

INQUEST INTO THE DEATH OF

L I S A   S H O R E

THE EVIDENCE OF DR. CHARLES SMITH

TAKEN JANUARY 20, 2000

BEFORE DR. JAMES CAIRNS, DEPUTY CHIEF CORONER

CORONER'S COURT, TORONTO

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

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

REPORTING PLUS  
(905) 477-0126

1 MS. BROWNE: Next witness, Mr. Coroner, is  
2 Dr. Charles Smith.

3

4 EXAMINATION-IN-CHIEF BY MS. BROWNE:

5 DR. CHARLES SMITH, SWORN:

6 Q. Dr. Smith, as I understand it, you're  
7 basically a pathologist with many, many years of  
8 experience. Is that correct?

9 A. About twenty years of experience.

10 Q. Twenty years? And that you've been, you  
11 got most of your education in Saskatchewan?

12 A. Like Dr. Mayers, I trained at the  
13 University of Saskatchewan. He was in the College of  
14 Pharmacy; I was in the College of Medicine.

15 Q. And you provided me with a copy of your  
16 C.V. which runs to a number of pages, 23. May that be  
17 marked as an exhibit, Mr. Coroner?

18 CONSTABLE CULLETON: Exhibit 28.

19

20 --- EXHIBIT NO. 28: C. V. of Dr. Charles Smith

21

22 BY MS. BROWNE:

23 Q. Currently where are you employed and  
24 what are you doing?

1           A.    I am employed in the Division of  
2 Pathology at the Hospital for Sick Children. My main  
3 role there is the Director of something called the  
4 Ontario Paediatric Forensic Pathology unit, which is a  
5 forensic pathology unit which was created both by the  
6 Ministry of the Solicitor General and the Hospital for  
7 Sick Children, as the Hospital takes on responsibility  
8 for doing Coroners' autopsies on children whose -- who  
9 may die in and around the Toronto area.

10           Q.    Your purview is any child who may die in  
11 around Toronto?

12           A.    If the Coroner decides that a postmortem  
13 examination is required, yeah. The body of that young  
14 person is likely to come to the Hospital for Sick  
15 Children.

16           Q.    About how many autopsies have you done?

17           A.    I don't know. Between one and two  
18 thousand, I suppose.

19           Q.    I understand that the autopsy in this  
20 particular case, the post mortem examination of Lisa  
21 Shore was done by a colleague of yours, is that  
22 correct?

23           A.    That's right, yeah. Dr. Glenn Taylor  
24 did the examination. Glenn and I are sort of similar

1 in backgrounds and similar in experience. He has, Dr.  
2 Taylor, for reasons if you think of the weather today,  
3 it's quite understandable, he is employed at the B.C.  
4 Childrens' Hospital in Vancouver where he -- where the  
5 work that he is doing out there is essentially the work  
6 that I do here.

7 Q. But you've had access to the post mortem  
8 report he prepared?

9 A. Yeah, several things. I have read his  
10 report of post mortem examination. I have gone over  
11 the microscopic slides to confirm his observations.  
12 When it was apparent that it was not going to be best  
13 for him to come back here to testify, I discussed the  
14 case with him to make sure that I knew everything that  
15 he knew, or if there was anything new or additional  
16 that wasn't in his report, that I was aware of it.

17 Q. And do you have a copy of that report  
18 with you?

19 A. I have a copy here, yes.

20 Q. We can discuss it, Doctor, after we have  
21 it marked as the next Exhibit. But first of all, could  
22 you just tell us ---

23 THE CORONER: Ms. Browne, just before you do  
24 that, I'd perhaps like to explain a few

1 things to the jury in that regard. The  
2 Paediatric Forensic Unit is based at the  
3 Hospital for Sick Children. They do most of  
4 our childrens' forensic autopsies, both for  
5 Toronto and complex ones from across the  
6 province. It is done there because they are  
7 paediatric forensic pathologists. They have  
8 special expertise in children, and they are  
9 -- it is not uncommon, even if there is a  
10 death at the Hospital for Sick Children, for  
11 the Paediatric Forensic unit there to do the  
12 autopsy. Under those circumstances, they are  
13 not acting as hospital employees; they are  
14 acting as a forensic pathologist reporting  
15 directly to the Coroner's Office. They do  
16 not give the results to the staff, and  
17 although there may be an appearance that a  
18 pathologist is doing the autopsy at the same  
19 hospital -- and this issue has come up in the  
20 past -- these are reputable people who  
21 clearly understand the divisions of the  
22 investigation and the down side of saying no,  
23 people of the expertise such as Dr. Smith and  
24 Dr. Taylor, we will not allow them to do the

1 autopsy, the down side to that is we would be  
2 having pathologists who are not experts in  
3 children doing the autopsies, which in fact  
4 would create much more of an issue than the  
5 fact that they're at Sick Kids. So this is  
6 something that our office, the Solicitor  
7 General and Sick Kids, when this unit was set  
8 up in 1991, went into our office, are  
9 satisfied that when they do an autopsy, it's  
10 done impartially and it reports to us, and  
11 that they will report their findings  
12 irrespective of whether those findings have  
13 any adverse effect or not on the Hospital for  
14 Sick Kids. But I'd like to put that on the  
15 record because I think it's important.

16 Also, with regard to the fact that  
17 Dr. Taylor did this autopsy and he's not here  
18 to testify, he, between the death and the  
19 time of this inquest, has taken a job as a  
20 forensic paediatric pathologist in Vancouver,  
21 trying to set up a similar unit in Vancouver  
22 to the unit that Dr. Smith is the director of  
23 here, and I did canvass with all the lawyers  
24 representing the different parties. Did they

1                   have any objection, providing Dr. Smith made  
2                   himself familiar enough with the case, did  
3                   they have any objection to Dr. Smith coming  
4                   and giving evidence on behalf of Dr. Taylor,  
5                   and there was a unanimous agreement that that  
6                   would be appropriate and nobody felt that  
7                   that was an issue.

8

9                   BY MS. BROWNE:

10                   Q.    Thank you, Dr. Cairns.  You have in  
11                   front of you Dr. Taylor's post mortem?

12                   A.    Yes, I do.

13                   Q.    Can you just tell us where he -- where  
14                   it was held, and when.

15                   A.    Dr. Taylor did the examination on the  
16                   22nd of October of 1998.  The post mortem examination  
17                   was performed in the Division of Pathology at the  
18                   Hospital for Sick Children.  He began the examination  
19                   about five hours after Lisa's death, and did a complete  
20                   post mortem examination, and at the same time, was  
21                   cognizant of the religious background or the faith of  
22                   Lisa and her family, and did so in the presence of a  
23                   Jewish member of the hospital chaplaincy group, in  
24                   order that he would follow what would be appropriate

1 for the Jewish faith.

