but the orders, as I said, you had also to write them
19 manually.

20 Q. So you have to write -- if you're in
21 Emergency, you write your orders manually such as that,
22 and you also enter them into this computer?

23 A. Yes. Since the patient goes to the
24 ward, and the ward is working basically with KidCom
25 orders.

1 Q. And what happens once you enter them
2 into the computer?

3 A. Well, first of all, every fellow gets
4 instruction in this computer system, and gets a
5 password. And, as well, the other people in the wards
6 have a password like a key, so to avoid that someone
7 who is not allowed has access to this data or might
8 even change or read orders or patient data which is not
9 for someone else meant. You need to have your
10 password.

11 Once you enter the system with your
12 password, you find your way through the chart and there
13 is a certain pathway which is dedicated for the pain
14 treatment. It is very, very simple once you understand
15 it. You basically choose the department and you go on
16 the mode you are treating the patient.

17 So, for example, a PCA mode or a PCA
18 mode with an infusion. So we have a different kind of
19 pain treatment as well, or an epidural, whatever you
20 choose with, you click it on. You enter the path of
21 this thing and it will guide you through the whole
22 thing. Every time you choose something you have to
23 click it on. You have to put in the doses and you are
24 -- every time you are clicking on something and an
25 order goes in there is an automatic signature appearing

1 beside it. In my case, I think I must be M. Schily,
2 MSCH or something. You will see it later.

3 Q. Yes, okay.

4 A. And so people who are reading it, they
5 are also recognizing who is the one who was signing.
6 And the pathway for the pain prescriptions is also
7 including prescriptions for monitoring and once we put
8 in the orders, they are only actually accessible for
9 hospital-wide use. So wherever the patient is going,
10 one of the things, the staff who are receiving the
11 patient is looking these orders up and acting on behalf
12 of these orders.

13 Q. Is that a standard thing in the
14 hospital, that wherever the patient goes the persons
15 who receive the patient check the KidCom?

16 A. Well, I suppose so.

17 Q. I think if you look at the chart that
18 you have in front of you, page 38, you might find
19 something you recognize. It's page 14 in the brief.

20 A. This, yeah, okay.

21 Q. Could you tell us what that is that
22 you're looking at?

23 A. Well, this is basically what I was
24 talking about, the KidCom order printout, and ---

25 Q. And would you just look at this? Is

1 this a blow-up of what you're referring to?

2 A. Yes, it is.

3 MS. BROWNE: Can this be marked as an
4 exhibit, Mr. Coroner?

5 THE CORONER: Exhibit number?

6 CORONER'S CONSTABLE: 6.

7 THE CORONER: We'll marked that as the next
8 exhibit, Number 6.

9

10 --- EXHIBIT NO. 6: Enlarged copy of daily orders summary.

11

12 BY MS. BROWNE:

13 Q. And we'll put this up on the easel so
14 that jury can follow along, and if you don't mind
15 getting up again?

16 A. If I can have a look again?

17 Q. Certainly. Yes, certainly.

18 A. So the printout, it's a summary of the
19 input we put in the computer, and it depends where we
20 put the -- where we would put our -- the summary
21 (inaudible) the name of the patient, and all the
22 patient-related data, date of birth, her height in
23 centimetres, her weight, which is more important here,
24 and the admittance date. (inaudible), 1998, 10, 21.

25 Q. And the unit?

1 A. Unit, I don't know what it means.
2 Q. EXP?
3 A. I can't tell you what it means. The
4 diagnosis, which was chronic pain. It is actually not
5 the whole truth. It's acute and chronic pain, that is
6 very important. And the responsible physician is in
7 this case the orthopaedic doctors.

8 Q. And this is to go to orthopaedics, is
9 it?

10 A. Yes, saying that the patient was
11 admitted.

12 Q. Now, if you could go just down to the
13 new orders entered for the day, check that and indicate
14 whether or not those are the orders that you entered on
15 the computer.

16 A. Okay. So here it's written in, " New
17 orders entered for the day 1998, 10/21." The time here
18 is 23:14.

19 Q. 11:14 for ---

20 A. 11:00, yes.

21 Q. As of p.m., right? Okay.

22 A. And there is something very interesting
23 appearing here. This is the word called "suspended,"
24 which I haven't met until I got the printout later this
25 year. This is not -- you won't see that in the

1 computer while you are putting in your orders.

2 Q. What does it indicate?

3 A. I was told by -- do you want me to ---

4 Q. Well, just tell me your source of
5 knowledge of that. What ---

6 A. KidCom computer.

7 Q. By the persons who are responsible for
8 operating the computer, they told you what "suspended"
9 means?

10 A. Yes.

11 Q. And we will have more information, but
12 what do you understand that it means?

13 A. I first didn't understand. You mean
14 now?

15 Q. Now.

16 A. I was told that once -- that this
17 information is based on ---

18 Q. Yes, I understand.

19 A. --- KidCom (inaudible) from there, so I
20 don't have a written ---

21 Q. Okay.

22 A. --- information. I was told that once
23 you open the -- you open the computer system, like,
24 with a key, the computer senses this and I was told you
25 need to activate by this process, and confirm that you

1 write the orders and then this one key here. I don't
2 know if there is then something written and activated.
3 I can't tell that. But "suspended" seems that this
4 wasn't done properly.

5 Then "DAT" I don't know what it means.

6 "DAT." "Pain control to be managed entirely" ---

7 THE CORONER: Perhaps I could just -- is it
8 consistent, do you think, with "diet as
9 tolerated?"

10 MS. BROWNE: That's good.

11 THE CORONER: I'm just asking.

12 THE WITNESS: Of date or ---

13 THE CORONER: No, "DAT"?

14 MS. BROWNE: Diet as tolerated.

15 THE CORONER: We'll leave it to someone
16 else.

17 THE WITNESS: Yeah, I couldn't tell you.
18 This is not something we put in. This
19 appears later.

20 THE CORONER: Thank you. Okay.

21
22 BY MS. BROWNE:

23 Q. What did you put -- what directions that
24 you made are reflected on the orders there?

25 A. Okay. This, first of all, is the

1 orthopaedic doctor and what he is indicating. My part
2 is starting here, in the second part, "suspended again
3 at 23:47," so this leaves us some minutes before 12:00.

4 "PCA morphine, 1 milligram per millilitre in NS."
5 "NS" means normal saline, "IV. Loading dose, zero
6 millilitre" and MSCH is my code, my signature.

7 It's the loading dose, just for
8 explanation, is zero. You can't avoid it. It
9 practically forces you to refer to say yes or no to
10 loading dose and you have to write something, so, I
11 always write zero. "Bolus dose, 1.5 millilitre," which
12 is 1.5 milligram. "Lockout period, six minutes.
13 Infusion rate, zero millilitre per hour."

14 In other terms, there's not an
15 additional infusion of narcotics running beside the
16 boluses, so only bolus. "Total dose limit, 20
17 millilitres over two hours," and my signature again.
18 There's coming another order suspended. "Patient is on
19 PCA device. No CNS depressants or narcotics to be
20 given unless approved by the anaesthesia pain service,"
21 and my sign again. Then under that, "acetaminophen,
22 zero milligrams," so none, no additional and my
23 signature again.

24 Q. And for those of us who are not doctors,
25 "CNS" is central nervous system; is that right?

1 A. That's right.

2 Q. No central nervous system depressants or
3 narcotics to be given.

4 A. So that you want me to -- what it means,
5 that someone who finds the patient and sees she's still
6 in pain will have an idea, oh, I want to do good and I
7 will admit some more narcotics beside the PCA, so this
8 is not allowed, and that's why the order is like that.

9 Q. All right, thank you. That's the end of
10 that one. If you would turn now, Doctor, to page 39 in
11 the chart. It's at 15 in Counsel's, and it's, I
12 believe, a continuation of this one?

13 A. Yeah.

14 Q. And you have some more orders on there?

15 A. Yes, I have.

16 Q. And again, would you have a look at
17 this? I'm going to ask that this be marked as the next
18 exhibit. Is this identical to what you have in front
19 of you?

20 A. Yes. It looks like the same.

21 MS. BROWNE: Exhibit 7?

22 THE CORONER: Exhibit Number 7.

23

24 --- EXHIBIT NO. 7: Enlarged page 39 of the chart being a
25 daily orders summary.

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BY MS. BROWNE:

Q. Sorry, we have to ask you to get up again. All right. Do you have orders entered on this page?

A. Yes, it's true. Again, my signature is here, my computer signature.

Q. And can you tell me the time these orders went in?

A. The first written has 23:48, so, it's the correct, as a continuation of the other one.

Q. And essentially what are you telling people to do there; is this more medication or is it some sort of instructions to nurses or what?

A. This part of the prescription is what I was explaining as before, but it's basically all the orders considering safety measures, considering what has to be available at the ward at the time we are dealing with PCA, and how in the case of emergency, what things have to be done and in what sort of way it has to be done, as well as an interpretation of a score, which we call sedation score, which you see below here.

Q. And does this involve certain equipment?

A. Yes. In the beginning we say, "Wants to

1 have a self-inflating bag" which is what we know as an
2 "ambubag" for ventilation of patient, a mask which has
3 to be attached, and as well, a mask for applying
4 oxygen. "Oxygen and suction at bedside," so in case
5 that there will be respiratory depression, (inaudible)
6 or whatever, that they would have equipment for CPR for
7 emergency treatment. And Nalaxone (ph.) Nalaxone is
8 for narcotics, it's a specific antidote. So this is
9 the drug we would inject for those cases where we would
10 realize that there was an overdose, and as a result of
11 overdose side effects, and then we would inject
12 Nalaxone, depending, of course, on the severity, as a
13 priority for giving first Nalaxone or the intubating
14 and ventilating the patient, would depend on the
15 severity of the ---

16 Q. So, do I understand ---

17 THE CORONER: May I just, just to help with
18 the clarity? The Nalaxone is a specific
19 antagonist for morphine, so that's if too
20 much morphine is given or if the patient, if
21 their breathing rate drops to a low rate that
22 would give you concern, then this particular
23 drug would be used to counteract the adverse
24 effects of morphine; is that correct?

25 THE WITNESS: That is correct.

1 THE CORONER: I am trying to split this down
2 so as to help the jury in lay language as
3 much as possible.

4 THE WITNESS: Basically it's not only
5 against the respiratory effect, but it's in
6 whole antagonizing the effect of the
7 morphine, and of all the narcotics, without
8 having an intrinsic narcotic activity.

9
10 BY MS. BROWNE:

11 Q. So that in order to safely administer
12 this PCA, these pieces of equipment should be there
13 beside the bed or close at hand enough to be used if
14 necessary. And specifically what Dr. Cairns mentioned,
15 this Nalaxone, in case there seems to be an overdose or
16 morphine, this would fight against it?

17 A. (inaudible) right away.

18 Q. And again, we have the word "suspended,"
19 which we've referred to before. You understand that
20 that means?

21 A. Well, like the KidCom people I talked to
22 for understanding it, and we have it basically where
23 (inaudible).

24 Q. All right. And that would mean that
25 "suspended" would remain on the computer until somebody

1 accessed the order and then the "suspended" would
2 disappear?

3 A. Well, I want to be careful here.

4 Q. Sure.

5 A. I ---

6 Q. You don't know?

7 A. I'm not the expert in this, so, perhaps
8 I can only tell you what I've been told.

9 Q. All right. So that's what -- you were
10 told basically what I just said?

11 A. I was told that you have to activate it.

12 Q. Right.

13 A. Now, I don't know if to activate it that
14 you confirm that you are doing it.

15 Q. Right.

16 A. Or by only reading it, therefore, I
17 don't want to ---

18 Q. Okay. That's fair, that's fair. The
19 next part at 239, you have a sedation scale, pain
20 scale, HR ---

21 A. Not a pain scale. A sedation score.

22 THE CORONER: Scale.

23
24 BY MS. BROWNE:

25 Q. Isn't there a pain scale after that?

1 A. I'm sure we have ---

2 Q. Sorry, 239.

3 THE CORONER: Last column.

4 THE WITNESS: Second line.

5

6 BY MS. BROWNE:

7 Q. Second line. If you read across.

8 A. Sorry, yeah.

9 Q. That's okay. Sedation scale.

10 A. "Sedation scale, pain scale, heart rate,
11 blood pressure." "BP" is blood pressure; "HR" is heart
12 rate. "RR" is respiratory rate. "Q1H," it's four
13 hours on admission.

14 Q. What does "Q1H" mean, "Q1H X four
15 hours"? What does that mean?

16 A. That's the time that these things have
17 to be checked. That is a nursing standard, which is
18 automatically going in this and the nurses are very
19 familiar with that.

20 Q. All right. So they were expected to
21 check the heart rate?

22 A. The frequency, they have to take these
23 things.

24 Q. All right. And then you have further on
25 the same ---

1 A. Yes. And the important thing is
2 actually at "on admission."

3 Q. Yes.

4 A. Then do you want me to go ---

5 Q. Yes. Go down to 240 and indicate what
6 you were saying there.

7 A. "Pain scale, heart rate, blood pressure
8 and pulse," so if those -- so, again, heart rate, blood
9 pressure, respiratory Q1H X 4 hours, "If dose or
10 infusion rate increase, then sedation scale and
11 respiratory rate Q1H and pain scale, heart rate, blood
12 pressure Q4H" and my signature.

13 Q. Can you put that layman's language? If
14 the dose or the infusion is increased, then what?

15 A. What it basically is, is the background
16 of these things, that we know there are certain times
17 where things might be normal constant, they get
18 changed, and you want to catch these moments and to
19 cover it with more check-ups. So one is, of course,
20 the moment the child or patient is moved from one place
21 to the other. The nurse who is admitting this patient
22 has to become more familiar with the patient, and the
23 timing where we started this pain drug is also
24 (inaudible), it's a new administration, and we want to
25 see if the check-ups reflect any changes or side

1 effects. So we want to have closer check-ups.

2 On the other side, if we see that either
3 we need to change our pain management, a), because
4 we're giving not enough pain treatment or b), because
5 we have side effects and we have to stop it, both
6 situations demand actually that we have closer check-
7 ups. This is reflected in these (inaudible).

8 Q. All right. And the next one, 241.
9 "Contact anaesthesia pain service." Am I right? "If
10 sedation score 3."

11 A. Yeah.

12 Q. "Respiration rate below 11 minutes."

13 THE CORONER: That's per minute.

14
15 BY MS. BROWNE:

16 Q. Sorry, that's --

17 A. Eleven breaths per minute.

18 Q. Eleven what per minute?

19 THE CORONER: Breaths.

20 THE WITNESS: Eleven respiratory rate.

21 Eleven breaths per minute.

22
23 BY MS. BROWNE:

24 Q. Breaths per minute. Thank you.

25 A. "Inadequate analgesia," which means

1 inadequate pain relief, "or pump malfunction. Four
2 (inaudible) and fellow, Dr. Schily." Pager number of
3 me (inaudible). The staff, now, the staff, we call the
4 OR desk only for one reason, since we want them to have
5 an option which is right away available. So this order
6 basically gives them the track to follow if there's any
7 problem occurring.

8 First of all, if it's not a super
9 emergency, which demands right away action, phoning the
10 pain fellow, wherever he is. He might be busy, he
11 might be at home, and calling him and explaining to
12 him. He knows the patient and he is the one that wants
13 to deal with this problem. If this is not quick
14 enough, not fast enough or you can't find him for
15 whatever reason, then we always include a second
16 option, and since we know that through the OR there are
17 always 24 hours might reach an anaesthetist, who is
18 also the one who is carrying the code pager which means
19 the work pager who is working (inaudible) in the
20 hospital. So this is the second way to get right away
21 help and assistance.

22 Q. So essentially, in this order, order
23 241, you're saying, if certain things happen, contact
24 you?

25 A. That's right.

1 Q. And then if they can't get you, get the
2 Emergency?

3 A. That's right.

4 Q. And the things that would happen is the
5 sedation score, is that the depth of her sleep?

6 A. The sedation score that you have down
7 here ---

8 Q. Okay.

9 A. --- it means, sedation means actually,
10 how much the patient is arousable.

11 Q. Right.

12 A. Or not arousable.

13 Q. So, okay.

14 A. This is a very important but also
15 difficult thing and we want therefore to have a dry
16 score, to have a common language between us, since we
17 don't see the patient sometimes, we want to write
18 things down, so we have 0, 1, 2, 3 and S.

19 Q. And in this you've got -- the sedation
20 score is 3, so if the patient becomes somnolent,
21 difficult to arouse, then that's one indication that
22 you should be called?

23 A. That is one indication that we should
24 know about and should reconsider that and what to do.

25 Q. Another indication, if the rates per

1 minute ---

2 A. Respiratory rate.

3 Q. --- respiratory rate that is, or breaths
4 per minute, drop below 11, then that's another
5 indication you should be called.

6 A. Yes. This is something important you
7 mentioned. Since the input of the breaths per minute,
8 if the physician is giving by himself, so this is not
9 standard, he has to write where he puts the limit, and,
10 of course, there's a difference between a small child,
11 which is breathing very fast and a bigger and older
12 child who is more breathing like an adult. So the
13 normal breathing pattern of an adult will be between 10
14 to 20 rate, sometimes even a little bit less than 10,
15 sometimes a little bit more than 20. It depends on the
16 situation.

17 I indicated 11 simply because of one
18 reason; I tend to put a little bit on the outstanding
19 number, not ten like in order to get the attention of
20 the nurse. That is something individual; I confess
21 that I do that. So if's it's ten, normally people
22 would put ten.

23 Q. And you put 11 because it's a different
24 kind of number?

25 A. Because I'm like that. I want the nurse

1 to read this not like a standard information.

2 Q. I see.

3 A. I want her really to be absolutely aware
4 that this has a high source priority and importance,
5 since the breaths per minute, this is basically the
6 first sign in a narcotic overdose, of a narcotic side
7 effect. Breaths are going down in (inaudible) and then
8 you have less breaths per minute.

9 Q. And that's calculated, did you say, on
10 her age and her weight and her condition?

11 A. That would be appropriate for a child.
12 Eleven breaths would be a healthy child.

13 Q. Right.

14 A. And would be not on oxygen and would be
15 a normal, an otherwise normal, healthy child.

16 Q. You also have after that, if we
17 understand it right, you were supposed to be contacted
18 if it appears that there was inadequate analgesia. She
19 appeared to be in pain. How would you do that?

20 A. Where ...

21 Q. "Inadequate analgesia." We're still on
22 241. Up, up, up, up. We're just right now where you
23 were. "Inadequate analgesia."

24 A. "Or pump malfunction."

25 Q. "Or pump malfunction." What's that

1 mean?

2 A. Well, the side effects, you might have
3 not a good setting. Pain treatment, I want to remind
4 you, is always something so individual. One person
5 might need much more and we always tend in the
6 beginning to get perhaps a quicker way to reach a
7 level. Of course, once a patient is in (inaudible) we
8 tend to keep -- not going on the highest dose, but to
9 keep a reasonable level. This unfortunately, it
10 includes those patients who are not very well treated,
11 and then we have to re-do our settings and to change
12 (inaudible) the settings and therefore, the order, if
13 pain relief is not appropriate, please contact us.

14 Q. And the last thing you record, is it a
15 pump malfunction?

16 A. Well, unfortunately, although these
17 pumps are very safe, very good, there might be a
18 battery problem, the pump is just not delivering or an
19 alarm is constantly going on of this pump, so this is
20 also a situation where ...

21 Q. Now, you have another order, which is
22 just below that. It's number, I guess, 242. It
23 indicates -- can you just tell us, what does it mean
24 "suspended to arouse"? Sorry, never mind "suspended."
25 "To arouse;" what does that mean? What's your aim

1 here?

2 A. Again, this is a little bit different
3 than we see once (inaudible) but, I believe this is
4 referring to the monitor, something like that,
5 (inaudible) like that, either malfunction, or it's
6 referring to what is written before, that the
7 (inaudible) these side effects (inaudible) so, arouse
8 the patient. Try to arouse and turn off the pump and
9 call anaesthesia pain service, apply the apnea monitor.

10 So, I understand this -- that this is referring to
11 what is written before.

12 Q. This apnea monitor, what did you intend
13 to indicate by that? What is an apnea monitor?

14 A. An apnea monitor, it's going to be
15 another page that this is indicated. The apnea
16 monitor, from my best understanding, is only a type of
17 signature which is measuring the oxygenation in the
18 blood, in the pulse blood. And in some other cases, it
19 might be as well a machine which is measuring the
20 movements of the chest. We call it impedance by a
21 system which is called impedance measuring, so the
22 extensions and movements of a chest are measured and
23 transferred to a number and this is time-related, so
24 you will get at this machine basically the rate of
25 breaths per minute. This is a second apnea monitor.

1 We know more apnea monitors, but these are the two
2 apnea monitors which are relevant to the pain treatment
3 of Lisa Shore.

4 Q. The first one is something that goes on
5 the finger; is that right?

6 A. It's going wherever we have a very good
7 thing to put it, it's a (inaudible) like a clip on your
8 finger. You might put it on your ear or on
9 (inaudible).

10 Q. I see. The other kind is something that
11 goes where?

12 A. The other kind is -- you have electrodes
13 on your chest and when you breathe, the chest will
14 extend and this is measured. The extension is measured
15 by a method which is (inaudible) measurements and these
16 monitors, they only give you rate, and they operate
17 (inaudible) give often false positive alarms and they
18 are problematic. I personally believe in the pulse
19 oximeter and they will give you a situation of how well
20 the blood is oxygenated (inaudible) has a problem. And
21 if you have a patient who is on oxygen, you might
22 almost not breathe and still you will have a good
23 (inaudible) A patient who is not on oxygen and is
24 normally healthy, this pulse oximeter will do a good
25 job in detecting side effects.

1 Q. Just the two other ones, the 242.
2 Sorry, 243, just below that you've got oximetry.
3 What's ---
4 A. This is the pulse oximeter.
5 Q. That's the pulse one?
6 A. It is actually a wrong name for -- but
7 it's understandable for everyone. "Oximetry" means the
8 general name for measuring oxygen in the blood. The
9 exact name for the machine is a pulse oximeter.
10 (inaudible)
11 Q. Do you know what a Corometric monitor
12 is?
13 A. This is the second monitor I mentioned,
14 that's measuring extensions and movement of the chest.
15 Q. Does an oximeter monitor mean the same
16 as an -- okay, I see.
17 A. As I pointed out, there are kinds of
18 machines. One is the oximeter or pulse oximeter. The
19 second kind is the Corometer, which is measuring
20 different incidents, this one does the chest movements,
21 so that's very different.
22 Q. We'll be dealing with this with somebody
23 else, Doctor,, but are you familiar with this machine?
24 This is just an example. It's not -- are you familiar
25 with what I'm showing you now?

1 A. I know them from the Hospital for Sick
2 Children. I don't like them, but that's -- that's the
3 alarm.

4 Q. Can you turn it off?

5 THE CORONER: What did you do, Ms. Browne?

6 MS. BROWNE: I don't know. It's not even
7 plugged into anything. I have no idea what I did. Go
8 ahead.

9 THE CORONER: It stopped.

10 THE WITNESS: So, this machine (inaudible)
11 it is attached like an ECG to the chest. It
12 is not an ECG, it's not for showing electric
13 activity of the heart. It is measuring --
14 and I see it has also something for the heart
15 rate. (inaudible) It was measuring heart
16 rate, but it's not (inaudible) machine, so
17 that (inaudible) for example, a heart attack,
18 angina pectoris or something like that. It's
19 just the heart rate and the respiratory rate.

20

21 BY MS. BROWNE:

22 Q. Obviously, it will go off if
23 something ---

24 A. No. The alarms are going off when the
25 (inaudible) or if it is detached or if you are moving a

1 lot or if you are not breathing, then the alarms should
2 go off if the machine is properly working. Again,
3 these things, they are certainly a good tool as an
4 additional tool. I trust more the other machine.

5 Q. All right. Thank you.

6 MS. BROWNE: Should I make this tentatively
7 an exhibit or wait, Mr. Coroner?

8 THE CORONER: No, I think there will be a
9 more appropriate one that will be brought by
10 Sick Kids.

11
12 BY MS. BROWNE:

13 Q. All right. And we have then the last
14 part on the chart, you've explained it before, 244 is
15 THE sedation scale. That's what you've explained
16 before. All right, now you can sit down. Thank you
17 very much. Do you recollect about what time you put
18 these orders into the computer?

19 A. It's written on here.

20 Q. Okay. Just tell us again.

21 A. So I remember when I was sitting there,
22 and the nurse reminded me, "Please, Dr. Schily, don't
23 forget to put in the orders."

24 Q. That's Nurse Matthews, right?

25 A. Yeah, I think so.

1 Q. Okay. And did you go off duty then or
2 did you go to another part of the hospital after that?

3 A. No. I was sitting at the desk, at the
4 main desk of -- I was -- all this time I was sitting,
5 not in the room, however, there's a little room in the
6 Emergency that the patient is and the nurse is going in
7 and out and taking care, and then there's a main desk
8 where the computer is, which is about ten metres almost
9 at an eye contact to the patient where I was sitting,
10 and also doing my discussions with the staff on call.

11 Q. And at some point Lisa was admitted and
12 moved into the orthopaedics ward?

13 A. Well, this happened later.

14 Q. How much later; do you know?

15 A. I recall that I went after 12:00 home.
16 I remember that since I didn't went because of the OR
17 after 12:00 home, but because of pain service, which
18 meant that I would have to work the next day.

19 And I recall when I arrived that I --
20 the agreement between me and Pauline was that we want
21 to admit Lisa only once she's settled better, better
22 managing with her pain, and we defined the pain scale
23 of 5. So, this was the target, basically, and I've got
24 it call at -- well, I have to look in the notes at that
25 time.

1 Q. Okay. Tell us what note you're looking
2 at.

3 THE CORONER: Page 5.

4 THE WITNESS: It must be in the ---

5 THE CORONER: Page 5.

6 MS. BROWNE: If it's of any assistance, Dr.
7 Cairns, while Dr. Schily is looking at that,

8 we've had assistance from one of our
9 investigating officers. She's made copies.

10 These are not exhibits, but they're an aid
11 for the jury. There are five copies.

12 They're exactly what is the short exhibit
13 that's been put in as the medical record, the
14 last admission, and it might make it easier
15 than to have to -- we don't have a lot

16 MR. GOMBERG: Well, I think we have this
17 one, I think.

18 MS. BROWNE: May we pass this out also?

19 MR. HAWKINS: I'm sorry. I'm confused.
20 What are you handing out?

21 MS. BROWNE: I've got five copies of the
22 chart.

23 MR. HAWKINS: Okay.

24 MS. POSNO: Is the order of the Coroner's
25 brief or the actual chart?

1 MS. BROWNE: This is the actual chart. It's
2 marked according to the chart. We've marked
3 both, actually. Where it duplicates in the
4 brief, we've got that, too.

5 MR. HAWKINS: Okay, that's fine. It's in
6 the Coroner's order?

7 MS. BROWNE: Yes.

8 MR. HAWKINS: It's in the Coroner's order,
9 which is different than the original.

10 THE WITNESS: So, I found it.

11

12 BY MS. BROWNE:

13 Q. I beg your pardon?

14 A. I found it.

15 Q. All right. And just one second while I
16 give these out. What is the number at the top of ---

17 A. 15, page number 15 at the ---

18 Q. Just a minute. Let me just have a look
19 and make sure we have it ...

20 A. Referring to what the nurse was writing.

21 Q. Give me just a second 'til I make sure.

22 For the benefit of Counsel, this is in the brief at
23 page 5 of the brief.

24 THE CORONER: Sorry, page?

25 MS. BROWNE: Page 5 of the brief. It's age

1 15 in the chart.

2 MR. GOMBERG: I think we have a blow-up of
3 this. I just don't have it in the courtroom
4 though, if that's of any assistance, Dr.
5 Cairns.

6 THE CORONER: It may well be, yes. Do you
7 want to get that? Is there a blow-up?

8 MR. GOMBERG: Excuse me. I may be able to
9 get it pretty quick.

10 MS. BROWNE: It's all right. We don't have
11 it?

12

13 BY MS. BROWNE:

14 Q. It appears we do not have a blow-up of
15 this page, but the jury can follow it along. They have
16 the page. You've got the page and Counsel has, so go
17 ahead. What was it you wished to draw our attention
18 to?

19 A. Well, the time. You asked me about the
20 time ---

21 Q. Yes.

22 A. --- when she was admitted to the ward.

23 Q. Yes. Yes.

24 A. The decision-making was somewhere
25 between what is written here, 1:05 and there are some

1 lines, that point that, "Dr. Schily paged. Child might
2 be admitted for floor with a current pain score of 8.
3 Report to 5A." Now, the time here is -- sorry, it's
4 01:05.

5 Q. So that was how it was left. This is
6 Ms. Matthews' notes, is it not?

7 A. That's correct.

8 Q. She indicated that the child would be
9 admitted to the floor, 5A, if she got to 8, her pain
10 was 8?

11 A. No. We changed our initial plan here.

12 Q. All right.

13 A. We wanted to have her better controlled,
14 better pain controlled.

15 Q. Right.

16 A. Since this didn't happen and since she
17 was in severe pain, she claimed that her pain score is
18 about 8 -- 7, 8, this is what I record, and she
19 actually didn't have here very much -- she didn't have
20 an environment which was giving her a chance to come to
21 a sleep and the parents pointed that out, so the nurse
22 reported me that, "Parents wish is to transfer her to a
23 ward." And Ms. Matthews asked me if I insist to reduce
24 her pain score more and I said, "Well, so, let's leave
25 it like this and let's send her, with this rather high

1 pain score, to a ward."

2 Q. All right.

3 A. This is to my best recollection.

4 Q. And to your knowledge, you went home?
5 You went home, right?

6 A. I was at that time home when I got the
7 page. I just arrived, basically.

8 Q. What time did you get the page?

9 A. Well, it is not exactly written here.
10 It must be somewhere close to 1:00, yeah.

11 Q. That was for you to notify that she went
12 to the ward?

13 A. That's correct, yes.

14 Q. Now, did you receive any further calls
15 that night?

16 A. I received after that call, one more
17 call, which was a little bit after 4:00.

18 Q. And what happened during that call?

19 A. What I remember from this call, first of
20 all, it's one year ago, and it was in the middle of the
21 night at 4:00, a telephone call, so there are things
22 which I might not remember. There are other things,
23 which I still remember.

24 Memory is sometimes after such a long
25 time in the middle of the night, in the middle of a

1 sleep, it's difficult to recollect exactly every word.

2 What I recollect is that I was reported about
3 respirates or breaths per minute, just about ten,
4 eleven. I don't remember exactly what it was; ten or
5 eleven. And I asked if otherwise everything is all
6 right, and I remember having heard that, "Well, the
7 vital signs are okay," and at that time I asked about
8 if Lisa is arousable, and -- sorry, I have to go back.

9 As I heard the thing about respiratory
10 rate, as a first reflex I said, "Take the machine away.

11 Take the machine out of the room." I don't think
12 since that is -- this sort of pain treatment, always
13 our first instinct, our first feeling that someone else
14 except the patient was hitting the button. That is the
15 way you can trick out these PCA machines. Later it
16 turned out it wasn't the case, but this is how we
17 normally should react. Take away the machine, that it
18 has no more danger that someone will use this machine.

19 So that is the first thing I actually
20 was reacting. And then what I still recollect at this
21 time was that, I thought, well, so her respiratory rate
22 just above ten, otherwise vital signs all right, and
23 arousable. "Did you want me to come," although my
24 judgment was actually, things are all right, and
25 assuming that all the monitoring and all these things

1 are done as I was ordering, I thought that it's proper
2 judgment to say, well -- still I wanted to give her the
3 option to bring me in hospital, and sometimes there are
4 other things, perhaps the nurse is worried. So I asked
5 that and she said, "No, there is no need."

6 So, I, as a final thing said, and this I
7 recollect clearly, "Go back and check all the
8 monitoring, check the respiration and the vital signs,
9 and if there's any doubt, please, inform me and I will
10 come." This was the last call I got during this night
11 shift. The next page was then the page which informed
12 me about her cardiac arrest.