2 Q. And essentially, can you just describe  
3 how tall she was, how much she weighed, and ...

4 A. Yeah, I can paint you just a bit of  
5 picture of her. She is about four and half feet tall,  
6 just over four and a half feet tall at the time of her  
7 death, and was appropriate in terms of her nutrition.  
8 There was nothing externally apparent on her which  
9 would indicate that there was any significant pre-  
10 existing disease processes. She had no congenital  
11 malformations, that sort of thing, I mean. The  
12 appearance of the body was such that one would expect  
13 this to be an otherwise healthy young woman.

14 The external marks on her body were  
15 simply those that would be attributable to medical  
16 intervention. And she had a couple of bruises on her  
17 legs, which once again, any active young person may  
18 well have, but apart from the medical intervention,  
19 there was nothing, there was nothing externally of  
20 significance of her, apart from the significance that  
21 she appeared to be normal.

22 Q. And when you examined the internal  
23 organs of the body, what did you find out?

24 A. Well, now, it's not me, but when Dr.

1 Taylor examined them, his report and I presume that you  
2 as jury members will get the report, the -- internally,  
3 there were several findings which I'll explain to you,  
4 none of which are sufficient to explain her death.

5 Her lungs were heavier than they  
6 normally would be, and some fluid had accumulated in  
7 the lungs, and that process of fluid accumulation in  
8 the lungs is called "pulmonary edema," and it's not an  
9 uncommon finding in a young person who dies. And so  
10 it's common in adults, too, but it's not an uncommon  
11 finding, and it's rather non-specific.

12 In similar fashion, her brain was larger  
13 than normal. Now, her head circumference was, to start  
14 with, was larger than normal and that's not a statement  
15 that is worrisome. Some children simply have slightly  
16 larger heads, you know, based on statistical  
17 situations. But her brain appeared not to be large in  
18 keeping with her large head and her body, but appeared  
19 also to be somewhat swollen. And swelling of the brain  
20 is also a change which, like fluid accumulation in the  
21 lungs, is non-specific but is seen not infrequently as  
22 part of the dying process in young people. So those  
23 were the two major findings that were apparent on naked  
24 eye observation.

1                   The next step in the post mortem  
2                   examination, after the naked eye observation, is to  
3                   examine the tissues under the microscope to see if  
4                   there is anything at a cellular level which is going  
5                   on. Microscopically, there was once again no evidence  
6                   or no explanation for Lisa's death. She did have some  
7                   inflammation in her upper airway and some inflammation  
8                   in her lungs. That would go along with having had  
9                   perhaps a mild cough or a cold in the days prior to  
10                  death, but it may be sufficiently mild that she may  
11                  have in fact been symptom free. So she may have had a  
12                  bit of a cough or sore throat prior to death, or she  
13                  may not have. But certainly that does not explain  
14                  death.

15                  She had a little bit of inflammation in  
16                  her stomach, so there is some gastritis. But once  
17                  again, that is something which she may have had, you  
18                  know, some minor symptoms such as heartburn, or she may  
19                  have been symptom free, once again, in the days prior  
20                  to her death. The remainder of the structures are  
21                  normal or virtually normal, the changes which are  
22                  present are those which, once again, may be seen in  
23                  children who die. And so those were the significant  
24                  findings microscopically.

1                   Dr. Taylor, in the course of the  
2 examination, did take samples, which as you heard from  
3 Dr. Mayers, were subject to toxicologic examination.  
4 At the end of Dr. Taylor's examination, he was unable  
5 to find an anatomic cause of death.

6                   Now let me, if I can, explain what that  
7 means to you, is if you were out shovelling snow today  
8 and then developed sudden chest pain and collapsed and  
9 died, an autopsy would likely show some problem with  
10 your coronary arteries or your heart. And so that  
11 would be an anatomic finding or structural finding  
12 which can explain death. You know, an older person who  
13 dies of pneumonia has inflammation in their lungs, and  
14 that is an anatomic finding which explains death.

15                   There are, however, situations in which  
16 a thorough post mortem examination on a person who dies  
17 unexpectedly fails to identify an anatomic or a  
18 structural abnormality, and let me give you an example.

19                   One example, for instance, would be if a person has  
20 epilepsy, we know that once in a while a person with  
21 epilepsy can die suddenly and unexpectedly. We presume  
22 they have a seizure and die, but you cannot, you know,  
23 anatomically with naked eye, or again, the microscope,  
24 you can't see a seizure after death. And so you have

1 the person who's died suddenly and unexpectedly, but  
2 you can't see what the cause is.

3 But by the same token, a person who may  
4 die of a drug overdose anatomically doesn't have  
5 anything wrong, though by toxicology you can see that  
6 there's an abnormal substance in the blood or in the  
7 body. So Lisa did not have an anatomic cause of death.

8 So at the end of Dr. Taylor's examination, there was  
9 nothing that he found that he could say, "this explains  
10 her death."

11 Q. Is there anything that he summarized  
12 that was (inaudible)?

13 A. Yeah, in his report, the report of the  
14 post mortem examination, you know, follows a certain  
15 format which is set out by law under the Coroner's Act.

16 And the last statement in the report is really a  
17 summary statement that the pathologist makes. And that  
18 last statement asks the pathologist what they believe  
19 the cause of death to be. And, you know, "I certify  
20 I've examined the body," and such, "and in my opinion,"  
21 you see, and then the opinion is stated. And Dr.  
22 Taylor's opinion was that there was no anatomic or  
23 toxicologic cause of death. And, of course, that  
24 second half of it, the toxicologic cause of death is

1 not one which he can -- is not one which is based upon  
2 his own toxicologic analysis, but that's simply based  
3 on the information that was provided to him in the  
4 report from Dr. Mayers.

5 Q. About any abnormal -- he did have some  
6 abnormal findings?

7 A. Yeah, there are abnormal findings which  
8 he listed in the report, and as you will read the  
9 report, you can see that list which is simply a summary  
10 of the abnormal findings. But that summary really  
11 relates to the fluid accumulation in the lungs, to the  
12 swelling of the brain, both of which are non-specific,  
13 and the mild inflammation which could perhaps be  
14 related to a respiratory tract infection. The mild  
15 inflammation in the stomach and in the esophagus could  
16 go along with something like reflux, or gastritis. So  
17 those were the positive findings, but none of those are  
18 sufficient to, in and of themselves, to explain Lisa's  
19 death.

20 Q. What Dr. Taylor found when he examined  
21 Lisa's body and tissues, was it consistent with a  
22 period of respiratory depression?

23 A. Yes, it would be. A young person who  
24 dies after a period of respiratory depression may have

1 some changes which are non-specific, but those changes  
2 relate to the brain and to the lungs. Fluid  
3 accumulation in the lungs, or pulmonary edema, as well  
4 as fluid accumulation in the brain or cerebral edema  
5 are findings which can occur in a person who dies  
6 because of respiratory depression. So these findings  
7 in Lisa of fluid accumulation in her lungs and a  
8 swollen brain fit with respiratory depression. But you  
9 need to understand that just because they are  
10 consistent with respiratory depression, doesn't in and  
11 of itself mean that there was a period of respiratory  
12 depression prior to death. It fits with it, but it  
13 doesn't prove it.