13 Q. So, as far as you remember, and bearing
14 in mind it's sometime ago, you received a call at 4:05
15 or thereabouts in the morning from a nurse you presumed
16 who was looking after Lisa. Said that her breaths per
17 minute were at ten or eleven, and she was calling as
18 requested by yourself, and the vital signs were okay,
19 and she -- they didn't need you to come; is that right?

20 A. This is what I recollect, yes.

21 Q. Did you receive any other pages or calls
22 at 2:00?

23 A. No.

24 Q. Or 3:00?

25 A. No.

1 Q. Or 6:00?

2 A. No.

3 Q. Okay.

4 THE CORONER: At 4:00, Doctor, just to
5 clarify that, was that a direct phone call to
6 you at home or were you woken up by your
7 pager going off?

8 THE WITNESS: No, this was by the pager,
9 which is a pager who is giving a noise, so
10 it's making a beep, beep, beep, and then it's
11 appearing on a little screen a number. We
12 then are phoning.

13 THE CORONER: Thank you, Doctor.

14

15 BY MS. BROWNE:

16 Q. Did you know to whom you were speaking
17 when you phoned, what nurse it was?

18 A. Well, she introduced herself so far as I
19 remember, as the nurse of 5A. This is the usual way of
20 introducing since we don't know every nurse personally,
21 unfortunately; as the nurse of 5A taking care for Lisa
22 Shore.

23 Q. Just one more thing; you said that you
24 told her to check all the monitoring, et cetera. Did
25 you ask if she was rousable?

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A. Oh, yes.

Q. What was the answer to that?

A. "She's arousable." This is what I
recollect.

Q. I'm sorry?

A. "She is arousable, yes."

Q. And then the next thing you heard ---

A. Again, I want to emphasize here, if I
say this is -- she is arousable, this is the context of
the thing, yeah. I didn't tape this phone call and it
is more than one year ago, so, please take it -- put
this together with what I am saying now, that it is
more than one year. As the context, I remember having
heard, "She is arousable." And that's another thing,
I'm not new in doing shifts. In my country we do the
same and we are trained in reacting in certain
pathways, so if there would have been something
different, a pulse that's high or a low blood pressure
or a saturation which is wrong, the minimum of things
would have been that I would have asked more and I
would certainly also have gone over. These are things
which I know longer than ten years' practice in
anaesthesia and they are basic reactions and ---

Q. Did you ask anything about heart rate?

A. Again, so far as I recollect I didn't

1 specify my question, so I didn't ask specific about all
2 the things. I was told, this is what I recollect, that
3 the vital signs are all right, and these vital signs
4 includes heart rate, respiratory rate and blood
5 pressure, temperature. In this case it should include
6 the saturation and I was asking about that, to my best
7 recollection.

8 Q. The saturation of oxygen?

9 A. Sorry? The oxygen saturation.

10 Q. Oxygen saturation?

11 A. That is a matter of definition if this
12 would belong to the vital signs, but it was part of the
13 monitoring, so ---

14 Q. I don't know if I'm following you. Are
15 you saying that you thought the oxygen saturation was
16 covered by the vital signs when they said the vital
17 signs are okay?

18 A. When I ask a nurse, "Are all the vital
19 signs all right?" and the patient is connected to a
20 pulse oximeter ---

21 Q. Right.

22 A. --- then it would be improper to answer,
23 "The vital signs are all right," so there's -- it
24 wouldn't go together that a very low pulse oximeter
25 result, alarming situation considering the oxygenation,

1 but normal breaths, this would -- such a patient in
2 such a set-up not going together. So if I get an
3 answer, "Vital signs are all right," this includes
4 oxygenation, and it's just otherwise not going
5 together.

6 Q. That's the last you heard until you
7 found out that she had died?

8 A. This was -- that's correct, yeah.

9 MS. BROWNE: Those are my questions then.

10 Thank you, Dr. Schily. You will have others
11 to question you, including the Coroner.

12 THE CORONER: It's 12:30 and I don't
13 particularly want to interrupt other
14 Counsel's examination, so it's perhaps a
15 reasonable time to break for lunch. We'll
16 recess until 1:45 for lunch. I give the jury
17 the usual caution.

18
19 --- LUNCHEON RECESS

20
21 THE CORONER: Mr. Hawkins, do you have some
22 questions of this witness?

23 MR. HAWKINS: I do, Dr. Cairns, yes. I
24 thank you.

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DR. MARKUS SCHILY, resumed:

CROSS-EXAMINATION BY MR. HAWKINS:

Q. Doctor, if I could just go over some of the chronology of your involvement with the patient a little bit. If I can get you to turn to -- do you have the original there or a copy, sir?

A. Sorry, I hardly can hear you.

Q. Do you have the original records there?

A. Yes. Can you just try to talk into the ---

Q. Okay. Can I ask you to turn to page 14 of those records, which is page 3 in the brief that the jury has?

A. Page 14?

Q. Page 14, which is the Emergency Nursing Record.

A. Yes. I have it.

Q. Now, you'll see in the top right corner there it says, "Pain fellow, 21:50?"

A. Yes, I see that.

Q. Now, does that -- just so we understand the sequence, does that sound as about the right time that you were called?

1 A. As I said, I don't recall exactly the
2 time. I know that I have been in the IOR. This is
3 what I recall, and it must be close to 10:00 at night,
4 so p.m., but I don't recall the exact time.

5 Q. Okay. So your recollection is close to
6 10:00, so that accords with the note that says 21:50.
7 Now, you were asked down at the bottom of the page
8 about the vital signs that are recorded there. If I
9 can just ask you a little bit about those vital signs.

10 The first one is "T" for temperature, and "37?"

11 A. That's correct, yeah.

12 Q. As I understand it, that's a normal
13 temperature?

14 A. That's it, yeah.

15 Q. That's textbook normal, 37?

16 A. It is the normal temperature, although
17 it's not outlined where you took it.

18 Q. Right.

19 A. Yeah.

20 Q. Okay.

21 A. But it is the normal temperature.

22 Q. Okay. Pulse rate of 92. Now, one of
23 the pain service nurses who you talked about a little
24 earlier, she indicated to me that the normal pulse
25 range for a child of Lisa's age would be about 70 to

1 110 as a normal pulse rate?

2 A. Yes. Depending -- well, a child not
3 being in pain and being normally, going around, and at
4 that age I would say, yeah, you're correct.

5 Q. Okay. Yeah, pulse is something that
6 varies in the normal population, and even in one person
7 at different times can vary significantly.

8 A. Yeah, that's right.

9 Q. And so a pulse rate of 92, that's within
10 the normal range?

11 A. That would sound reasonable, yeah, for
12 the situation.

13 Q. Respirations of 20. Again, I'm told
14 that normal respirations for a child of Lisa's age is,
15 again, roughly 12 to 20 per minute?

16 A. Yes.

17 Q. Okay. So on Lisa's arrival she's within
18 the normal range, but at the high end of normal.

19 A. She's in the normal range, yes.

20 Q. And then respirations, as well,
21 depending on -- well, I guess at the low end, whether a
22 person is sleeping or not, respirations typically get
23 lower when you're sleeping.

24 A. Not -- depending why you sleep. If you
25 sleep because of the sleeping that's including --

1 especially if you received narcotics and you're
2 sleeping because of narcotics, then the respiratory
3 rate is going down.

4 If you are sleeping because -- and you
5 were feeling uncomfortable and feeling -- being upset
6 because of whatever, and now you fall asleep, your
7 respiratory rate, so your breaths per minute, will also
8 go down.

9 Q. Okay.

10 A. But this is an emotional matter.

11 Q. Right.

12 A. So there are drug effects and there are
13 emotional effects.

14 Q. Right. And then at the high end, sort
15 of the emotional effect that you have is when someone
16 is anxious, in pain or when they've been exercising
17 hard, their respiration rate sort of climbs towards the
18 end high end?

19 A. That's correct. If there's a stress
20 reaction we call it, then the respiratory rate, we all
21 know it is going up.

22 Q. Then if I can ask you to turn to the
23 next page, and again, I recognize that you don't
24 remember precisely when you arrived, but if we can sort
25 of narrow it down. If you see the note at 22:20, which

1 is the first note on page 4, or what I guess is the
2 back of your page 14, the nursing note at 22:20.

3 A. Okay.

4 Q. Starting there again, we have a blood
5 pressure done of 110 over 60.

6 A. Yes.

7 Q. And again, as I understand that, that's
8 a normal blood pressure?

9 A. That's a reasonable, normal blood
10 pressure.

11 Q. Okay. And as you see at the bottom of
12 that note, the second last line of the first note it
13 says, "Right leg pain, P - have pain team assess
14 child."

15 A. Yes.

16 Q. Would I take it then that that's, you
17 know, a reasonable assumption, that if they're still
18 talking about the pain team assessing the child, you
19 have not arrived at that point?

20 A. I think the best is to ask the nurse
21 what she means here.

22 Q. Okay.

23 A. If she means that I was informed to come
24 -- so if she means pain team informed to assess the
25 child or if the meaning is that this is a fact which is

1 already post factum, so ---

2 Q. Okay. And then you come to the
3 Emergency Department and you assess the child and you
4 don't again recall precisely when that happened?

5 A. No, I don't recall the exact hour since
6 -- you have to understand, if I might quickly explain?
7 At what times a physician would take the exact time,
8 it's every time where he's writing a prescription or if
9 he is in a situation like a cardiac arrest or
10 something, then we take -- we look at the watch, and we
11 really stop the time. For coming down for assessing a
12 child, I wouldn't regularly look at the time when I'm
13 arriving now to -- this is normally the nurse doing and
14 writing it down.

15 Q. And in this case, other than the orders
16 that you wrote, you did not make any notes of your own
17 about your assessment of the child?

18 A. That's true.

19 Q. And in describing your assessment of the
20 child as you've done today, you're relying to some
21 extent on your memory and to some extent on the notes
22 made by other people around that assessment?

23 A. I'm relying on my memory and I -- yes.

24 Q. Okay. So to a certain extent, you're
25 relying on the nurse's notes in terms of what was

1 happening with the child in the Emergency Department at
2 that time?

3 A. Well, since this was a very tragic and a
4 very difficult event, for this situation I made some
5 private notes as well, and so my memory in terms of
6 these things is quite exact. It's not included in
7 these papers here, but since Lisa died, I was writing
8 down the next day for my own recollection these facts
9 so my personal impression how I met Lisa, what was my
10 impression of her pain, and -- is this answering your
11 question? So this is my -- my personal memory is
12 basically what I am recollecting, and secondly, what I
13 the next day was writing down and sending to the CMPA.

14 Q. Okay. So in terms of the notes that we
15 have, you haven't made any notes in the chart?

16 A. In the chart, that's correct.

17 Q. Okay.

18 A. I put my own -- what we are already
19 discussing, nothing else.

20 Q. And for purposes of testifying today,
21 you're relying on what you remember and you're relying
22 on, for specifics as to time, as to vital signs, that
23 sort of thing, you're relying on what the nurses have
24 noted down?

25 A. That is correct, but may I explain here?

1 I'm relying -- since you are asking me also on the
2 notes which I was writing the next day, the following
3 day, after this event and which are kept with me and
4 which I was sending to the CMPA.

5 MR. GOMBERG: Dr. Cairns, this is the first
6 that I'm hearing about this, and I know or I
7 suspect it's the first that Ms. Browne's
8 hearing about, and I wonder whether this is
9 an issue that ought to be addressed in the
10 absence of the jury? Not that I think that
11 anything should be hidden from them, but this
12 is a technical area.

13 THE CORONER: Any other Counsel wish to
14 speak on this?

15 MS. POSNO: I know what Dr. Schily is
16 speaking of, and there is an explanation. I
17 have no difficulty in dealing with it in the
18 absence of the jury.

19 THE CORONER: Fine. If we could have the
20 jury excused for just a few minutes, ladies
21 and gentlemen?

22
23 --- JURY EXCUSED.

24
25 MS. POSNO: The notes which Dr. Schily is

1 referring is essentially a narrative account
2 of his recollection prepared the morning he
3 learned of these events, or the day he
4 learned of these events.

5 This was prepared with the anticipation
6 that one day there may be litigation or
7 something arising from this, and right now
8 there is privilege claimed on the notes.
9 They've been produced to nobody. They have
10 never formed part of the hospital record.
11 Except to his lawyers.

12 MR. GOMBERG: Well, there's a serious
13 problem with that, Deputy Chief Coroner, and
14 the problem is this: First of all, I'm
15 finding out about those notes for the first
16 time now, so that's a problem.

17 The second problem with that position is
18 this: There is no civil case and Dr. Schily
19 has been released of any liability. The
20 other thing is he's got the protection of the
21 Evidence Act, so I'd like to see the notes.
22 Those are my submissions.

23 MS. BROWNE: I second that motion. As far
24 as I understand, there is no litigation
25 contemplated. In fact, there won't be any,

1 and I certainly am just taken by surprise. I
2 would have thought that that would have been
3 producible according to the Coroner's
4 warrant.

5 THE CORONER: Mr. Hawkins?

6 MR. HAWKINS: I take no position, Dr.
7 Cairns. It's simply my questioning was to
8 explore what notes he had made in the chart.

9 THE CORONER: Do you have anything to add
10 having heard the submissions by other
11 Counsel?

12 MS. POSNO: No. And I think it should be
13 clarified, it's not as though these notes --
14 the notes have been categorized as privileged
15 because of the earlier dealings in this
16 litigation. I think what's happened here is
17 nobody turned their minds to the fact that
18 these would be potentially at issue in the
19 Coroner's Inquest.

20 If there's an issue and the notes are to
21 be produced, we have them here with us, so
22 it's really not a difficulty in that regard.

23 THE CORONER: It appears that taking what
24 Counsel have said, there is no further civil
25 litigation in this matter, so the matter of

1 privilege regarding future civil litigation
2 seems to be no longer a viable issue.

3 The witness, I think, is trying his best
4 to remember what did or did not happen that
5 night. There are limited notes on the chart
6 by the witness, but the witness has indicated
7 that since this was such a tragic event, it
8 sticks out very well in his mind, and if he
9 made concurrent notes at the time, then I
10 think they may be relevant in terms of saying
11 how much his memory is different now than it
12 was then.

13 As I to understand, Doctor, these are
14 notes that you made the next day following --
15 on the day of Lisa's death?

16 THE WITNESS: Right. Yes.

17 THE CORONER: I think those notes would be
18 very valuable in front of this jury to
19 establish clearly what your recollection is.

20 You've said you remember certain things, but
21 notes, we do normally rely heavily on notes,
22 and if these are additional notes, even
23 though they're not on the chart, it would be
24 my feeling that they should be at this time
25 presented, and whether we need five minutes

1 or whether we can photocopy them and continue
2 the line of questioning, I'm not sure, but my
3 ruling would be is, that those notes should
4 now be produced.

5 MS. POSNO: I've seen the records, and we'll
6 produce them now. It's more than a page, so
7 perhaps a small adjournment for five minutes
8 may be appropriate for Counsel.

9 THE CORONER: If we recess for ten minutes
10 would that be sufficient if I get Coroner's
11 Counsel to assist with the photocopying?
12 Would that be sufficient to all Counsel?

13 MR. GOMBERG: Yes, thank you, sir.

14 THE CORONER: All right. We'll recess for
15 ten minutes.

16
17 --- A BRIEF RECESS

18
19 THE CORONER: Do all Counsel now have a copy
20 of the notes made by Dr. Schily?

21 MR. GOMBERG: Yes.

22 THE CORONER: I think, Mr. Hawkins, you were
23 asking some questions, so if you would like
24 to continue at this time?

25 MR. HAWKINS: Yes, I'm content to continue.

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DR. MARKUS SCHILY, resumed:

CONTINUED CROSS-EXAMINATION BY MR. HAWKINS:

Q. Okay, Doctor. So again, just to come back to it briefly, that night when you treated Lisa, you made no notes of any sort in the chart except the orders that you wrote?

A. Yes.

Q. And, in particular, you made no notes of your own assessment of the child?

A. No.

Q. Then we have the nurse's note at 23:50, which I think we just started to refer to. The nurse there has recorded a pulse of 88 and a respiration of 16. Those are again normal?

A. Yes.

Q. And the respiration rate, in fact, has come down from 22 to 16, sort of more into the normal range as opposed to at the high end.

A. Both are normal.

Q. Both are normal. Okay, thank you. And at that stage, after you did your first assessment, you then went off to get the PCA pump from the recovery room and you brought it back to the Emergency

1 Department?

2 A. Yes.

3 Q. Okay. And if we flip the page over,
4 just to continue on page 5, which is your page 15, it's
5 at 00:15 we see the nurse report, "PCA pump set up by
6 anaesthesia fellow."

7 A. Yes.

8 Q. And in this case, actually, you set up
9 the pump, and as I understand it, Pauline Matthews sort
10 of did it with you and double checked what you were
11 doing?

12 A. Well, that is true, but let me explain
13 this, perhaps, the procedure of setting up a drug
14 infusion or a pump. The physician in Sick Kids is
15 basically in these cases normally not counting the
16 morphine. He's giving the prescription, how much to
17 put, how to dilute and how to prepare, and the
18 execution of this thing is done by the nurses. But
19 since the nurses were not too familiar with the
20 handling of the pump, I was giving advice how to -- you
21 have to switch a key and how to put in to dial in the
22 parameters in the pump, in the PCA device.

23 Q. Okay. So in this case, while normally
24 nurses set up the PCA pump, in this case you set it up
25 with assistance from Pauline Matthews?

1 A. I was dialling in the parameters.

2 Q. Right.

3 A. I was not diluting or preparing the
4 syringe with the morphine.

5 Q. Okay. And the morphine in this case, as
6 I understand it, it comes sort of pre-packaged in small
7 containers that you then -- or small vials that you add
8 by syringe into the PCA pump?

9 A. The morphine usually comes in small
10 vials of 10 milligrams so far as it concern -- at least
11 these are the vials we have in recovery room. I don't
12 know if there are different vials existing otherwise.
13 And the nurses are preparing it with these vials. They
14 double check. There are normally a team of two people
15 and they're signing since it's a narcotic and there's a
16 book where they sign it.

17 Q. Okay. And you were there as this
18 happened and you're satisfied that they put 50
19 milligrams in 50 cc's as was ordered or that's what
20 happened?

21 A. Well, I was physically in the Emergency.

22 Q. Okay. Then the PCA pump is started on
23 your orders and then the nurse takes vital signs at
24 00:40, and we've got a pulse of 90, respirations of 14
25 and a blood pressure of 106 over 84.

1 A. Yes.

2 Q. Again, those are normal vital signs?

3 A. Those are also normal vital signs, yes.

4 Q. And the patient has continued stable to
5 that point or the vital signs are stable?

6 A. The vital signs are stable. The patient
7 is not stable considering the pain score, yeah, so the
8 pain score is still high up.

9 Q. Right. Okay. And at that stage, you
10 leave the Emergency Department and then you're called
11 sometime later, which the nurse has recorded at 1:05,
12 querying whether the patient can be admitted to the
13 floor with a pain scale of 8?

14 A. Yes.

15 Q. And that's another page that you receive
16 on your pager?

17 A. That is a page which I received from the
18 Emergency, yes.

19 Q. And at that point of the evening, 1:05,
20 you are at home at this point?

21 A. Well, as I said, from the notes of the
22 nurse, I have difficulty understanding if this is
23 exactly the time where she was paging me. I just know
24 that I got the page at home.

25 Q. Okay. And this was -- to your

1 recollection you got home sometime after or at about
2 1:00 a.m., so it would be a little bit after that?
3 Okay. Again, you don't remember the precise time?

4 A. There's nothing written exactly about
5 it, and this is -- again, that's something, getting
6 home and not watching exactly the timing and I don't
7 recollect the exact time of the paging.

8 Q. Right.

9 A. I just know that I was at home and it
10 wasn't long after I came home.

11 Q. Okay. Now, if I can ask you to turn to
12 the flow sheet for that night on the ward, which is
13 page 48.

14 A. Yes.

15 Q. And I take it you're familiar with this
16 flow sheet, which records the patient's care that
17 night?

18 A. I have seen it, yes.

19 Q. Okay. Now, I understand, and you've
20 testified that the first page you received was at
21 roughly 4:00. Doctor, do you agree with me that from
22 the discussions you participated in at the hospital
23 after this event, that you're aware that a nurse will
24 indicate that she paged you at 2:50?

25 A. I heard that, yes.

1 Q. And your evidence is that you did not
2 receive that page?

3 A. My evidence is that I didn't receive any
4 page. I didn't hear any page at 2:00, so no sound from
5 my pager, from my bell boy, and I was not answering to
6 any page. I didn't -- I was aware that there was any
7 page.

8 Q. Okay. Now, you understand as well that
9 the nurse will indicate that she paged you at 2:50?

10 A. Oh, I don't know if she ---

11 THE CORONER: Mr. Hawkins, I apologize for
12 interrupting you? Page what is it we're
13 looking at?

14 MR. HAWKINS: It's his page 48. I believe
15 it's page 11 in the brief.

16 THE CORONER: Page 11 of the brief. Thank
17 you, Mr. Hawkins.

18 MR. HAWKINS: Sorry, I thought I said that.
19 I apologize.

20 THE WITNESS: Sorry, could you repeat your
21 question?

22

23 BY MR. HAWKINS:

24 Q. Now, Doctor, you indicated that you had
25 heard that a nurse apparently paged you earlier than

1 4:00, but you said you didn't receive that page?

2 A. Yes.

3 Q. Okay. And had you heard as well that
4 the nurse had indicated that she had paged you at 2:50,
5 2-5-0 in the morning?

6 A. Well, I was discussing it with Dr.
7 Posno. With Mrs. Posno.

8 Q. Okay. Now, in looking at that flow
9 sheet at 2:50 in the morning, the nurse records the
10 patient's respiration's at eight, ten?

11 A. Yes.

12 Q. And I take it that you would agree with
13 me that -- well, if I look at the discussion you had
14 with the nurse at 4:00 a.m., when the nurse records
15 vital signs or respirations of eight and ten, the first
16 thing you'd expect her to do is take away the PCA pump?

17 A. I didn't understand your question. You
18 want to ask me if I would have heard her saying that
19 the respiration is eight to ten?

20 Q. No. Doctor, what I'd like you to do is
21 look at that entry at 2:50, please, and if you had --
22 why don't we do it this way? If you had heard of
23 respirations of eight and ten at 2:50, the first thing
24 you would have said is, "Take way the PCA pump?"

25 A. Yes.

1 Q. Okay. And the nurse has, in fact,
2 recorded that she took away the PCA pump on that line
3 at 2:50?

4 A. Yes. That's written there.

5 Q. You'd also expect the nurse to do a
6 respiratory assessment, check out the patient's
7 breathing?

8 A. Oh, we expect that all the -- that is
9 the part of the proper monitoring of the night crew.

10 Q. And that's something you expect the
11 nurses to do on an ongoing basis?

12 A. This is something which belongs to
13 proper monitoring of PCA.

14 Q. Okay. And in this case the nurse has
15 noted, if you look at that line, "Chest clear. Good
16 air entry." So she's obviously assessed the patient's
17 breathing at that time?

18 A. Well, this is -- the assessment of
19 breathing is not something special. This is something
20 which should go throughout the whole PCA therapy.

21 Q. Yes, but where a nurse has recorded,
22 "Chest clear. Good A/E," good air entry ---

23 A. Okay.

24 Q. --- you'd accept that that means she's
25 done a chest assessment?

1 A. I just can assume from what is written
2 that if she's writing, "Chest clear." Where is that?

3 Q. Across the line where it says, "Chest
4 clear, CLR, good A/E."

5 A. Oh, yeah. I assume that she was putting
6 her stethoscope on the chest and was listening to
7 breathing sounds at the chest.

8 Q. And again, with the respirations of
9 eight and ten, you would expect the nurse to page you?

10 A. Yes, definitely.

11 Q. And, Doctor, I recognize, as I'm sure
12 you do, that no paging system, or for that matter, no
13 technology is perfect, and sometimes pages don't go
14 through?

15 A. That's right.

16 Q. And if in this case, as seems to have
17 happened, the page doesn't go through, you'd expect the
18 nurse to page you back?

19 A. That's right.

20 Q. And, in fact, what the nurse did here,
21 either as you remember it, the first page, or as she
22 remembers it, the second page, she did call you back
23 and she did speak with you shortly after 4:00?

24 A. Well, I wasn't aware that she was paging
25 me back, since I didn't know about the first page, but

1 she paged me, that is true, at 4:00 or shortly after
2 4:00.

3 Q. Right. And if she paged you earlier and
4 for some reason this hadn't gone through ---

5 A. I'm sorry?

6 Q. If she paged you earlier and for some
7 reason this had not gone through, you'd expect her to
8 page you back?

9 A. Yes, indeed. But not at 4:00, I expect
10 her to do that right away, and if she wouldn't have
11 caught me there, I would expect from a nurse -- well,
12 it's natural that if you're in an emergency situation,
13 that you look then for the second option, which I was
14 outlining, which is the OR desk.

15 Q. And in this situation what you'd also
16 expect the nurse to do is continue to monitor the
17 patient?

18 A. Oh, yes.

19 Q. Okay.

20 A. Definitely.

21 Q. And then the discussion that you have
22 with the nurse at 4:00, again, you made no notes of
23 that discussion at the time?

24 A. I was at home laying in the bed and I
25 didn't have any chart.

1 Q. Okay.

2 A. And the next day I did -- because of
3 these tragic events, my own personal notes, which now
4 are here.

5 Q. Okay. And at that time, and I think you
6 testified earlier this morning, you'd been woken up.
7 It was the middle of the night and there are parts of
8 those discussions that you do not recollect?

9 A. Well, I have my notes, but certain
10 expressions, if you ask me now to recollect if she
11 said, "Vital signs are good. Vital signs are okay,"
12 these fine distinctions, I couldn't say that I remember
13 that. For that, time is too long.

14 Q. Okay. Doctor, I didn't hear you this
15 morning saying you missed fine distinctions. I heard
16 you this morning saying that there were certain things
17 you might not remember, it was the middle of the night,
18 this was a year ago. You said that on more than one
19 occasion.

20 A. That's correct, yeah.

21 Q. Okay.

22 A. I'm relying therefore partly now on my
23 notes.

24 Q. Thank you. And you understand that when
25 a nurse -- or maybe you don't, but do you understand

1 that when a nurse pages you in the middle of the night,
2 she typically has this flow sheet right in front of
3 her?

4 A. I assume.

5 Q. Okay.

6 A. Yeah.

7 Q. And what the nurse has written at 4:05
8 is, "Very drowsy. Pain service aware of," and an arrow
9 down, which I take to be "decreased RR and sedation."
10 Are you familiar with that entry?

11 A. Yes.

12 Q. And the reference "decreased RR," would
13 you agree with me that the only reference earlier in
14 that flow sheet to a decreased respirations is the one
15 at 2:50, the respirations at eight and ten?

16 A. Just a minute. Yeah, that's written
17 here, yes.

18 Q. Okay. And that's the only reference
19 prior to 4:05 of decreased respirations, are
20 respirations below what you'd consider normal?

21 A. Well, this is what is written here.

22 Q. Okay. And the note there says she told
23 you about the patient's sedation, and did the nurse
24 tell you about the patient's sedation?

25 A. What I recall is that she said the

1 "patient is rousable."

2 Q. So the nurse gave you a report on the
3 patient's sedation?

4 A. Of the ability to arouse her, yes.

5 Q. And the ability to arouse is the
6 information that you're looking for in terms of what is
7 the patient's sedation?

8 A. Well, we were discussing before the
9 importance of the sedation score, and a patient who is
10 rousable, it means basically that he has enough blood
11 flow in his brain to think, to open his eyes and to
12 respond.

13 Q. All right.

14 A. A patient you can't wake up, there's
15 something strange or he's a very good sleeper if there
16 is no drug interference, or he might be what we call
17 over-sedated. So this is the important distinction,
18 and therefore, a patient being arousable, this is a
19 very important thing to hear, yes.

20 Q. Okay. And so when the nurse tells you
21 that the patient is arousable, the nurse is telling you
22 about the patient's level of sedation as she's recorded
23 there that she has?

24 A. Well, that is not -- she is giving -- if
25 you take the word "arousable," and if you're correct,

1 this will, from the category of our sedation score put
2 her in a certain score, but not in the matter -- I
3 didn't get here a specific score level, and I also
4 don't see any sedation score outlined here in this flow
5 sheet. I don't recall that I got specific numbers.

6 Q. Okay. But you didn't ask for a specific
7 number for the sedation score?

8 A. I don't recall that I asked that, that's
9 true.

10 Q. And in terms of a sedation score, what
11 you're interested in is, is the patient arousable or
12 not?

13 A. Look, the basic information, as I said,
14 is that we're interested to know if the patient is
15 arousable. This is the most important thing we want to
16 know.

17 Q. And that's what the nurse told you?

18 A. And that is what she told, and I'm not
19 aware about a sedation score or something like that.

20 Q. And what we also see on this flow sheet
21 is that on three occasions the nurse has recorded that
22 the patient was asleep. If you look at the flow sheet,
23 Doctor, on three occasions the nurse has recorded that
24 the patient was asleep?

25 A. Yes, that's true.

1 Q. At 3:20, 5:00 and 6:00?

2 A. Yes.

3 Q. And I understand that as part of the
4 sedation score, the sedation scale runs 0 to 3 with the
5 final category being asleep.

6 A. Well, look, a patient can be asleep also
7 considering the sedation score, but arousable. One is
8 not excluding the other thing.

9 Q. Okay. But when ---

10 A. If you check the patient and you see the
11 patient is asleep, but you easily can arouse him, the
12 other question is, but it's perhaps not for here, if
13 it's a good thing every hour to arouse a patient to
14 check, but definitely, yes. The answer is yes.

15 Q. Okay. But asleep, when the nurse
16 records, "asleep" ---

17 A. Yes.

18 Q. --- that is part of the sedation score
19 testing.

20 A. That is -- if a nurse is writing in her
21 chart, "The patient is asleep," that is an important
22 note, which indicates only one thing, only part of the
23 story. It indicates that the patient is asleep. It
24 doesn't indicate whether the patient is rousable or
25 not.

1 Q. And then if I ask you to look at 5:00,
2 you'll see that the nurse has recorded a temperature of
3 35.7, with the indication "PO" above it?

4 A. Sorry, at ---

5 Q. At 5:00?

6 A. At 5:00. Yes, I see that.

7 Q. Her temperature is 35.7 with the
8 indication "PO" above it.

9 A. Yes.

10 Q. "PO" I take it you'd agree with me is an
11 oral temperature, yes?

12 A. This is normally the word for para os,
13 which means in the mouth.

14 Q. Yes, okay. So when the nurse writes
15 that she's taken a PO temperature, that means she's
16 asked the patient to open her mouth, the patient has
17 opened her mouth and the temperature has been taken?

18 A. Well, I assume that. That's the normal
19 way you put in ---

20 Q. Okay. Thank you. And again, Doctor,
21 the discussion at 4:00, the nurse has the flow sheet in
22 front of her. My understanding is that she advised you
23 of the vital signs numbers as recorded on the flow
24 sheet. Would you agree with me that that's what the
25 nurse did, or would you agree with me that it's

1 possible the nurse advised you of the numbers on the
2 flow sheet?

3 A. May I explain my side? I wasn't next to
4 the nurse. I can assume many things. I was at home in
5 the bed and I have my recollection of today, and my
6 recollection is that I heard something global about
7 vital signs, and I don't recollect anything else, and
8 you also have to understand that as our point before,
9 we have our certain reflexes. If I would have heard
10 one of the vital signs is wrong, is outstanding, is
11 pathological, I believe that even at 4:00, I would have
12 asked more, and I would have asked what is about
13 saturation. How high is saturation? What is about the
14 blood pressure, how is the blood pressure, and so this
15 is my recollection, that I didn't get these details.
16 Now, if the nurse had her flow sheet or not, I wasn't
17 there.