14 Q. And just further to that, I take it from  
15 what Dr. Taylor has put into his report which the jury  
16 will see, and what you've gone over and looked at the  
17 slides, that the process of dying was not short. Did  
18 he say anything about that at all?

19 A. The presence of swelling of the brain is  
20 something that doesn't -- or swelling of the brain is  
21 something which doesn't occur instantaneously. It  
22 takes at least some minutes to occur. Now whether  
23 those some minutes are ten or fifteen minutes, or more,  
24 is extremely variable, and can depend on the individual

1 and the situation, and all sorts of other factors. So  
2 that would suggest that the dying process wasn't  
3 instantaneous. It wasn't as if she was stable at one  
4 point in time, and then dead a minute later. It  
5 suggests that at least for a few minutes, a dying  
6 process was going on, but I can't say how long it was.

7 It may be ten or fifteen minutes; it may be longer  
8 than that.

9 Q. We've heard evidence and we'll probably  
10 hear further evidence that there was an increase in her  
11 heart beat during the time prior to her death. You  
12 didn't find -- there's no finding in there of any heart  
13 disease?

14 A. Dr. Taylor paid specific attention to  
15 that, because there are situations in which young  
16 people can die of heart disease that is essentially  
17 undiagnosable or unpredictable. The most common of  
18 those is something called "myocarditis" which simply  
19 means inflammation of the heart muscle, and it's very,  
20 very uncommon for a young person to die of myocarditis,  
21 but in a city like Toronto, we might have perhaps two  
22 or three deaths a year from that.

23 Dr. Taylor did pay particular attention  
24 to the examination of Lisa's heart in order to rule out

1 this possibility, though it's -- though it's reasonably  
2 remote. Once again, young people don't die suddenly  
3 and unexpectedly very often. It's an uncommon event to  
4 start with. And his examination of the heart muscle  
5 revealed no -- or indicated the myocarditis was not  
6 present. I reviewed the heart muscle, as well, just to  
7 answer that question, and I'm satisfied with -- that I  
8 agree with his conclusion.

9 Q. Thank you. Those are my questions, Dr.  
10 Smith. I would ask that this report be marked as an  
11 Exhibit and entered so the jury can have a look at it  
12 after Dr. Smith is finished his testimony.

13 THE CORONER: Perhaps I just have one  
14 question of Dr. Smith. We know that Lisa had  
15 a medical condition called "reflex  
16 sympathetic dystrophy," and I'm correct that  
17 that's not a condition that you can diagnose  
18 at autopsy?

19 THE WITNESS: Your statement is correct.

20 THE CORONER: And that there is no  
21 association of reflex sympathetic dystrophy  
22 in and of itself being anything. It was a  
23 chronic pain condition; it's not a condition  
24 from which you die, obviously.

1 THE WITNESS: That statement is correct.

2

3 CROSS-EXAMINATION BY MR. KRKACHOVSKI:

4 Q. Thank you, Mr. Coroner. Doctor, I just  
5 want to understand some of the documentation that we  
6 have here in a package. I'm not sure if this is  
7 already before the jury as an Exhibit, Mr. Coroner.  
8 It's titled, "The Hospital for Sick Children Final  
9 Clinical Death Note" which appears at page 24 of the  
10 (inaudible) volume of documentation. Can someone help  
11 me as to whether this is part of the exhibits that are  
12 before the jury?

13 MS. BROWNE: It is, it should be part of the  
14 exhibits -- Lisa's record which is Exhibit  
15 Number 3.

16 MR. HAWKINS: The jury have the records, I  
17 think.

18 THE CORONER: Yes, the jury have the  
19 records. What page, Mr. Krkachovski?

20 MR. KRKACHOVSKI: Page 4.

21 MR. HAWKINS: Page 6 in your chart.

22 THE WITNESS: I'm sorry?

23 MR. HAWKINS: Page 6 in your chart.

24 THE WITNESS: Yeah, I have it, thank you.

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BY MR. KRKACHOVSKI:

Q. The title speaks for itself, but can you tell me what this is and why it was prepared?

A. This form, actually, is one which has been in use in the hospital for about ten or fifteen years, and in fact I was one of the people who developed this form. The form was developed for the purpose that when a person dies at the hospital, a standard approach to handling the medical intervention is for the responsible physician or one of the members of house staff to dictate a Discharge Summary or Death Summary.

Unfortunately, just because of work flow and secretarial issues and such, it often takes some days before that information shows up on the chart, so what we wanted was some brief information that would allow the pathologist or anyone who needed to know something of the clinical information on a young person who died, to know that without having to wait for the Discharge Summary. It was developed largely to help pathologists so that when we perform a post mortem examination, we understand really what the issues or the questions are.

1                   And it's used by a Coroner, if the  
2                   Coroner is called in to the hospital to review a death,  
3                   the final clinical death note will often capsule the  
4                   story and help them identify the issues and determine,  
5                   for instance, whether it's a Coroner's case or not. So  
6                   it's just a -- it's a summary which is filled out at  
7                   the time of death.

8                   The summary does have its limitations.  
9                   You know, it's, (a), not exhaustive; and, (b), may be  
10                  filled out by someone who is not familiar with the  
11                  total hospital course of the individual, but is an  
12                  attempt to communicate meaningful information to those  
13                  people who need to know it in the hours after a person  
14                  dies.

15                 Q.    All right. I gather from what you say  
16                 Dr. Taylor would have had this document before doing  
17                 the autopsy?

18                 A.    I presume he would have, because he  
19                 would have seen the chart, and it would be very unusual  
20                 for this not to be on the chart at the time that the  
21                 pathologist performs a post mortem examination.

22                 Q.    Now, at the very top, it identifies the  
23                 responsible physician as Dr. James Wright. How does  
24                 Dr. Wright fit into the sequence of events, do you

1 know?

2 A. Dr. Wright is an Orthopod, Orthopaedic  
3 Surgeon, but whether he was present in the hospital at  
4 the time of her death, or that sort of thing, I  
5 honestly don't know.

6 Q. I note at the very bottom, it seems to  
7 have -- well, we see the name of Dr. Joel Lobo, and I  
8 assume that's Dr. Lobo's signature to the right?

9 A. I presume so.

10 Q. I think it's fair to presume that.  
11 Again, do you know how Dr. Lobo fits in there?

12 A. I don't know the, sort of, the events or  
13 the flow of responsibility or the individuals who were  
14 involved with Lisa in her final hours of life, and so  
15 whether he, you know, had significant involvement, or  
16 was simply, sort of a member of staff who was on duty,  
17 I honestly don't know.

18 Q. Can you comment at all as to why Dr.  
19 Wright would not have prepared this document?

20 A. Very frequently, it's the responsibility  
21 of other members of the staff, the house staff, a  
22 fellow or perhaps a senior resident to fill out these  
23 forms. It's not necessarily the responsibility of the  
24 -- of the most responsible physician, or in Dr.