18 Q. Okay.

19 A. I was at home.

20 Q. You were at home in bed having just been
21 woken up?

22 A. I was at home, in bed, waking up,
23 switching on the light and talking in the phone.

24 Q. And the judgment that you made at that
25 time, based on the information you'd received is that

1 the patient did not require you to attend or did not
2 require further active intervention at that point?

3 A. Well, if you get such a phone call at
4 home, you have to make your own clinical judgment. If
5 you get -- you get a certain amount of information
6 about the clinical -- about the problems and about the
7 clinical shape of the patient. You make up your
8 judgment. What I did at that night, coming to the
9 judgment that clinic vital signs are all right, and she
10 is arousable, and assuming that things like saturation
11 and blood pressure and pulse are all right, I concluded
12 that there's no need right away to go. But I remind
13 that I was asking even if her opinion is that I -- if I
14 should come over, and I offered that, and as another
15 thing I asked her to go again and to recheck all the
16 vital signs, including saturation and to call me right
17 away if there would be anything else.

18 Q. And so while it's your decision, the
19 conclusion collectively that you and the nurse came to
20 is that there wasn't a need for you to come to the
21 hospital at that point?

22 A. The conclusion, that's correct, yes.

23 Q. Okay. And so it's your decision, but
24 that's kind of a collective conclusion that you and the
25 nurse make?

1 A. No. Since it's my responsibility to go
2 over or not, the clinical judgment is, of course, mine.
3 Offering the nurse help, I think that's a matter of
4 courtesy and of looking if there's anything else that
5 could help.

6 Q. Okay. Thank you, Doctor. Those are my
7 questions. Thank you.

8 THE CORONER: Mr. Gomberg?

9 MR. GOMBERG: Thank you, Dr. Cairns.

10
11 CROSS-EXAMINATION BY MR. GOMBERG:

12 Q. Dr. Schily, I'm Frank Gomberg and I
13 represent the parents of the late Lisa Shore. I want
14 to thank you for having come from Israel for the
15 purpose of giving this evidence.

16 I have two basic things that I want to
17 deal with, if I may, before I move to the orders. And
18 the first is this: I take it you'd agree with me as a
19 matter of principle that the information flow between
20 the doctor and the nurse, in this case between you and
21 the nursing staff, is critical both ways? That is
22 information flowing from you to the nurse in the way of
23 orders, and the information flowing from the nurse to
24 you in terms of reporting to you what's going on?

25 A. That's right.

1 Q. All right. So the information flow is
2 critical to the making of proper clinical decisions,
3 right?

4 A. Yes.

5 Q. Right. And you're only as good as the
6 information that you have, right?

7 A. Yeah, that's definitely true.

8 Q. All right. And if the information that
9 you get is deficient, then the decision that you make
10 may very well be deficient or wrong, true?

11 A. Yes.

12 Q. All right. Now, the second thing is
13 that -- and it's basic, because I don't understand some
14 of this medical terminology, but you'd agree with me
15 that what this is all about is morphine being a very,
16 very dangerous agent, right?

17 A. Well, morphine has dangerous side
18 effects.

19 Q. Well, the reason that we're talking
20 about monitoring respiratory rate and heart rate and
21 oxygen saturation and all of these other things that
22 we've been talking about for an hour or two, is because
23 morphine has the potential to kill people, right?

24 A. Yes. But I want to -- if you allow me,
25 I want to explain that.

1 Q. Please.

2 A. Morphine is, I think, the most used drug
3 for pain treatment in the whole world, so, at one side
4 it's true, morphine has the potential to kill people
5 once you overdose, once you're not early enough
6 detecting side effects and therefore we monitor
7 carefully side effects. But on the other side, it's,
8 in good hands and good environment, a very safe drug if
9 proper used.

10 Q. All right. I'm not criticizing. I want
11 you to understand, I'm not criticizing the decision to
12 use morphine, that's not part of the questioning. What
13 I'm asking you, though, is the reason that you have all
14 of these failsafes in place, because there's a
15 recognition on the part of the medical profession that
16 when you put somebody on morphine, bad things can
17 happen?

18 A. Right. Yes.

19 Q. All right. And one of those bad things,
20 and I'm quoting from your notes, is "misuse may cause
21 death." That's what you said, right?

22 A. Oh, yes. Yeah.

23 Q. All right. So what we're trying to
24 prevent, in fact, is exactly what happened in this
25 case, and that is death, right?

1 A. Yes.

2 Q. All right.

3 MR. GOMBERG: Now, what I'd like to do, Mr.
4 Coroner, if I may, is take Dr. Schily through
5 the orders that he made, and I'm particularly
6 interested now, I don't know the exhibit
7 number, but the second page of the KidCom
8 order.

9 THE CORONER: Exhibit No. 7.

10

11 BY MR. GOMBERG:

12 Q. Now, I'd like to go through these with
13 you in order that the jury and Mr. Coroner and the rest
14 of us can determine which of these orders were complied
15 with and which ones weren't, all right?

16 All right. Now firstly, Number 238 says
17 "Suspended, self-inflating bag, mask oxygen and suction
18 at bedside. Nalaxone available." All right. That was
19 an order that you made?

20 A. Yes.

21 Q. All right. And that was an order, I
22 take it, Doctor, that you intended to be transmitted
23 from the Emergency Room to the orthopaedic floor; is
24 that right?

25 A. Yes.

1 Q. All right. Now, I'm not sure whether
2 this came out as clearly as it might have, but is it
3 your understanding, Doctor, that that order that you
4 made was never transmitted to the orthopaedic floor?

5 A. Well, I wasn't aware of that.

6 Q. I'm not suggesting you were. I'm asking
7 you now in 1999 as you testify, are you aware of the
8 fact that that order never got from where it was given
9 by you to the orthopaedic ward where it was intended to
10 be acted on?

11 A. I was told, yeah.

12 Q. All right.

13 A. By KidCom people.

14 Q. All right. So, in other words, you
15 believe me when I say to you that they didn't know
16 about that order on the orthopaedic ward because it
17 never got there; is that right?

18 A. Yes.

19 Q. And certainly, you'd agree with me that
20 that wasn't your understanding as you lay in bed at
21 2:00 or 3:00 or 4:00 in the morning?

22 A. Oh, definitely not, no.

23 Q. All right. And might I suggest that if
24 it was your understanding that that order didn't get
25 there, that you would have immediately jumped out of

1 bed and ran back to the hospital?

2 A. Yes.

3 Q. All right. Because that's something
4 that's very, very serious, yes?

5 A. Yes.

6 Q. All right. Now, Order 239, "Sedation
7 scale, pain scale, HR." That means heart rate?

8 A. Yes.

9 Q. "Blood pressure, respiratory rate, Q1H X
10 4 hours," right?

11 A. Yes.

12 Q. All right. Now, am I correct that what
13 that means is that a sedation scale, a pain scale, a
14 heart rate, a blood pressure and a respiratory rate,
15 all of those vital signs are supposed to be taken every
16 hour for the first four hours?

17 A. Yes.

18 Q. All right. And that was your order,
19 Doctor?

20 A. Yes.

21 Q. And you intended that order to be acted
22 upon?

23 A. Yes.

24 Q. Do you now know in 1999 that that order
25 never made its way from the Emergency Room to the

1 orthopaedic ward?

2 A. This is what I was told, yes.

3 Q. All right. And I suggest to you that
4 it's nothing less than shocking that -- you were
5 shocked when you heard that?

6 A. Yeah, really.

7 Q. Is that fair?

8 A. Oh, yeah.

9 Q. In fact, shocked may be an under-
10 statement, right?

11 A. Yes.

12 Q. Yes?

13 A. Yes.

14 Q. All right. Now, let's just talk about
15 the next order, that's Number 240. "Sedation scale,
16 pain scale," then it says, "heart rate, blood pressure,
17 respiratory rate, Q1H X4 hours. If dose or infusion
18 rate increase, then sedation scale and respiratory
19 rate, every hour," right, and "pain scale, heart rate,
20 blood pressure every four hours." Is that what that
21 says?

22 A. Yeah.

23 Q. All right. And that was a very specific
24 order, right?

25 A. Yeah.

1 Q. By the way, you don't just make these
2 orders without thinking about them? Like, you sit down
3 and think about what you want to order, don't you?

4 A. That's one thing, and on the other side,
5 these are protocols based on conferences and
6 literature, how often you should check these things.

7 Q. All right. Well, it's of critical
8 importance that that order go up to the floor, right?

9 A. Yes.

10 Q. All right. And it's your understanding
11 that that order as well never made it from the
12 Emergency Room to the orthopaedic floor, right?

13 A. This is what I was told, yes.

14 THE CORONER: I wonder, Doctor, if you could
15 keep your voice up a little bit, please?

16 THE WITNESS: Sorry, yeah. Yes.

17
18 BY MR. GOMBERG:

19 Q. All right. Now, then it says -- 241 I'm
20 reading from now. It says, "Contact anaesthesia pain
21 service if sedation score 3, respiratory rate below 11
22 per minute, inadequate analgesia or pump malfunction."

23 And your pager number is there, and that was another
24 important order, right?

25 A. Yes.

1 Q. All right. And it's your understanding
2 that that order as well never made it to the
3 orthopaedic floor, right?

4 A. Right.

5 Q. And for that order not to have made it
6 to the orthopaedic floor was also something that you
7 found shocking when you found out about it?

8 A. Yes.

9 Q. Because this young girl is on morphine
10 and we've already established that morphine can kill
11 you, right?

12 A. Right.

13 Q. Number 242, "Turn off pump and call
14 anaesthesia pain service, apnea monitor." Now, I'm not
15 sure I understood this, so, let me just ask you. An
16 apnea monitor, that's different from oximetry, correct?

17 A. I include, in general, for apnea
18 monitoring, I include pulse oximeter. In this term, I
19 understand that certainly apnea monitor, it's meaning
20 this Corometer we saw before.

21 Q. All right. But is it fair to say I
22 understood your evidence correctly, that oximetry
23 monitoring, that's the blood or the oxygen saturation
24 level in the blood ---

25 A. Yes.

1 Q. --- is far preferable to the Corometric
2 part -- to the apnea part of the Corometric monitor
3 from your perspective?

4 A. That is my understanding for monitoring
5 in these cases, yes.

6 Q. All right. Well, so having that little
7 device on the finger, that measures the oxygen
8 saturation in the blood; is that right?

9 A. Yes.

10 Q. And that's a fairly precise measurement,
11 right?

12 A. This is for a person which is not on
13 oxygen, a fairly precise thing, yes.

14 Q. All right. And your understanding is
15 that Lisa Shore was not on oxygen?

16 A. She was not on oxygen.

17 Q. And therefore, that would have been a
18 very precise recording if -- a recording of the oxygen
19 saturation in her blood, right?

20 A. Right.

21 Q. All right. Except there's one problem,
22 right; that was never done, true? In other words, she
23 was never placed on oximetry in keeping with your
24 order; is that your understanding?

25 A. That is my understanding, yes.

1 Q. All right. And when you found out about
2 that you were nothing less than shocked, true?

3 A. Yes.

4 Q. All right. Now, the sedation scale. I
5 may have missed this, and I think you did talk about
6 it, but just briefly, why is the -- I take it sedation
7 scale, from your perspective, it -- and it's in the
8 record here, is a technical thing? It means something
9 to doctors, right, and to nurses?

10 A. Yes.

11 Q. All right. It doesn't just mean how
12 sleepy you are?

13 A. No. It's giving more information. It's
14 normally also not how sleepy you are, it's also how
15 easy you are arousable.

16 Q. All right. So in other words, you can
17 be sleeping, I can be sleeping, you shake me, I get up
18 right away, all right, I was in a deep sleep but you
19 aroused me fairly easily.

20 A. Exactly.

21 Q. All right. And that means that I may
22 not be as ill as somebody who may not be sleeping as
23 deeply as I am, but who may not be arousable?

24 A. Yes.

25 Q. All right. Now, I take it that the

1 sedation scale -- you wanted a sedation scale to be
2 done on Lisa Shore again because she was on morphine,
3 right?

4 A. Right.

5 Q. All right. And we have the
6 interpretations of what that sedation scale would mean
7 right underneath. I take it you'd agree with me that a
8 sedation scale wasn't done at all on Lisa Shore?

9 A. Right.

10 Q. All right. And when you found out about
11 that, unfortunately, after Lisa passed away, that, too,
12 was shocking to you?

13 A. Yes.

14 THE CORONER: Now, what I'd like to do if I
15 may, Mr. Coroner, is to go through what was
16 done by the nurses on the floor. I have a
17 blow-up of ---

18 THE CORONER: Just before you do that, Mr.
19 Gomberg, if you don't mind, I'd like to try
20 and clarify what you have done under Order
21 242. You have, "Turn off pump and call
22 anaesthesia pain service." Then you have,
23 "Apnea monitor." What I'm trying to
24 understand, by "apnea monitor" you mean a
25 monitor like the Corometric monitor that we

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have referred to earlier?

THE WITNESS: The normal apnea monitor refers to the Corometric.

THE CORONER: Fine. Can you tell me if you're writing that order, does that order, did you intend that the Corometric monitor or an apnea monitor would be on Lisa all the time or only if there was a problem?

THE WITNESS: No. The intention was that both the pulse oximeter and the Corometric apnea monitor would be activated all the time.

THE CORONER: Okay. So from the time that she went to the ward until at least she was observed by the doctors next morning ---

THE WITNESS: Yes.

THE CORONER: --- it was your interpretation that there would be an oximetry monitor on her and also a Corometric monitor that was demonstrated earlier, and which we will have much more detail in future; is that correct?

THE WITNESS: That's correct.

THE CORONER: Am I understanding you correctly?

THE WITNESS: Yes.

1 THE CORONER: Thank you, Doctor.

2 MR. GOMBERG: All right.

3 THE CORONER: Sorry, Mr. Gomberg.

4 MR. GOMBERG: No. Thank you.

5

6 BY MR. GOMBERG:

7 Q. Dr. Schily, I'd like to take you back to
8 the -- this is a little bit difficult because you'll
9 have to look at your orders and at the flow sheet sort
10 of at the same time, which is not easy to do. Do you
11 have the flow sheet there, Doctor?

12 A. Yes.

13 Q. All right. Well, you see where it says,
14 "1:45," which is the first entry right at the top?

15 A. Yes.

16 Q. And it says, "Temperature 36, pulse 72,
17 respiration 16, blood pressure 90 over 60," right?

18 A. Yes.

19 Q. All right. Now, I take it you'd agree
20 with me that no further temperatures were taken until
21 4:20 in the morning?

22 A. Well, it looks like until 5:00.

23 Q. Before 5:00? I can't read it and I'm
24 trying to be as fair as I can to the hospital. Maybe
25 it's 5:00. I don't know.

1 A. Well, it's the same colour of the -- I
2 therefore assume that it is 5:00.

3 Q. All right. I don't have -- mine isn't
4 in colour, so I accept what you're saying. I just have
5 a photocopy. In any event, no temperature was taken
6 from 1:45 to 5:00 in the morning, right?

7 A. That's correct, yes.

8 Q. Now, that's not acceptable, is it, in
9 terms of vital signs being taken every hour?

10 A. For temperature, I wouldn't be worried
11 very much, since I also didn't ask especially for
12 temperature monitoring. Temperature is routine, which
13 is done sporadically and for a need for a certain time,
14 so I wouldn't ask them hourly to take the temperature.

15 Q. All right. Well, let's talk about the
16 pulse, all right? The pulse at 1:45 is 72 per minute,
17 right?

18 A. Yes, that's correct.

19 Q. All right. And you asked that the heart
20 rate be taken once an hour for the first four hours.
21 That's Order 239, right?

22 A. Yes.

23 Q. All right. And that wasn't done, was
24 it?

25 A. No.

1 Q. Now that is not optimal, is it?

2 A. No.

3 Q. All right. In fact, you were shocked

4 when you found out that that order wasn't complied

5 with, right?

6 A. Yes.

7 Q. All right. Now, the respirations that

8 were taken as shown up there, more than once an hour,

9 and they go from 16 to 14 to 12 to 8 to 10, and when

10 they're 8 to 10, you'd agree, that's at 2:50 in the

11 morning, right?

12 A. Yes.

13 Q. Right. And eight to ten is a

14 respiration rate that causes you some concern, right?

15 A. Yes.

16 Q. All right. In fact, it causes you a lot

17 of concern, right?

18 A. It causes concern, yes.

19 Q. All right. Well, would it cause you

20 enough concern to want to know what the pulse was at

21 that particular point in time?

22 A. Yes.

23 Q. All right. And there was no pulse taken

24 at that point, was there?

25 A. No, I don't see it.

1 Q. All right. And that's not optimal care,
2 is it?

3 A. No.

4 Q. All right. In fact, it shocked you when
5 you found out that the rate was that low and no pulse
6 was taken, right?

7 A. Right.

8 Q. Now, we talked about temperature, I
9 guess the temperature could have been taken at that
10 point too, right? I mean, we've got an eight to ten.

11 A. Again, I have to admit that I didn't ask
12 for temperature monitoring during all these times.

13 Q. Right.

14 A. So, the vital signs for our purpose, a
15 temperature, if you have something which makes it
16 necessary to have a temperature. For example, a high
17 pulse.

18 Q. Right.

19 A. Then you need a temperature, yeah. If
20 there's -- and otherwise, for a hospitalized child, I
21 would have a routine temperature check, but not hourly.

22 This is my understanding of nursing, and is this
23 answering your question?

24 Q. All right. Yes, well it does, because
25 the pulse was 120 at 3:20 in the morning, and the

1 respiration was 12 and no temperature was taken. I
2 thought you just said that when the pulse is high, it's
3 a good idea to take the temperature?

4 A. That's correct. For this time I would
5 want then a temperature.

6 Q. So you would have wanted a temperature
7 at 3:20 in the morning?

8 A. That's right.

9 Q. And you would have wanted a temperature
10 at 2:50 in the morning, given very low respiration?

11 A. Yes.

12 Q. And they weren't taken at either time,
13 right?

14 A. No.

15 Q. And when you looked at the chart the
16 next morning, that was shocking, wasn't it?

17 A. Yes. No, I didn't look at the next
18 morning at the chart.

19 Q. You looked at ---

20 A. I didn't see the chart until I -- I
21 received it having insight after the Coroner had
22 released the chart. Before that I never saw the
23 charting or anything of these details.

24 Q. All right.

25 A. And I didn't know about these things.

1 Q. All right. But when you found out about
2 them they were surprising, to say the least?

3 A. That's true.

4 Q. All right. Now, 4:15 in the morning,
5 the respiration's ten and the pulse rate's 134. I take
6 it you'd agree with me that you would have wanted to
7 see a temperature at that time, as well?

8 A. Yes, that's true.

9 Q. All right. And you were never told that
10 the respiration was ten and the pulse rate was 134;
11 nobody ever told you that, did they?

12 A. I don't recollect that I heard something
13 like this.

14 Q. Well if you would have heard that,
15 Doctor, you would have done something about it, right?

16 A. That's true, yeah.

17 Q. All right. And one of the things that
18 you might have done is you would have either phoned in
19 or told them to see the anaesthesia person at the
20 hospital or you would have gotten up out of bed at 4:15
21 and come to the hospital, right?

22 A. Yes.

23 Q. All right. Now, by the way, was the
24 blood pressure ever taken again from 1:45 in the
25 morning up to the time that Lisa died over six hours --

1 let's say about six hours later, five and a half hours
2 later?

3 A. No, I don't see any other blood
4 pressures here.

5 Q. And I take it you'd agree with me that
6 we don't have to go through your orders one by one,
7 that that's a violation of what was in the orders that
8 you made?

9 A. I'd say it, yeah.

10 Q. Pardon?

11 A. Yes.

12 Q. In fact, you wanted the blood pressure
13 to be taken once an hour for the first four hours,
14 right?

15 A. Yes.

16 Q. And then you wanted it taken thereafter
17 less frequently, but you still wanted it to be taken,
18 right?

19 A. Yes. It's part of the vital signs.

20 Q. It's part of the vital signs. Now, just
21 to get back to the orders that you made, there's a
22 significance to CNS, that's central nervous system,
23 depressants being given to somebody who's on morphine,
24 right?

25 A. Right.

1 Q. And the significance of that is that
2 morphine itself is a depressant, right?

3 A. That's right, yeah.

4 Q. All right. And if you have one
5 depressant, CNS, central nervous system depressant, and
6 you have another one, that makes the situation even
7 more threatening, right?

8 A. That's true.

9 Q. All right. And I take it you'd agree
10 with me that Amitriptyline is a CNS depressant?

11 A. Amitriptyline has a sedative effect,
12 yeah.

13 Q. All right. So if it's not chemically a
14 CNS depressant, it certainly has CNS depressant
15 features to it?

16 A. It has in some way, yes.

17 Q. All right. And Lisa was on
18 Amitriptyline?

19 A. That's true.

20 Q. All right. And therefore it was even
21 more important that she be monitored carefully than
22 somebody who's not on Amitriptyline and is just on
23 morphine; isn't that right?

24 A. Oh, it's very important for us to be
25 monitoring, yes.

1 Q. Now, I just want to clarify a point that
2 came up earlier on, and the point relates to this: The
3 PCA, that's the Patient Controlled Analgesia Pump,
4 that's sort of like a remote control television
5 clicker, right? You click it and it delivers a dose of
6 morphine?

7 A. Yes.

8 Q. All right. And as I understand it, we
9 don't have to get into all of the technical details,
10 but there's some lockouts, in the sense that if you
11 click it, you can't click it again for another six
12 minutes?

13 A. That's true.

14 Q. And then if you click it a certain
15 number of times in two hours, regardless of the six
16 minute thing, you can't click it anymore, or you can
17 click it, but it's not going to deliver medication?

18 A. That's one thing, and very often you
19 will -- it would sound an alarm as well.

20 Q. All right. And the discussion -- first
21 of all, do you agree with me that the child has to be
22 reasonably mature, or an adult, if an adult's on a PCA,
23 has to be reasonably mature so that there's no feeling
24 that they may abuse it?

25 A. That's true.

1 Q. All right. So there's certain lockout
2 features which prevent abuse beyond a certain point,
3 but I guess they can fail and you want to make sure
4 that you have somebody who's not going to just be
5 clicking it every five seconds?

6 A. Yes.

7 Q. All right. So the child has to be
8 reasonably mature, and I take it you have to have some
9 trust with the parents in the sense that the parents
10 can defeat the purpose of the machine if the parents
11 come over and click it?

12 A. I'm sorry? Sorry, but ---

13 Q. Okay. You don't want the parents
14 clicking the machine?

15 A. Definitely not, no.

16 Q. All right. And, in fact, the nurses and
17 the doctors are not supposed to click the machine
18 either, right?

19 A. That's true, yes.

20 Q. All right. So you have to be reasonably
21 confident that the patient is reliable and that the
22 parents are reliable in the sense that they're not
23 going to be clicking the machine?

24 A. Yes.

25 Q. Now, is it correct that to do a sedation

1 scale one has to wake the child up?

2 A. Yes, that's true.

3 Q. All right. Now, you talked earlier, and
4 I was looking at you. I think you smiled about whether
5 or not it's a good thing to be waking a child up all
6 the time, but I take it that's an issue as to whether
7 or not it's a good thing or a bad thing? It's a
8 medical issue.

9 A. Oh, I'm very sorry. I'm apologizing if
10 I looked smiling. I think that is not a funny thing,
11 and I want to emphasize I believe in sedation score and
12 I believe waking up children for this issue, since I
13 believe that the importance of the sedation score is so
14 high that I prefer having waken up -- having -- that
15 the child is awake at different times of the night
16 rather than having a disaster.

17 Q. All right, I understand. And I wasn't
18 imputing anything to you. I just wanted to make sure
19 that I understood what you were saying correctly, and
20 that is that -- and this is the point. The vital signs
21 are supposed to be taken as ordered regardless of
22 whether the child is sleeping or not sleeping, true?

23 A. True, yes.

24 Q. All right. Because in the global scheme
25 of things, it doesn't matter that much whether you wake

1 a child up, right?

2 A. Yes.

3 Q. In the global scheme of things?

4 A. That's true.

5 Q. All right. Because you're better off

6 waking the child up to take blood pressure, to take a

7 respiration rate, or whatever you have to do. Blood

8 pressure, I guess, is the big one?

9 A. Yeah.

10 Q. Because you have to physically do

11 something to the child's arm, right?

12 A. Right.

13 Q. All right. But you're still always

14 better off waking the child than saying, "No, I'm not

15 going to listen to that order because I don't want to

16 wake the child up?"

17 A. Right.

18 Q. Now, as part of your job as an

19 anesthesiologist and a pain expert, do you set the --

20 first of all, do you use or did you use at Sick Kids

21 and do you use now the so-called Corometric monitors?

22 A. If I used?

23 Q. Have you used them in terms of setting

24 them up or do you use them now?

25 A. Well, I didn't use them before I came to

1 Sick Kids.

2 Q. Right.

3 A. And I don't use them now as a staff
4 anaesthetist in my hospital. I first of all -- first
5 time I got to know these machines at Hospital for Sick
6 Children, they give a certain information. I wouldn't
7 set them up. This is standard nursing protocol, and so
8 the alarms, I wouldn't set. Yeah, this is a nursing
9 procedure. And since I believe -- I'm a strong
10 believer in oxygen saturation monitoring; I always,
11 from very beginning, was asking for my patients an
12 oxygen saturation monitoring.

13 Q. By the way, what's the significance of
14 oxygen saturation? Is that that if the oxygen
15 saturation in the blood falls below a certain level
16 that's dangerous because the child isn't getting oxygen
17 to the brain and to the vital organs?

18 A. That's true, yes.

19 Q. All right. And is that measured by a
20 percentage of oxygen in the blood?

21 A. Yes, that is a percentage and it's the
22 oxygen saturation in the arterial blood, so an
23 infraction of a positive blood.

24 Q. All right. Now, I'm not going to ask
25 you because you said that you don't set up the

1 parameters on the Corometric monitor, but I just -- you
2 understand how they work, I take it?

3 A. The parameters?

4 Q. Yes.

5 A. The alarms?

6 Q. The Corometric monitor, as I understand
7 it, has as setting for low heart rate and high heart
8 rate, right?

9 A. Exactly. For respiratory rate.

10 Q. And the same thing with the respiratory
11 rate?

12 A. Yes.

13 Q. Is that right?

14 A. Yes.

15 Q. All right. So it's set within certain
16 parameters so if the rates are 100 to 200 heart beats
17 -- I'm not saying this is accurate, but then if it goes
18 below 100 it rings and if it goes above 200 it rings;
19 is that right?

20 A. This is normally like the alarms are
21 working, yes.

22 Q. All right. And the same thing with the
23 breathing, is the breathing is 11 to 20, if it goes
24 below 11 in a minute it rings?

25 A. Yes.

1 Q. And keeps ringing?

2 A. Yes.

3 Q. And if it goes above 20 it rings; is
4 that right?

5 A. Yes. That's right.

6 Q. All right. And you said that the reason
7 that oximetry is more accurate with regard to the
8 oxygen in the blood is because it actually measures the
9 percentage of oxygen in the blood as opposed to the
10 compressions of the chest, for breathing I'm talking
11 about.

12 A. Well, you know, there might be cases
13 where someone is on this other monitor and he's still
14 breathing, but perhaps having a shallow breathing and
15 he's perhaps already absolutely blue, and if you would
16 put the pulse oximeter, you would have a saturation
17 which is already less than we would like to have. So
18 what we wanted to know is how well the patient is
19 saturated with oxygen. This is the target point, and
20 therefore I prefer to target -- to monitor the target
21 point and not something which is only indirectly
22 monitoring. So respiratory rate is only an indicator
23 for bad saturation. And I prefer to have a saturation
24 as a monitor.

25 Q. Now, the other thing I wanted to ask you

1 about relates to the PCA pump and the delivery of drugs
2 or morphine, I mean. Do you have any information now,
3 that's in 1999, as we sit here, as to what the last
4 time -- at what hour Lisa last made a demand on that
5 pump?

6 A. I don't have now, right now the last
7 time, I have to admit.

8 Q. All right.

9 A. Although I'm aware that there's a memory
10 in this machine and this should be available.

11 Q. It is, and I'm not going to ask you
12 about it if you're not aware of it. I'm sure we're
13 going to hear about that.

14 MR. GOMBERG: May I have your indulgence,
15 Mr. Coroner, for a minute?

16 THE CORONER: Certainly.

17
18 BY MR. GOMBERG:

19 Q. Yeah, the other thing I wanted to ask
20 you about is this page which you've heard about from
21 Mr. Hawkins at 2:00. That's the page, I think, that
22 you say you never got, all right? Have you checked the
23 records to see whether there's any recording of that
24 page having been made to you?

25 A. Which records?

1 Q. The hospital record.

2 A. Hospital record?

3 Q. The flow chart.

4 A. I don't know ...

5 Q. That chart?

6 A. Oh, yeah. Well, in this chart I don't

7 see at 2:00 a record. Flow chart, I don't see anything

8 which is at 2:00 mentioning a page.

9 Q. Just so I understand this, is it your

10 evidence that if you'd been paged at 2:00 and you

11 didn't get the page, that you ought to have been paged

12 again, say within the next five or ten minutes? Is

13 that your evidence?

14 A. That is what I assume normally should

15 happen or would happen.

16 Q. Why?

17 A. Since we get paged for certain reasons,

18 and considering the protocol, and if there's a reason

19 to page us, it's only my -- that's the most natural

20 thing, that you should insist and keeping paging.

21 Q. All right. Well, just from a lay

22 perspective, it seems to me that if you're paged in the

23 first place ---

24 A. Yes.

25 Q. --- you're paged for something that's

1 important?

2 A. Yeah.

3 Q. Right?

4 A. Right.

5 Q. If it's important enough to page you the
6 first time, then it's important enough to make sure you
7 get the page. Do you agree with that?

8 A. I agree with that, yeah.

9 Q. Is it fair to say that generally
10 speaking you're disappointed with the level of
11 information that was communicated to you?

12 A. Well, yes.

13 Q. Thank you.

14 THE CORONER: This is a reasonable time to
15 have the afternoon recess. We'll recess for
16 20 minutes. I should remind the witness
17 you're on the stand and nobody should speak
18 to you during the recess. And likewise, I
19 give the jury the usual warning.

20

21 --- A BRIEF RECESS

22

23 MR. GOMBERG: Dr. Cairns, I apologize. I
24 mis-spoke. I have two more questions, I
25 think, if I may?

1 THE CORONER: Yes, Mr. Gomberg.

2 MR. GOMBERG: Firstly, I neglected to ask
3 you, Mr. Coroner, that the chart be marked as
4 the next exhibit, which I think is Exhibit 8.

5 CORONER'S CONSTABLE: Exhibit 8.

6 THE CORONER: Exhibit 8. Thank you.

7

8 --- EXHIBIT NO. 8: Blow-up of flow sheet.

9

10 DR. MARKUS SCHILY, resumed:

11 CONTINUED CROSS-EXAMINATION BY MR. GOMBERG:

12 Q. Now, Dr. Schily, your notes, these are
13 the notes that we got today. Could you turn to Page 3,
14 please? These are the typewritten notes.

15 THE CORONER: Oh, I'm sorry, Doctor, he's
16 referring to the ---

17 MR. GOMBERG: Maybe we can call them the
18 CMPA notes.

19 THE CORONER: --- private notes you made
20 that are not on the chart. The notes that
21 you forwarded to the Canadian Medical
22 Protective Society. That's them.

23

24 BY MR. GOMBERG:

25 Q. Dr. Schily, I take it that after this

1 event you had a discussion with a resident, and you've
2 referred to this person as the resident who was called
3 to help in the CPR. Do you see that at paragraph 2,
4 page 3?

5 A. Yes.

6 Q. All right. And that resident,
7 obviously, when you -- I didn't ask you about this, but
8 you were paged I think you said the following morning
9 and you returned the page. That was sometime after,
10 say, 7:45 in the morning?

11 A. That's true, yeah. I don't recall the
12 exact time, but I got the page where they told me that
13 there was a code going on and CPR at the ward.