1 Wright's case, the most responsible surgeon. And it's  
2 just part of the way that work is handled in a teaching  
3 hospital as trainees at certain levels are given  
4 responsibility for things like dictating letters,  
5 dictating Discharge Summaries, or filling out a final  
6 clinical death note.

7 Q. Again, looking at the bottom line across  
8 from Dr. Joel Lobo's signature, we see a date, "October  
9 the 22nd, 1998, time 8:45." Would it be fair to  
10 conclude that this document was prepared on that date  
11 at that time?

12 A. I would -- that's the conclusion that I  
13 would reach with this, yes.

14 Q. All right. Now would Dr. Wright have  
15 seen this after Dr. Lobo prepared it in the normal  
16 course?

17 A. Now, Dr. Wright would have seen it at  
18 some point in time, or could have seen it at some point  
19 in time, because he obviously has to sign off on the  
20 chart. Whether he saw it that morning or not until  
21 some days afterwards, I don't know.

22 Q. Now, in the very middle of the document  
23 there's a line that reads: "In my opinion, the  
24 immediate cause of death is," and handwritten is,

1 "respiratory arrest."

2 A. That's correct.

3 Q. Would that have been Dr. Lobo's opinion  
4 or Dr. Wright's opinion, or both, or can you comment?

5 A. Well, it's obviously Dr. Lobo's opinion  
6 if he's the one who has signed this document. Whether  
7 that reflects Dr. Wright's opinion, whether Dr. Wright  
8 discussed it with Dr. Lobo, are things that I can't  
9 answer.

10 Q. Can you comment at all as to what Dr.  
11 Lobo would have had regard to in arriving at his  
12 opinion? That is to say, would he have talked to  
13 staff, would he have looked at Lisa's chart? What  
14 would he have looked to in making that assessment?

15 A. He could have done any of those things;  
16 I mean, he may well have been present at the  
17 resuscitation. As a responsible -- I presume Dr. Lobo  
18 is a, you know, was a licensed physician, you know, at  
19 some level, and so he would have every reason to have  
20 access to all of the relevant information, medical  
21 information from Lisa's health record, but how much he  
22 had at that point in time and who he discussed things  
23 with, and whether he was present at the resuscitation,  
24 those sorts of things, I can't help you at all.

1 Q. If you can turn the page to 25, there is  
2 a document titled, "The Hospital for Sick Children's  
3 Hospital Report, Coroner's Case." Staff physician  
4 again at the top, is Dr. James Wright. There isn't a  
5 hand written note at the bottom as to who signed this,  
6 but just comparing the signature to page 24, it seems  
7 to be Dr. Lobo.

8 A. Now, I'm in trouble here. Now, your  
9 page 25 may be different than the page 25.

10 MS. BROWNE: You're at page 7 in yours.

11 THE WITNESS: Oh, I'm sorry.

12 MR. KRKACHOVSKI: We've got two numbering  
13 sequences.

14 THE WITNESS: All right, thank you, yes.

15

16 BY MR. KRKACHOVSKI:

17 Q. All right. If you compare what the  
18 document you looked at a minute ago and this one, I  
19 mentioned that at the bottom there isn't a handwritten  
20 note as to who signed it, but it appears to be in  
21 Dr. Lobo's ...

22 A. It's the same signature, yes.

23 Q. Would this have been before Dr. Taylor  
24 at the time of the autopsy, as well, in the normal

1 course?

2 A. Yeah, yeah. And let me sort of explain  
3 what's gone on here. We created these two sheets of  
4 paper for the purpose that I indicated, now. And some  
5 time ago it became clear that there was redundancy  
6 here. So generally in the hospital, the first piece of  
7 paper, the final clinical death note, is all that's  
8 filled out. In this case, this is an older form which  
9 is not -- which is not necessary because the  
10 information on it is largely included in the first one.  
11 So this is -- so Dr. Lobo has obviously filled out  
12 more paper work than would be absolutely necessary for  
13 the communication of information.

14 Q. And he states again at the bottom, "in  
15 my opinion, the immediate cause of death is," and again  
16 he's written in "respiratory failure."

17 A. That's right.

18 Q. Now would Dr. Taylor have had regard to  
19 Dr. Lobo's views in performing the autopsy and trying  
20 to determine a cause of death?

21 A. I presume that this was on the chart. I  
22 have no reason to believe that it would not have been  
23 available to Dr. Taylor that day.

24 Q. And from what you've seen, has Dr.

1 Taylor ruled out respiratory failure as a cause of  
2 death? I'm unclear.

3 A. Well, respiratory failure is really a  
4 clinical diagnosis, not a pathological diagnosis. And  
5 respiratory failure, you know, is, because it's not a  
6 disease, but rather is a description of the sequelae of  
7 some disease. The job of the pathologist is not to say  
8 there's respiratory failure; that's a clinical  
9 diagnosis. The job of the pathologist is to try and  
10 come up with an explanation for it. Respiratory  
11 failure can occur for a variety of reasons, and so Dr.  
12 Taylor cannot in his autopsy report make a, you know,  
13 make an anatomic diagnosis of respiratory failure. All  
14 he can do is to consider the causes or the sequelae of  
15 respiratory failure and document whether he can  
16 identify any causes or anything that would go along  
17 with that clinical diagnosis.

18 Q. Are we able to say that Lisa had  
19 respiratory failure that led to her death, but we're  
20 unclear as to why she had respiratory failure?

21 A. Well, now, you probably shouldn't ask me  
22 as a pathologist on that because respiratory failure is  
23 a clinical diagnosis. I mean, I'm a licensed  
24 physician. I can look at a chart and say, yes, it

1 looks like respiratory failure. But if you're asking  
2 about sort of the, you know, the clinical diagnosis and  
3 the clinical sequelae or the basis of the diagnosis for  
4 that, you may want to ask someone who is a clinician as  
5 opposed to a pathologist.

6 Q. Dr. MacLeod, for example?

7 A. Yeah, he'd be a good person to ask.

8 Q. Have you looked at Lisa's chart to make  
9 that assessment; that is to say, whether she  
10 experienced respiratory failure?

11 A. Well, I have looked at the information  
12 concerning monitoring and such, and I note there were  
13 some changes. But once again, I'm not sure I'm the  
14 best person to ask that question of.

15 Q. Fair enough. The last document I want  
16 to refer you to, again it appears as page 32 in my  
17 bundle of documents. I have no idea what it might be  
18 in yours.

19 A. What, what?

20 Q. It's a typed Death Summary ...

21 MR. GOMBERG: It's page 11.

22 THE WITNESS: Thank you.

23  
24 BY MR. KRKACHOVSKI:

1 Q. Do you have it before you, Dr. Smith?

2 A. Yes.

3 Q. All right. Just flipping quickly to the  
4 second page, this appears to have been authored and  
5 signed by Dr. Wright?

6 A. Yes. The secretarial notation, in fact,  
7 indicates that "JW/EH" to me would indicate that he's  
8 the individual who dictated it, besides being the  
9 individual who signed it.

10 Q. And I think you alluded to this document  
11 in answering my first series of questions. Again, what  
12 is the purpose of this document? Why was it created?

13 A. The Death Summary?

14 Q. Yes.

15 A. The Death Summary is a requirement  
16 under, I think it's Public Hospitals Act of Ontario,  
17 but I may have gotten the name wrong. There must be a  
18 Discharge or a Death Summary written upon discharge of  
19 every person who's discharged from hospital in this  
20 province, and so this is simply a summary of the  
21 hospital course for an individual; in this case, Dr.  
22 Wright dictated it, it looks to me, several days, some  
23 days after Lisa died.

24 Q. I apologize, the dates are on the second

1 page.

2 A. Yeah. Usually what happens is it takes  
3 several days for all of the bits and pieces of a record  
4 to come together. There may be x-ray reports and lab  
5 reports and that sort of thing which are assembled by  
6 the workers in the Health Records Department, and then  
7 it's presented to the responsible physician.

8 Q. In the normal course, I presume Dr.  
9 Wright would have looked at Lisa's chart in preparing  
10 this Death Summary?

11 A. I would expect so.

12 Q. Would he likely have spoken with the  
13 staff on duty at the time, and the resuscitation team  
14 for that sense, as well?

15 A. Knowing Dr. Wright, I would expect so,  
16 but I can't prove it.

17 Q. Fair enough. Looking at the very last  
18 paragraph on page one, he talks about the fact that  
19 Lisa was on a PCA pump. Would you expect Dr. Wright to  
20 have noted all of the equipment that Lisa was on at the  
21 time of her death?

22 A. No. No, that would be -- unless he was  
23 -- was sort of in the room at the time of collapse,  
24 there's little reason that he would do so. Certainly

1 identifying a significant medical device like a PCA  
2 pump is reasonable, but identifying everything that may  
3 be present may not be possible.

4 Q. Would you attach any significance to the  
5 fact that there is no mention of a Corometric monitor  
6 in, not just this paragraph, but anywhere in this Death  
7 Summary?

8 A. No, I don't. It's, in my experience,  
9 looking at Discharge Summaries both from the Hospital  
10 for Sick Children as well as Death Summaries on  
11 children who die in other institutions in which I may  
12 be involved in performing an autopsy, the mention of  
13 sort of the monitoring devices that are used,  
14 conventionally, is not, is not common practice at all.

15 Q. In this case, we've heard earlier  
16 evidence that Nurse Doerksen expressed some confusion  
17 or concern as to why the monitor did not sound. We've  
18 subsequently discovered it didn't sound because it  
19 wasn't turned on at the time, but given her state of  
20 confusion, would that not have given rise to a comment  
21 from Dr. Wright in this Death Summary? That is to say,  
22 is the monitor a factor in this?

23 A. I'm not sure I'm the best person to  
24 answer that question. I mean, what you're asking me,

1 as I see it, are two things. Number one, is monitoring  
2 a factor. Number two, should Dr. Wright have included  
3 that in his Discharge Summary. And I don't know that I  
4 can answer what he knew, what he should have included,  
5 and I don't know enough about what's going on with Lisa  
6 to know whether the monitoring was a factor.

7 Q. That's a fair statement. Let me ask you  
8 this: if the monitor was an issue in any way, would  
9 you expect it to have been noted in this report?

10 A. I certainly have seen Discharge  
11 Summaries or Final Clinical Death Notes which draw  
12 attention to the fact that it may be an issue, or it  
13 may be perceived by the family to be an issue.  
14 Whether, you know, whether Dr. Wright knew of it as an  
15 issue and whether he ascribed any importance to it  
16 clinically as an issue is something that I can't  
17 speculate on.

18 Q. Thank you, Doctor.

19 THE CORONER: Ms. Posno?

20

21 CROSS-EXAMINATION BY MS. POSNO:

22 Q. Just a couple of questions, Dr. Smith.  
23 We represent Dr. Schily in this inquest. There may be  
24 an issue from reading Dr. MacLeod's report as to the

1 time the blood samples were taken from Lisa's body.  
2 And from my review and understanding of the toxicology  
3 report, there is no reference of any resuscitation type  
4 drugs mentioned in that report. I think it's called  
5 naloxone. None of those drugs were found in the  
6 toxicology report?

7 A. As I read the toxicology report, your  
8 statement's correct.

9 Q. So can we assume that the blood samples  
10 were taken prior to the administration of those drugs  
11 during the resuscitation effort?

12 A. I'm sorry, the blood samples that were  
13 used for toxicologic analysis?

14 Q. That's right.

15 A. No, no, no. They were samples that were  
16 taken by Dr. Taylor at postmortem examination. They  
17 would have been taken perhaps about 1:00 in the  
18 afternoon on the 22nd of October.

19 Q. And have you seen the report of Dr.  
20 MacLeod?

21 A. Well, I saw -- I saw a report that Dr.  
22 MacLeod authored perhaps two months ago or something, I  
23 don't know if that's what you're referring to.

24 Q. That's the one I'm referring to. I'm

1 just wondering if you can give us any guidance as to  
2 whether, are those the blood samples that Dr. MacLeod  
3 is referring to within his report as well?

4 A. That's my understanding.

5 Q. Okay, so those blood samples were taken  
6 during the autopsy, then?

7 A. That's right. You need to understand  
8 that not all drugs will show up on toxicologic  
9 analysis, and don't ask me which ones will or will not  
10 show up because some I know will; some I know won't.  
11 The ones that you mentioned, I simply don't know.

12 Q. Right, and it may be an issue of whether  
13 they were screened for. I mean, it's not a suggestion  
14 that those are the drugs that people were concerned  
15 about.

16 THE CORONER: Under the circumstances, it  
17 would not be normal to screen for the drugs  
18 that were being used in resuscitation. Those  
19 obviously, that's after the girl has died,  
20 and we will commonly have reports where  
21 people have been resuscitated, but there's no  
22 comment made on the epinephrine or the sodium  
23 bicarbonate, or to the lidocaine.

24

1           BY MS. POSNO:

2                   Q.    Okay, well, that's very helpful.  So we  
3                   can -- we understand then that the blood samples in  
4                   this case that we're speaking of are post mortem blood  
5                   samples taken during the autopsy.  So the potential  
6                   issue that was discussed with the prior witness, Dr.  
7                   Mayers, may be an issue in this case, whether morphine  
8                   concentrations rise following death.

9                   A.    Yeah, that's a theoretical possibility.

10                  Q.    Thanks very much, Dr. Smith.

11                  THE CORONER:    Mr. Hawkins?

12

13           CROSS-EXAMINATION BY MR. HAWKINS:

14                   Q.    Sorry, Dr. Mayers who testified, in  
15                   addition to asking whether the samples were post mortem  
16                   or not, said there may be a difference between  
17                   peripheral and heart sample?