14 Q. All right. So it was sometime probably
15 between 7:00 and 8:00. You didn't make a note of that?

16 A. I didn't make a note of that.

17 Q. Or between 7:15 and 8:00. Now, you had
18 a discussion. So what did you do? That page came up
19 on your machine and you phoned the hospital?

20 A. Oh, no, I wasn't -- this page was when I
21 was already in hospital.

22 Q. Oh, you were back in the hospital?

23 A. I was taking care in the morning already
24 for another patient. I was preparing a research, a
25 clinical trial, and I was busy with another patient at

1 the moment the pager went off and I heard that there's
2 a code going on in 5A.

3 Q. All right. But you did not attend that
4 code?

5 A. No. The resident went or he was already
6 there. I don't know. I don't have any idea. I know
7 that the resident of anaesthesia went to this code.

8 Q. All right. And is that the resident
9 that you refer to at paragraph 2, page 3 of your notes?

10 A. That's right.

11 Q. All right. And who is that resident,
12 please?

13 A. I don't -- I'm sorry, I don't recall his
14 name, but I know exactly who it was and I don't recall
15 his name.

16 Q. All right. And that resident passed
17 some information onto you that morning; is that right?

18 A. That's true, yeah.

19 Q. All right. And you made a note of that,
20 I think you said earlier, and the note that you made
21 was incorporated into these notes which went to CMPA,
22 right?

23 A. That's true, yeah.

24 Q. All right. And that was a note that you
25 made that morning or that afternoon or that evening.

1 We're talking about October 22nd, 1998?

2 A. That's true, yeah.

3 Q. All right. And you strove or you
4 attempted to be as accurate as you could be when you
5 made that note, correct?

6 A. That's correct, yes.

7 Q. Because you knew that this could give
8 rise to further proceedings, including possibly a
9 Coroner's Inquest?

10 A. I didn't know what will happen, but I
11 was very worried what ---

12 Q. All right. Well, without getting into
13 the details, you may not have known what was going to
14 happen, but you knew there was a good chance that
15 something would happen?

16 A. Oh, yes. Yeah.

17 Q. All right. Now ---

18 MR. HAWKINS: Dr. Cairns, if I might
19 interject? I think I know where my friend is
20 going and we're getting into what's classic
21 hearsay. Dr. Schily has identified that he
22 can't name who told him that. You know that
23 we are hearing from numerous people who were
24 present at the code, so for Mr. Gomberg to
25 read from a letter that Dr. Schily wrote to

1 his lawyer after the fact about a discussion
2 with somebody he can't name, I think is
3 highly inappropriate and clearly contravenes
4 the rules against hearsay, which says put the
5 witness in the box, and we are going to be
6 putting a number of witnesses in this witness
7 box as to what happened at the code.

8 MR. GOMBERG: Well, they're his notes. They
9 were made contemporaneously with the event.
10 As you said about two hours ago, the strict
11 rules of hearsay do not apply in a Coroner's
12 Inquest. I don't know whether this doctor is
13 coming or not coming, and I can take you
14 through the sections that deal with this
15 stuff, but it's clearly appropriate for me to
16 ask him this and I suppose if Mr. Hawkins
17 wants or wanted to, he could have cross-
18 examined him on this. I found out about
19 these notes for the first time about an hour
20 and a half ago. They were made
21 contemporaneously with the event or soon
22 thereafter and they deal with a very, very
23 material issue, and that is whether or not
24 the child, we've heard she wasn't on
25 oximetry, whether she was on any kind of a

1 monitor at all.

2 THE CORONER: Ms. Browne, do you have any
3 comments?

4 MR. BROWNE: I just wanted to say, Dr.
5 Cairns, that I got this, as you know, just
6 when Mr. Gomberg did. The question as to
7 whether or not there were any monitors
8 attached to Lisa in the morning and during
9 the night is going to be a big issue,
10 probably the biggest one at this inquest, and
11 it's certainly relevant what is said here by
12 this unnamed resident, and it's certainly
13 relevant for us to find out if that person
14 can be a witness, can be interviewed by the
15 police officers on behalf of the Coroner and
16 the Coroner's Counsel or whether, indeed,
17 anyone else wishes to call this man as a
18 witness. But he does say something about the
19 monitors and I think that we should be able
20 to find out what.

21 THE CORONER: Ms. Posno, do you have any
22 opinion?

23 MS. POSNO: I have concerns about the source
24 of the information in the same way Mr.
25 Hawkins has indicated, that it's based on

1 hearsay evidence. That I think can be
2 explored with the physician so that the jury
3 is aware how much information Dr. Schily had
4 when he wrote this.

5 There's no question he's writing
6 something that was told to him by somebody
7 else. It does deal with an issue that is of
8 relevance, but there is some concern as to
9 how dependable that information is, and that
10 should be explored.

11 THE CORONER: Mr. Hawkins, any further
12 comments?

13 MR. HAWKINS: I make the same point as
14 before, Dr. Cairns. You and your Crown
15 Attorney have set the witness list for this
16 inquest. The witness list is appropriate to
17 add to with real people to put in the witness
18 stand.

19 When Dr. Schily cannot testify as to who
20 this unnamed person was who said whatever it
21 was that was said to him, based on the
22 Coroner's Act, that does not accord with the
23 provision in the Coroner's Act which suggests
24 that evidence that is useful or potentially
25 probative be put forward. The people who can

1 testify are the people at the code.

2 What someone said to Dr. Schily, with no
3 information as to who that was, with no
4 information as to when that person arrived at
5 the code, with no information as to the
6 source of that person's information, that
7 does not meet the standards of proof required
8 by the Coroner's Act. Call the people who
9 were at the code if that is an issue.

10 THE CORONER: Well, the Coroner's Act does
11 state that the strict rules of evidence do
12 not apply, and that hearsay evidence is
13 allowed. One will have to put on the hearsay
14 evidence, there's an issue of credibility,
15 and the weight that has to be borne on it.

16 Are you telling me that you can provide
17 me with every single person that was at that
18 cardiac arrest so that we can go through them
19 all? Part of the purpose was to try and
20 reduce to a minimum the number of people that
21 we would call in that regard.

22 MR. HAWKINS: All of the physicians who were
23 present at the code are listed and clearly
24 set out in the records. Those records have
25 been available to your office since October

1 of '98, and to Counsel since October of 1998.

2 So all of the physicians are clearly
3 identified in the records before you.

4 THE CORONER: That's fine. Mr. Gomberg?

5 MR. GOMBERG: Well, the thing is this, that
6 I'm looking at the resuscitation record.

7 There are five doctors there. I know that
8 one of them is in Portland, Oregon, so I
9 guess she's not coming, and I think that that
10 ends the discussion right there.

11 It's very nice for the people on the
12 other side of the aisle to say that these
13 people are available, but they're not exactly
14 available to me, and since they're outside
15 the ambit of your subpoena, Mr. Coroner, I
16 guess they're not available to you either.

17 Now, the thing is this. There were five
18 people in the room. I'm happy to be precise
19 and lead them through the names. He's not
20 said he doesn't know who it is, he just says
21 he doesn't remember his name. Who cares?

22 THE CORONER: Well, are you saying that he
23 may be able to remember the name if you read
24 him through the names?

25 MR. GOMBERG: Well, sure. They are five

1 names in the records.

2 THE CORONER: Will that be of any assistance
3 to you?

4 THE WITNESS: I know the person. I'm very
5 sorry to admit that -- I can describe the
6 person. I know the person. I was working
7 with the person, but I'm not hundred percent
8 sure that I will recognize the name, and ---

9 MR. GOMBERG: I mean, this isn't even the
10 true situation, Deputy Chief Coroner, where
11 he doesn't know who it is. He knows who it
12 is, he just can't attach a name to the
13 person.

14 THE CORONER: This particular witness has
15 come from Israel and this particular witness
16 has to return to Israel tomorrow, and
17 therefore we do not have an opportunity to
18 recall him at a later date, and I am, since
19 the strict rules of evidence do not apply at
20 an inquest, and since hearsay is allowable,
21 although the weight to which that evidence
22 will be given will be something that we can
23 direct the jury, and I will direct the jury
24 at a later time, I'm going to allow Mr.
25 Gomberg, with that proviso, to go ahead and

1 ask the question.

2
3 BY MR. GOMBERG:

4 Q. When you spoke to this person -- first
5 of all, when did you speak to this person?

6 A. Right after he returned from the CPR,
7 from the code.

8 Q. Well, just to help the jury and to help
9 the Deputy Chief Coroner, that would have been sometime
10 within, say, an hour, between 8:00 and 9:00 in the
11 morning, something like that?

12 A. Could be, yes.

13 Q. All right. And I take it that you were
14 on a -- you knew at that point that Lisa Shore had
15 died, right?

16 A. Yes.

17 Q. You tried to be as accurate as you could
18 when you made the note?

19 A. Yes.

20 Q. What did you make a note of? In other
21 words, what were you told?

22 A. Well, the resident, I knew that he went
23 there for assistance, and again, I emphasize, this is
24 secondhand information. I wasn't there, and this is
25 only what he said. And what he said I was writing

1 here, what I heard by then.

2 Q. Well, can you tell me what that is,
3 because the jurors don't know what it is.

4 A. Oh, sorry. So, perhaps I'll read. "The
5 resident who was called to help in the CPR told me that
6 the whole dose of morphine which Lisa received was 11
7 milligrams, and including the morphine in the Emergency
8 Room boluses and PCA."

9 Q. Now, let me stop you there for a minute.
10 He told you that she had received a total of 11
11 milligrams of morphine; that she had received a total
12 of 11 milligrams of Morphine, right?

13 A. Well, yes, this is what I was writing.

14 Q. All right.

15 A. And again, this is a first impression we
16 got and I didn't check that. I didn't have any access
17 to the chart and this is only what I've heard by then.

18 Q. To be clear, I'm not suggesting that
19 this is what happened. I'm just suggesting that this
20 is what you were told, right?

21 A. This is what I was told by then, yes.

22 Q. All right. So you were told that there
23 were 11 milligrams of morphine, that Lisa had had 11
24 milligrams of morphine, both by way of the boluses,
25 that means by way of the intravenous or by shots, I

1 mean, and by way of a PCA, that's the patient-
2 controlled analgesia?

3 A. That's ---

4 Q. That's what you were told, right?

5 A. That's right, yes.

6 Q. And that's what you wrote down, right?

7 A. Right.

8 Q. All right. What were you told about the
9 monitors being attached or not attached?

10 A. I was told when he entered, at the time
11 he joined the CPR, which started already, he wasn't
12 there the first person. When he came to the ward he
13 didn't find a monitor attached, not the monitor
14 attached to the child.

15 Q. All right. And did he say -- what did
16 he tell you about whether alarms were going off or not
17 going off when the orthopaedic team entered the room?

18 A. I don't recall that we were talking
19 about that. He wasn't there when the orthopaedic team
20 entered the room, so I didn't hear about that
21 something.

22 Q. Well, is that in your notes, Doctor?

23 A. Sorry. That's true. I heard something
24 about that by that time, that's true. I'm writing
25 that, "No alarms went off when the orthopaedic team

1 entered the room." That's true. Sorry.

2 Q. Well, just to be clear about it.

3 A. Yeah.

4 Q. Just to be clear about it, when you

5 spoke to that orthopaedic -- to that doctor who is a

6 member of the orthopaedic team; is that right?

7 A. That doctor?

8 Q. Yeah.

9 A. No. He was -- he's an anaesthetist.

10 Q. All right. So he was an anaesthetist.

11 A. And he was a member of the CPR team

12 then.

13 Q. All right. So he was the member of the

14 CPR team and what he told you and what you wrote down

15 was that the monitors weren't attached properly.

16 That's what he told you and that's what you wrote down,

17 right?

18 A. That is true, yes.

19 Q. All right. And he told you, and I quote

20 from your note ---

21 A. Yeah.

22 Q. --- "No alarms went off when the

23 orthopaedic team entered the room." That's what he

24 told you and that's what you wrote down?

25 A. That's what he told me. That's true.

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Q. All right.

A. That's correct.

Q. And then he says that the -- I guess the orthopaedic team, realizing first that Lisa was dead by noticing that she was pale. That's what he told you and that's what you wrote down?

A. Yes.

Q. All right. And then I asked you about this earlier, but Lisa didn't receive any morphine medications from the PCA device since 1:45 a.m. Do you remember we talked about that a little bit before?

A. Yes, that's true.

Q. All right. And is that something that that anesthesiologist told you?

A. That was some -- yes.

Q. Sorry.

A. That's correct.

Q. All right. So that anesthesiologist also told you that the last hit that Lisa got from the PCA pump was at 1:45 a.m. That's what you were told and that's what you wrote down?

A. Yes.

Q. Thank you. Those are my questions.

THE CORONER: I'm going to indicate to the jury at this time that I did say I would

1 allow this evidence, but you will have to
2 weigh the credibility of it at a later time,
3 since this is hearsay evidence. To enable
4 you to weigh that credibility at a later
5 stage, this witness was told by this
6 individual that the total dose of morphine
7 was 11 milligrams. The last dose of morphine
8 was at 1:45 a.m.

9 You will hear other evidence in that
10 regard, which I hope will assist you in
11 weighing how much weight you can put on what
12 this particular witness was told at that
13 time. And I also need to stress to you at
14 this time that the witness is indicating that
15 the resident to whom he spoke was not one of
16 the first people into the room.

17 So with that proviso I'm allowing your
18 statement as it is, and I'm not taking away
19 from your statement in terms of what you have
20 recorded, but in terms of the credibility or
21 the accuracy of the statement, since it is
22 not something that you saw yourself, but were
23 told, and we will come back to that at a
24 later time.

25 Ms. Posno?

1 MS. POSNO: Thank you.

2
3 CROSS-EXAMINATION BY MS. POSNO:

4 Q. Just a couple of questions for you, Dr.
5 Schily. There's been mention of morphine being a
6 dangerous drug. If you could describe for us, please,
7 why morphine was prescribed in this case?

8 A. Our decision-making was actually based
9 on the fact that we dealt with chronic pain and an
10 acute pain on the chronic pain. So we had an outbreak
11 of severe pain, and it was influenced by the fact that
12 it was in the middle of the night. It was influenced
13 by the fact that the -- in the past a trial was
14 performed doing different pain relief methods, like an
15 epidural block, which failed, obviously.

16 So we took what is the most normal thing
17 in the world in such a situation or in acute pain. We
18 treated her with morphine and after I heard that Lisa
19 was treated in the past with morphine. I'm not sure if
20 I answered all your question.

21 Q. That's fine, Dr. Schily. When did you
22 first learn that Lisa Shore had died?

23 A. When did I first hear?

24 Q. Learn.

25 A. Learn? When the resident returned, so

1 far as I recall. I don't know if someone else was
2 saying -- spreading the rumour before, but it was
3 shortly after I got the code.

4 Q. And you found out from the resident that
5 she had died?

6 A. I think so, yes. Yeah.

7 Q. And before that and before you received
8 the code, had you been aware of any problem with her
9 condition, with her level of stability?

10 A. No, absolutely not.

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

13 A. Well, since I assumed that everything is
14 fine, since I assumed that she's properly monitored,
15 and since I didn't get a second page and I actually
16 asked for rechecking all the vital signs and the
17 saturation, I went back to sleep and was getting up as
18 normal and going to hospital, and my intention was
19 actually to go and look after Lisa in the morning and
20 find her fine.

21 Q. Just so it's clear, Dr. Schily, did you
22 have any involvement at all in the resuscitation
23 efforts?

24 A. No.

25 Q. Those are my questions. Thank you, Mr.

1 Coroner.

2 THE CORONER: Are there any further
3 questions of Dr. Schily? First of all by the
4 jury. Do the jury have any questions of Dr.
5 Schily?

6 JUROR #2: I have a few.

7 THE CORONER: Yes.

8
9 CROSS-EXAMINATION BY THE JURY:

10 BY JUROR #2:

11 Q. Okay. Dr. Schily, I'd just like to
12 clarify, is this a safety check when you put together
13 your orders and send them through is there not some way
14 of knowing if they did go through?