18                   A.    And central, yes, that's correct.

19                   Q.    Which type of samples were these?

20                   A.    Now, I presumed all along that they were  
21                   taken from the blood which would be found in Lisa's  
22                   heart.  It is our standard practice in forensic  
23                   autopsies to do that in children, simply because it's  
24                   very difficult in children to get peripheral samples.

1 It's much easier in an adult. And I must tell you, at  
2 the coffee break, I phoned Dr. Taylor's office a couple  
3 of times, but there is a three-hour time change. He's  
4 normally in the office before 8:00 in the morning, but  
5 for whatever reason, I got voice mail in the hospital  
6 this morning. So I can't say for sure whether they  
7 were heart or not heart. I presume that they were  
8 samples from blood from one of her heart chambers.

9 Q. Now, the jury has, as you know, a number  
10 of questions to be answered at the end of the case.  
11 One of the questions is how, which is the medical cause  
12 of death. Mr. Krkachovski took you to a couple of  
13 notes by Dr. Lobo which said "respiratory arrest,  
14 respiratory failure." He also took you to the Death  
15 Summary by Dr. Wright which says at the time of death  
16 dictation, there was no identifiable cause of death?

17 A. That's correct.

18 Q. And we have your comments and Dr.  
19 Taylor's report. Can you assist the jury in filling in  
20 the blank, or filling in the how or the cause of death?

21 A. There's a couple statements that are, a  
22 couple of blanks, to use Mr. Hawkins' term, that are  
23 filled in when completing the paperwork for death, one  
24 of which is often -- rests on the shoulders of the

1 pathologist if an autopsy's been done, and that's what  
2 the cause of death is. And in this case, Dr. Taylor  
3 has said there's no anatomic or toxicologic cause of  
4 death. And unless there is different information  
5 concerning the toxicology, I have no reason to believe  
6 there is any reason to -- for him to change his opinion  
7 concerning the anatomic cause of death. So the first  
8 blank that could be filled in is simply that when there  
9 is no anatomic cause of death, there may not be a  
10 toxicologic cause of death.

11 The second blank is one which tends not  
12 to be filled in by the pathologist, but it asks about  
13 -- about the manner of death, and there's sort of an  
14 overall simple classification for thinking about  
15 deaths. Most deaths are due to natural disease, but  
16 some deaths are due to accidents, some can be suicides,  
17 some can be homicides, and then there's a small group  
18 of deaths which at the end of the day, we simply don't  
19 know why the person died. And so that manner of death  
20 is undetermined, so there's really just the five  
21 possibilities that the death of any one individual can  
22 fall into.

23 Most sudden and unexpected deaths in  
24 young people are due to natural disease, but some are

1 not. They can be due to accidents or the other causes.

2 The difficulty in something like Lisa's death is  
3 whether or not toxicology will be sufficient to explain  
4 her death, and if it is, then, you know, then the  
5 manner of death may well be attributed appropriately to  
6 that. It is possible at the end of the day that people  
7 don't know, and as such, then it would be the  
8 responsibility of the Coroner or a Coroner's jury to  
9 come to a conclusion that they don't know, and  
10 therefore it could be undetermined.

11 It's not infrequent for a person like  
12 Dr. Taylor to be asked by a Coroner as to establish  
13 just which of these five categories it fits into.  
14 Reading his report, I'd presume that he was pointing to  
15 an undetermined category; whether that's the way it  
16 will be at the end of the day is your determination,  
17 not his.

18 Q. And on what you've read, you indicated  
19 that Taylor was pointing to "undetermined." Do you  
20 have an opinion on, in answer to the manner of death  
21 question?

22 A. Well, certainly looking at the  
23 toxicologic analysis and hearing the words of Dr.  
24 Mayers this morning, I would myself underline I don't

1 fill out the form, I would myself choose the term  
2 "undetermined," but whether or not there is further  
3 information that may change that, I don't know, but  
4 certainly in the absence of any new information or a  
5 different opinion, I would leave it as undetermined.

6 Q. And you've just -- we will be hearing  
7 from some other experts, Dr. MacLeod and also  
8 Paediatric Review. You've had their reports and you've  
9 read their reports?

10 A. I have, yes.

11 Q. Thank you. Those are my questions.

12 THE CORONER: Mr. Gomberg?

13

14 CROSS-EXAMINATION BY MR. GOMBERG:

15 Q. I just have a few. First of all, I'd  
16 comment that I'm not sure whether it's good to see you  
17 again or not. We always meet under very bad  
18 circumstances. You can't comment, I take it, as a  
19 pathologist, on things like Corometric monitors,  
20 whether they're present or absent. In this case,  
21 that's a clinical issue?

22 A. Yeah, and unless the monitor, you know,  
23 was included in the medical equipment that was left  
24 with the body. A pathologist can't comment its

1 presence, and certainly cannot comment on its use.

2 Q. Now, it leads to another question and  
3 that is this, that if there was a Corometric monitor  
4 and if it was attached to the body, then I take it that  
5 you would expect to see that at the autopsy?

6 A. The monitor?

7 Q. Right.

8 A. I don't know that a Corometric monitor  
9 has ever, has ever been left with the body. It's not  
10 uncommon to have monitor leads left with the body.

11 Q. All right.

12 A. But the actual monitor, the device  
13 itself, I can't think that I've ever seen it.

14 Q. All right. And in this case it raises  
15 another -- but you've raised the point, I suppose, that  
16 I was going to raise, and that is that there is no  
17 notation -- I see you looking at the report.

18 A. Yeah.

19 Q. And presumably you're looking for the  
20 same reason that I was about to look, and that is to  
21 figure out whether there is a notation of leads or  
22 there's no notation of leads?

23 A. Yeah. There is no notation of leads.  
24 Now, this may be a personal practice issue. I know

1 that I count leads on a body, but I know there are  
2 other pathologists who pay no attention to leads,  
3 because it's really, you know, it's not a medical  
4 device which is invasive, and therefore of no  
5 significance to the pathologist. It would be like,  
6 like the temperature probe on skin surface or  
7 something. It doesn't affect the disease process, so,  
8 you know, whether Dr. Taylor -- and I'm not sure what  
9 his practice is, I must apologize to you, whether he is  
10 someone who counts EKG leads or counts monitor leads,  
11 or does not, I don't know.

12 Q. No.

13 A. If it's an important question, we may be  
14 able to find the answer to the question because there  
15 may be photographic evidence of that, if it's something  
16 that you need to know.

17 Q. All right. So just to be clear, because  
18 I'm not sure that much turns on it. Let's assume for  
19 the minute that there were no leads on the body, all  
20 right? Just follow this through for a minute. That  
21 doesn't mean ergo that there were never leads on the  
22 body?

23 A. And the obverse statement is true.  
24 There may be no leads on the body until the point of

1 collapse and beginning resuscitation, and then leads  
2 are attached.

3 Q. I understand. So the fact that you  
4 don't find them there is not significant one way or  
5 another in terms of trying to figure out whether they  
6 were ever there?

7 A. I think that's a fair statement.

8 Q. All right. Now, the other thing that I  
9 wanted to be clear with you is this, because I think  
10 Mr. Krkachovski got into this. In terms of the Death  
11 Summary, that's prepared by a clinician, right?

12 A. Do you mean the dictated report?

13 Q. Yes.

14 A. Or just the final ---

15 Q. No, no, I'm talking about the dictated  
16 report.

17 A. Dictated report, that's right. That's  
18 prepared by the responsible clinician or her or his  
19 designate.

20 Q. And in this case, that's Dr. Wright?

21 A. That's correct.

22 Q. All right. And you as a pathologist, I  
23 appreciate you didn't do the autopsy in this case, but  
24 either you or Dr. Taylor, you don't rely on the Death

1 Summary and the accuracy of details in the Death  
2 Summary when you're doing the autopsy?

3 A. No, the Death Summaries are usually not  
4 available unless it's a clinician who happens to type  
5 the report themselves and print it out. And that does  
6 happen. Some individuals do that. But the answer is  
7 no. Now, what frequently happens is in the days after  
8 the post mortem examination is done, the pathologist  
9 will call for the medical chart once again, to see all  
10 of the information that may have been added that wasn't  
11 present on the chart at the time of post mortem. So  
12 Dr. Taylor may well in the end have seen the Death  
13 Summary, but he may have seen it weeks after Lisa's  
14 death.

15 Q. All right. Well, just to be clear, in  
16 terms of the timing issues, though, and you've  
17 identified I think the major one, it appears this, and  
18 I'm talking now about the typed Death Summary ---

19 A. It was ---

20 Q. --- was dictated on October 29th and the  
21 autopsy was long over by then.

22 A. It was performed a week earlier.

23 Q. And the only reason I'm asking that is  
24 as a pathologist testifying today, you can't tell us

1           whether information in that Death Summary is accurate  
2           or inaccurate, right?

3                     A.    No, I can't.

4                     Q.    All right.  And I'm talking, for  
5           example, about drug quantities that were administered  
6           and things like that, you just have no way of knowing  
7           that?

8                     A.    That's correct.

9                     Q.    All right.  Now the only other question  
10          that I have for you relates to the issue of the  
11          swelling of the brain.  And I think that you did your  
12          best to give us as much information as you could on  
13          that, and I think you said that that may indicate that  
14          the death process was a ten or fifteen-minute process.

15                    A.    Or longer.

16                    Q.    Or longer.

17                    A.    Now, I shouldn't say the death.  The  
18          swelling of the brain will occur, and you understand  
19          it's for a whole variety of reasons, one of which can  
20          be deficiency in oxygenation or in blood flow.  And so  
21          if there was a deficiency in oxygenation, not an  
22          absolute lack of oxygen or not an absolute cessation of  
23          blood flow, but rather a relative deficiency such that,  
24          such that the brain didn't obtain its requirements,

1 that that swelling of the brain can be expected in that  
2 situation. So if we see swelling of the brain in Lisa,  
3 is it possible that that indicates that for a period of  
4 time prior to death, there was insufficient oxygenation  
5 of the tissues of her brain, and yes, that's a  
6 possibility. I can't say that it is the explanation.

7 Q. Right.

8 A. But it's a possibility.

9 Q. All right, now the last question that I  
10 have, I suspect that you're the wrong person to ask the  
11 question of, but if you confirm that, that's fine, then  
12 I don't need an answer, but can you talk about or are  
13 you the wrong person to talk about the reversibility of  
14 that condition?

15 A. Of cerebral edema?

16 Q. Right.

17 A. I can answer the question generally, and  
18 that is that cerebral edema is reversible. What is  
19 irreversible is when cerebral edema gets to the point  
20 where it causes distortion of the structures of the  
21 brain, which in the report here has clearly not  
22 occurred, so it's not as if there's destruction of the  
23 base of the brain which occurs kind of as the final  
24 event in a marked degree of swelling of the brain.

1 Lisa's brain showed a much more mild degree of  
2 swelling, so the swelling itself is reversible.

3 The question that you didn't ask, which  
4 is really the more important one is that because  
5 swelling is really just a sequelae or a by-product of  
6 some process that's affecting the brain, the issue is  
7 has the process affected the brain in any other way  
8 such that there are irreversible changes? And let me  
9 give you an example. If I were to hit you on the head  
10 with a hammer, you would have a swollen brain, but you  
11 may also have permanent damage to your brain besides  
12 the swelling. The swelling will go away, but other  
13 structural damage may not.

14 And so sort of the second half of the  
15 question is while swelling of the brain is reversible,  
16 was there anything else in her brain, were there other  
17 changes in her brain caused by whatever caused the  
18 swelling? And Dr. Taylor has not identified any other  
19 structural changes there, so I have to think that on  
20 the balance of probability, the swelling is reversible,  
21 and I have no reason to believe there's other  
22 abnormalities of her brain that would represent  
23 permanent changes.

24 Q. All right, just so I understand it, and

1 I appreciate you can't be precise on this, but if the  
2 period is ten or fifteen minutes or longer, as you  
3 said, then given the fact that you found no gross  
4 anatomic -- not you, that Dr. Taylor found no gross  
5 anatomical abnormalities with the brain such as might  
6 occur if somebody was hit over the head with a hammer  
7 or if the thing progressed so long that you could get  
8 them ---

9 A. Yeah, some of the nerve cells start  
10 dying, that kind of thing.

11 Q. All right, such as in a drowning or  
12 something like that, or a strangulation, all right.  
13 That this type of condition could have been reversed?

14 A. That's how I would interpret his  
15 findings, yes.

16 Q. Thank you very much.

17 THE CORONER: Just before the jury's  
18 questions, Dr. Smith, now I think just for  
19 the explanation of the jury, deaths that our  
20 office investigate and for which you are very  
21 much a lead role in them, do fall into those  
22 where following a death, your autopsy will  
23 find a definite cause of death that clearly  
24 indicates it's a disease process, and it's

1                   therefore natural causes, or that it's --  
2                   there are injuries from a traffic fatality  
3                   indicating it's accidental, and the same with  
4                   suicides and homicides. You will, at times,  
5                   from your autopsy, you will have at the end  
6                   of the autopsy, you will find no  
7                   abnormalities in the body that will give you  
8                   the cause of death.

9                   THE WITNESS:    That's correct.

10                  THE CORONER:    And under normal conditions,  
11                  the next line of investigation is that  
12                  various samples will be taken for toxicology  
13                  to see if that will give the answer, and in  
14                  addition, you may well take some microscopic  
15                  slides to see if you can find some of the  
16                  more rare causes of death.

17                  THE WITNESS:    That's correct.

18                  THE CORONER:    And that having that secondary  
19                  process, despite those two, there will still,  
20                  following that double investigation, be  
21                  deaths where it cannot be explained either  
22                  following the autopsy, or following the  
23                  toxicology.