15 A. Sorry?

16 Q. Sorry. When you put through orders on a
17 patient when a patient is admitted and especially if
18 they're being transferred to another floor, is there
19 any way that you normally would know if your orders
20 have gone through? A safety check on the computer that
21 the orders had gone through and that the nurses had
22 received orders?

23 A. If I understand you, if there -- you ask
24 me if there is a procedure of rechecking that the
25 orders got through and the nurses were reading it? Is

1 that what you are asking me?

2 Q. Yes.

3 A. No. There is not a common procedure,
4 and since the KidCom system is like a chart, and it is
5 actually a computerized chart and a follow-up and
6 besides, of course, the KidCom system there is the
7 written chart and the documents of the KidCom system,
8 which are printed out and going into the written chart.

9 And this is not a common policy to my best knowledge,
10 that we, as a physician, check after the nurses if they
11 -- although we very much try to be in contact, but
12 remember that the nurses are working in shifts.

13 Q. Yes.

14 A. We can't reassess every shift.

15 Q. No.

16 A. Is this answering your question?

17 Q. Just to clarify. So if a patient is
18 admitted and they're being transferred to a ward, then
19 you would enter your orders onto the KidCom and a paper
20 would be printed off?

21 A. And at the ward there's a computer.

22 Q. Yes. And they should be able to read
23 from the computer?

24 A. And one of the first things the nurse is
25 either checking if there is something printed out of

1 the KidCom or looking in the computer if there's
2 something to print out. This is my understanding.

3 Q. Okay.

4 A. But I'm not a nurse.

5 Q. No.

6 A. And so ---

7 Q. Just one other question from that. They
8 did not receive your orders up on the orthopaedic.
9 Would they not, on receiving a patient, would they not
10 be looking for orders? Wouldn't they find it strange
11 that they didn't have orders?

12 A. I can't answer this question. I wasn't
13 there.

14 THE CORONER: Perhaps I can just help the
15 jury. There will be further evidence in
16 regard to that. Because of the timing of Dr.
17 Schily's evidence, there is a little bit of
18 your education on the KidCom orders that I
19 would have preferred to have introduced to
20 you before Dr. Schily's evidence, but he was
21 coming back from Israel and this was the only
22 timing that I could make that available. So
23 hopefully that will be a little bit clearer.

24 Can I just, in regard to that, Dr.
25 Schily, on page 36 I think it is, of the

1 notes or page 7 in the file that we all have,
2 if you just turn to that for a second? It's
3 your orders, and on the line, one, two,
4 three, four -- on the fifth line down, you
5 say there, there's an arrow, "See KidCom
6 orders."

7 THE WITNESS: Yes.

8 THE CORONER: Can you tell the jury what you
9 assume that means or what you meant by that?

10 THE WITNESS: Well, it clearly means, look,
11 check the computer after my orders. So this
12 was -- basically, perhaps this is actually
13 perhaps what you meant.

14 JUROR #2: Yes.

15 THE WITNESS: There was in the chart, in the
16 written chart there was a hint, additional
17 hint of doing the normal work.

18 JUROR #2: Yes. Okay.

19 THE CORONER: Can I interpret that? Am I
20 wrong to interpret that, that that is a note
21 that you are giving to the nurses on the ward
22 to say that in addition to these handwritten
23 notes or handwritten orders, they are to look
24 at the KidCom orders because you have written
25 additional orders in that; is that correct?

1 THE WITNESS: That is correct. And to
2 explain it, I want to prevent that someone
3 would think this is all what is needed to be
4 done, and this is all what is done, so that
5 is why I was writing.

6 THE CORONER: And I assure you, you will
7 hear more detailed evidence about what
8 happens to orders in that regard. Does the
9 jury have other questions? Yes?

10
11 BY JUROR #5:

12 Q. What does CMPA stand for? CMPA stands
13 for? What is it?

14 A. What it is, CMPA?

15 Q. Yeah. You wrote a letter saying ---

16 A. Something ---

17 Q. You wrote a letter.

18 A. Yes. CMPA means the -- could you ---

19 MR. GOMBERG: Canadian Medical Protective
20 Association.

21 THE CORONER: Canadian Medical Protective
22 Association.

23 THE WITNESS: Oh, thank you very much. Yes.

24 THE CORONER: Any other questions from jury
25 members?

1 JUROR #2: I had another one.

2 THE CORONER: Please, feel free to ask him.

3 JUROR #2: Yes.

4 THE CORONER: Because Dr. Schily will not be
5 available, so, just as well to answer them
6 now.

7

8 BY JUROR #2:

9 Q. Just to clarify my own knowledge of
10 procedure. When a patient is being -- when a doctor is
11 asking that a patient be hooked up to a machine, is it
12 just common practice that you give the instructions to
13 the nurses and then leave it to them to do? You don't
14 do a follow-up, you know, in a short period come back
15 to make sure that it's all been implemented?

16 Q. Well, we very often -- the PCA treatment
17 in the Hospital for Sick Children is a very common
18 daily procedure to be performed on almost every ward.
19 5A is a ward where PCA machines are existing very
20 often, and so we do do our rounds and we do check on
21 our rounds the PCA machines. We normally, for a normal
22 -- normally PCA is started after surgery. So PCA is
23 started by the nurses in the recovery room very often.

24 Q. Mm-hmm.

25 A. And if there is the doubt that the

1 nurses are not understanding to handle, to set up the
2 machine, we are giving a hand and we are advising and
3 the follow-up is very often through telephone, but, if
4 needed, of course, we come, and we do on additional, of
5 course, our regular rounds to reassess.

6 THE CORONER: You have a question? Yes.

7
8 BY JUROR #1:

9 Q. Just prior to the break you were asked a
10 question, whether you were dissatisfied with the level
11 of information given to you. It wasn't clear who gave
12 that level of -- that information to you that you were
13 dissatisfied with. That question was put to you by
14 Counsel.

15 A. Perhaps if you say it like that's the
16 level of information you got. This is a little bit
17 misleading, and let me shortly explain. Now I'm
18 sitting here and know much more than I knew at 4:00 in
19 the morning.

20 At 4:00 in the morning, what I got I was
21 sort of happy with it and thought that is all right.
22 What I know now that I didn't get the information, and
23 I think it wasn't all right, since I didn't get the
24 details. So I'm now taking consideration what we know
25 now and what I know now, I'm very unhappy about the

1 dis-communication. How you say in English? Lack of
2 communication.

3 THE CORONER: Does that answer your question
4 or was it more specifically that you were
5 wanting to know who the individual was?
6

7 BY JUROR #1:

8 Q. Well, it was, yes. Not the individual,
9 but the individuals, if it was more than one.

10 A. We're not transferring to me ---

11 Q. The nursing staff or ---

12 A. Well, yes. I have would expected more
13 from the ---

14 Q. Was that exactly the concern ---

15 A. Yes.

16 Q. --- when you said you were dissatisfied?

17 A. Yes.

18 Q. Thank you.

19 THE CORONER: The nursing staff will be
20 testifying at this inquest, so you will get
21 an opportunity to hear more evidence in that
22 regard. Does the jury have any other
23 questions?

24 Do any Counsel, I'm going to be pretty
25 liberal because the physician will not be

1 available later on, and therefore, are there
2 any other questions or issues that any
3 Counsel want to bring up at this time with
4 regard to Dr. Schily's testimony? Ms.
5 Browne?

6
7 RE-EXAMINATION BY MS. BROWNE:

8 Q. I just wanted to clarify before you
9 left, Dr. Schily. The blow-up, the chart that's on the
10 easel at the moment and that has been marked Exhibit A.

11 THE CORONER: 8.

12
13 BY MS. BROWNE:

14 Q. Sorry, 8. Sorry, thank you. That is
15 explained as the blow-up of the flow sheet when she was
16 in the ward and the entries into the record. You had
17 testified that you received a page at 4:00 a.m.; is
18 that right?

19 A. That's right.

20 Q. The chart, Exhibit 8, indicates that
21 what was disturbing the nurses was at 2:50 a.m., right?

22 A. That's right.

23 Q. And you were asked by Counsel whether or
24 not you were paged at 2:50 a.m. and you said that you
25 didn't get a page.

1 A. No.

2 Q. And you thought that if it had been
3 important you would have received a page right back; is
4 that ---

5 A. I assume, yeah.

6 Q. All right. When you did get the page at
7 4:00 a.m., did anybody paging you refer to the concern
8 at 2:50 a.m. and why you didn't page back?

9 A. Did anybody, sorry?

10 Q. When you received the page at 4:00
11 a.m. ---

12 A. Yes.

13 Q. --- and you spoke to somebody,
14 presumably a nurse?

15 A. Yes.

16 Q. Did the person you were speaking to ask
17 you why you didn't return the page at 2:50 a.m.?

18 A. I don't recall such a question.

19 Q. Did you ask the nurse what happened at
20 2:50 a.m.?

21 A. Oh, I wasn't -- I didn't have the flow
22 sheet. I didn't have the information about it, so how
23 could I ask?

24 Q. So you didn't know about any concern at
25 2:50 a.m.?

1 A. No.

2 Q. But you would have expected someone to
3 ask you had they been concerned, would you?

4 A. Yes.

5 Q. Thank you. I just wanted to clarify
6 that.

7 THE CORONER: Any further questions?

8 MS. POSNO: Dr. Cairns, I just have one
9 question for Dr. Schily following up on a comment of one of
10 the jurors.

11

12 RE-EXAMINATION BY MS. POSNO:

13 Q. A question was asked of you, Dr. Schily,
14 regarding the physician's role in checking on
15 monitoring and equipment after you've given orders, and
16 you addressed the PCA pump and the doctor's role in
17 assisting with the PCA pump and how it's standard
18 procedure for the nurses to set up.

19 Carrying that just a little bit further
20 in terms of the monitoring that you had requested, is
21 there any role on the physician to go and confirm that
22 your orders in terms of the monitoring have been
23 properly connected?

24 A. No, that is not a standard procedure
25 which would a physician do. Again, if we would and if

1 it would happen that on our rounds we would find a
2 patient who is not properly connected to a monitor,
3 this would not astonish me very much, this would cause
4 that I would be really upset about that. So it's not a
5 standard thing. This is a nursing thing. The order is
6 written and they have to be followed and it's the
7 opposite if there's a question we have to be approached
8 about and be informed why this is not done.

9 So if, for example, all the monitors
10 would disappear from Ward 5A and there wouldn't be a
11 monitor available, I would expect to know it, because I
12 would have -- I would have to cancel in written form my
13 order, this or that, this is not valid.

14 MR. HAWKINS: I have two further questions
15 for Dr. Schily.

16 THE CORONER: Yes, please. That's fine.

17
18 RE-EXAMINATION BY MR. HAWKINS:

19 Q. Doctor, you were familiar with the use
20 of the KidCom system?

21 A. Yes.

22 Q. And I take it that when you arrived at
23 the Hospital for Sick Children in June of '98, that a
24 part of your orientation process would have included
25 some instruction on how to use the KidCom system?

1 A. That's true, yes.

2 Q. And so if we hear evidence later that
3 one of the standard instructions on the KidCom system
4 is that for the resident who enters orders to telephone
5 the ward and tell them, tell the nurses on the ward
6 that there are KidCom orders, if we hear that that's
7 part of the KidCom standards, that would be a standard
8 that you either weren't aware of or that you were told
9 in the training but forgot about?

10 A. Did I understand you that you said
11 resident, is as a standard procedure phoning the ward
12 and telling them that there are KidCom orders, that
13 this is a standard?

14 Q. Yes. My understanding is that the
15 standard is that the resident is to call the nurses on
16 the ward and tell them that there are KidCom orders.

17 A. Well, that was something ---

18 Q. Were you aware of that standard?

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

23 Q. But in this case you made no phone call
24 to the nurses on the ward to tell them there were
25 KidCom orders?

1 A. No. But I told the nurse -- by this
2 time the child was in the Emergency and I was talking
3 to the nurse and the nurse was going personally to the
4 ward, so Pauline, the nurse of Emergency was
5 transferring personally the child and she was aware
6 about the fact that there were KidCom orders.

7 Q. And, Doctor, I guess a final point, and
8 just, I again, I'd ask you to turn to this note that
9 you wrote to the CMPA, which is your insurance company.

10 At the bottom of page 2, and again, I take it from Mr.
11 Gomberg's questions you were trying to be accurate in
12 this note when you wrote it? Doctor, you were doing
13 your best to be accurate in this note when you wrote
14 it?

15 A. Yes.

16 Q. Okay. And am I quoting correctly at the
17 bottom of that note, and I take it you wrote this? "I
18 asked the nurse to make sure the PCA was off and to
19 remove it from the patient's bed. It was stopped
20 before that as the nurse has said." That's your
21 recollection at that time of what the nurse told you?

22 A. Yes.

23 Q. Okay.

24 A. My recollection.

25 Q. So the nurse told you that the PCA pump

1 had been stopped before that?

2 A. May I explain that?

3 Q. Is that what you wrote down, Doctor?

4 A. Yes, but I have to explain here
5 something.

6 Q. Okay. Thank you.

7 MS. POSNO: Perhaps, Mr. Coroner, Dr. Schily
8 would be allowed to finish?

9 THE CORONER: Yes. We're not into yes and
10 no answers insofar as this is not a trial,
11 and if the physician wishes to further
12 explain that answer, I will give him that
13 opportunity.

14 MR. HAWKINS: I'm perfectly content if he
15 wishes to explain it. I simply wanted the
16 confirmation that that's what the nurse said,
17 "Stopped before that."

18 THE CORONER: Fine, I understand.

19 MR. HAWKINS: That's what he wrote down.

20 THE CORONER: I understand your question.
21 He's answered your question. Are you asking
22 me that you'd like to explain that in more
23 detail?

24 THE WITNESS: Yes.

25 THE CORONER: I give you permission.

1 THE WITNESS: So far as I recollect, as I
2 remember, it was said that she didn't need it
3 anymore and wasn't using it anymore. This is
4 what I understood.

5
6 BY MR. HAWKINS:

7 Q. And that's not something that's recorded
8 in your note that you wrote the day after to the CMPA?

9 A. Well, it is written it was stopped
10 before, and this is -- I admit this is misleading. It
11 has to be -- it wasn't used anymore, so instead of
12 stopped.

13 MR. HAWKINS: Thank you, Doctor.

14 THE CORONER: Yes, the jury member has
15 another question.

16
17 RE-EXAMINATION BY JUROR #5:

18 Q. Was the KidCom working that day when
19 you ---

20 A. Oh, yes.

21 Q. On all the floors?

22 A. I didn't check the KidCom on the floor.

23 Q. You didn't check?

24 A. No.

25 THE CORONER: Any other questions? Thank

1 you, Dr. Schily. I do thank you for taking
2 the time to fly from Israel. I think it's
3 very important that as many witnesses that
4 were there that night testify. I appreciate
5 you were under no obligation to come here
6 today and I do thank you for taking the time
7 to fly from Israel. I know you're flying
8 back tomorrow, but it's been a great help to
9 this jury and myself. You may step down.
10 And I'm also at this time going to allow Dr.
11 Schily to return tomorrow to Israel as he's
12 arranged. Thank you.

13 Ms. Browne, that's all the witnesses for
14 today?

15 MS. BROWNE: I think that's all the ones we
16 can comfortably get through.

17 THE CORONER: We will adjourn until 9:30
18 tomorrow morning, and I'm wondering if it
19 would be of some benefit if I could meet with
20 Counsel in the boardroom just so that we can
21 perhaps make some arrangements about the
22 line-up of witnesses for tomorrow. It should
23 not take very long. We'll adjourn until 9:30
24 tomorrow morning. And I warn the jury that
25 they should not discuss this among anyone but

1 yourselves. I also would much prefer that
2 throughout the course of this inquest, that
3 you do not watch media outlets or read
4 newspapers, as I want you to be able to give
5 your verdict purely on the evidence that's
6 presented, any evidence here. Thank you.

7
8
9 --- ADJOURNED.

10
11
12 THIS IS TO CERTIFY that the
13 foregoing is a true and
14 accurate transcription of my
15 recordings and notes, to the
16 best of my skill and ability.

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24 Barbara A. Pollard
25 Certified Court Reporter

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