24                  THE WITNESS:    That's correct.

1 THE CORONER: And that those are the types  
2 of deaths where then a further investigation  
3 of both the clinical aspects, looking at the  
4 record, and the hiring of additional experts  
5 may be necessary, and those are typically the  
6 types of cases that go to the Paediatric  
7 Review Committee, where it takes a multi-  
8 discipline approach of clinicians,  
9 pathologists, and other experts to try and  
10 come up with an answer that is not, that has  
11 avoided the normal investigative processes.

12 THE WITNESS: Yes, that happens.

13 THE CORONER: And therefore when you say  
14 that there's no anatomical cause, or no  
15 toxicological cause of death in Lisa's, that  
16 is as a result of the autopsy and the  
17 toxicology that Dr. Taylor has performed.

18 THE WITNESS: That's right.

19 THE CORONER: It still leaves the question  
20 as to whether further investigation by other  
21 experts may bring forth additional  
22 information that when it's all taken to  
23 conclusion, there may still be a decision  
24 that a cause of death has been arrived at.

1 THE WITNESS: That's correct. That's right,  
2 and sometimes that happens in the weeks after  
3 death. Sometimes it's years later, and we  
4 can come up with, you know, discover diseases  
5 and go back for instance, to the Coroner's  
6 office years later, and they will re-classify  
7 a death, yeah.

8 THE CORONER: And is it fair to say that in  
9 this case, that certainly when Lisa died that  
10 our office initially were looking for a cause  
11 of death from the autopsy?

12 THE WITNESS: That's correct.

13 THE CORONER: And that the report we had was  
14 there was no, no physical, no anatomical, no  
15 disease process and no injuries to Lisa that  
16 would explain her death, and that given the  
17 history that she was in hospital on a  
18 morphine pump, the next logical investigative  
19 step would be to do toxicology. And that the  
20 final autopsy report does not come out until  
21 March of 1999 when that toxicology has been  
22 completed.

23 THE WITNESS: I think there was not only  
24 toxicology, I think there were other special

1 investigations of pump mechanisms and that  
2 sort of thing, as well, that Dr. Taylor had  
3 knowledge of.

4 THE CORONER: And therefore the next likely  
5 cause in terms of frequency at that time was  
6 to expect that there would be a cause of  
7 death found that could be explained on  
8 toxicology alone. And that turned out not to  
9 be the case.

10 THE WITNESS: That's right.

11 THE CORONER: And at that stage, then, it  
12 was referred to a multi-discipline committee  
13 to look at additional information and to  
14 review the whole thing in greater detail,  
15 including a blow-by-blow analysis, which is  
16 what the jury are doing at this time, to see  
17 if at the end of that process, a cause of  
18 death can be established.

19 THE WITNESS: Yeah, as I recall that was the  
20 flow. After the standard and the special  
21 investigations, the Paediatric Death Review  
22 Committee spent some time working on Lisa's  
23 death.

24 THE CORONER: So as far as the jury at this

1 stage, they don't really have any evidence as  
2 far as I can see, from either you or Dr.  
3 Mayers as to the cause of death at this time,  
4 but that's not to exclude the possibility  
5 that when they've heard from other experts,  
6 that there may still be a cause of death that  
7 would be acceptable to them.

8 THE WITNESS: Yeah, that's right. That  
9 situation may well change.

10 THE CORONER: Do the jury have any questions  
11 of Dr. Smith?

12

13 CROSS-EXAMINATION BY THE JURY:

14 BY JUROR #4:

15 Q. I'm not sure if you'd be aware of the  
16 situation. Had it been 4:00 that somebody approached  
17 Lisa, would there be a chance that she would still have  
18 been alive?

19 A. I don't know that I'm the right person  
20 to answer that question, because you're asking about,  
21 sort of, the situations ...

22 Q. If they were warned well enough in  
23 advance, instead of finding her dead at 7:00?

24 A. Run that question by me again?

1 Q. From what we understand, the monitor  
2 wasn't working. Had it been working and it detected  
3 that there was a problem at 4:00 ---

4 A. If it detected there was a problem, I  
5 understand.

6 Q. --- and if a nurse attended the patient,  
7 would Lisa still be alive today?

8 A. If it was a problem that was  
9 identifiable and correctable, then I think that's a  
10 reasonable expectation. My problem is I don't know, I  
11 don't know why she died, and I don't know at what point  
12 in the process death was predictable or inevitable, and  
13 that's why I'm a little reluctant to answer the  
14 question. I'm wondering if at the end of the day, it's  
15 a monitoring issue that may be related to drug  
16 administration or drug interaction or that sort of  
17 thing. Probably the best person to answer that  
18 question is not me, but is either Dr. MacLeod or  
19 perhaps Dr. Williams, the paediatrician, who can come  
20 along at the end of the process and put the whole  
21 picture together for you.

22 THE CORONER: Yes.

23

24 BY JUROR #2:

1 Q. Just further to Mr. Gomberg's question  
2 about the leads, if the leads had been removed, would  
3 there have been markings on the body? Is it too far  
4 after?

5 A. Probably not. Generally, when the leads  
6 are removed, there may be, you know, a very small  
7 amount of sort of residual material on the skin  
8 surface, but it may not be there. Generally, in  
9 situations such as Lisa's death, the staff leave the  
10 important equipment in place, such as intravenous lines  
11 and that sort of thing, but something like the  
12 monitoring leads may well have been removed by hospital  
13 staff.

14 JUROR #1: Yes?

15 THE CORONER: Please.

16

17 BY JUROR #1:

18 Q. I see on the Final Clinical Death Note,  
19 page 6, that we looked at just a while ago, it shows  
20 that there's some acetaminophen used. Would  
21 acetaminophen have showed up, shown up in the blood  
22 toxicology tests?

23 A. I expect it would. I expect it would  
24 have.

1 Q. Should have, it would have, it should  
2 have?

3 THE CORONER: Let me help you with that, so  
4 we don't spend too much time. There is, in  
5 one of the orders, that's I think is  
6 whoever's written that has read the order  
7 that acetaminophen had been given. There is  
8 in fact in it that acetaminophen is  
9 cancelled.

10 JUROR #1: So this is a mistake, then?

11 THE CORONER: So that's an impression that  
12 is wrong.

13 JUROR #1: That's to be ignored.

14 THE CORONER: So no acetaminophen was given,  
15 but if it had been, it would have shown up in  
16 the toxicology, but so we don't spend 25  
17 minutes I will help you with that.

18 JUROR #1: That's fine, thank you.

19 THE CORONER: Any further questions of Dr.  
20 Smith? Thank you very much, Dr. Smith. We  
21 will have a recess for lunch, and we'll  
22 recess until 2:15, as Dr. MacLeod has  
23 indicated with the weather, we may be here  
24 for 2:00 but it may be 2:15, so, we'll recess

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and start with Dr. MacLeod at 2:15.

--- LUNCHEON RECESS

THIS IS TO CERTIFY that the foregoing  
is a true and accurate transcription of  
my recordings and notes, to the best of  
my skill and ability.

Barbara A. Pollard  
Certified Court Reporter

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