

INQUEST INTO THE DEATH OF

L I S A S H O R E

SUBMISSION BY MR. GOMBERG

THE TESTIMONY OF JENNIFER STINSON

TAKEN JANUARY 26, 2000

BEFORE DR. JAMES CAIRNS, DEPUTY CHIEF CORONER

CORONER'S COURT, TORONTO

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

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| 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
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1 THE CORONER: Good morning ladies and
2 gentlemen of the jury. We did adjourn on
3 Friday, the issue for which we had adjourned
4 for has been resolved, so we're now able to
5 continue with the inquest. It is my
6 understanding from the Coroner's Constable
7 that there were some further questions that
8 you want to ask of Nurse Stinson, so we're
9 going to start with your questions from her
10 this morning.

11 MR. GOMBERG: Dr. Cairns, just before we
12 begin, there's some issues that I'd like to
13 raise with the court and I'd like to raise
14 them in the absence of the jury, and I think
15 it's appropriate that they be raised in the
16 absence of the jury.

17 THE CORONER: That's fine, Mr. Gomberg. If
18 we could excuse the jury for a few minutes?
19

20 --- THE JURY IS EXCUSED
21

22 MR. GOMBERG: Thank you, Dr. Cairns. Dr.
23 Cairns, I raise these issues advisedly and
24 after having sought advice from people who

1 are much more experienced and knowledgeable
2 in this area than I am.

3 The family has some very serious
4 concerns about the hospital records and in
5 particular Dr. Schily's orders and when they
6 were looked at. The only way to get to the
7 truth of that matter, in my submission, is to
8 have a Coroner's warrant issued to determine
9 when those records were looked at and by
10 whom.

11 We respectfully request that a computer
12 expert look at the Kidcom system at the
13 hospital and check these issues for the
14 benefit of the jury and the court. This
15 expert will then have to testify and explain
16 this to the jury and to you, Deputy Chief
17 Coroner. That's the first point.

18 THE CORONER: So that is with regard -- we
19 know that Dr. Schily wrote orders in the
20 Emergency Department, we know from the record
21 we have that they were suspended. We know
22 that they did not appear in the first copy of
23 the hospital record ---

24 MR. GOMBERG: Right.

1 THE CORONER: --- that was obtained by both
2 the family and by our office, and what you're
3 requesting is can we retain someone who can
4 let us know when first the existence of these
5 orders became apparent to anyone in the
6 hospital, is that summarizing?

7 MR. GOMBERG: It does, I think that what it
8 does is you left out one little point, but
9 which I don't think is particularly critical,
10 and that is we also know that they were
11 printed up at least on January 26th. We
12 don't know whether they were printed up in
13 December, we don't whether they were printed
14 up in November, all we know is that we have a
15 printout of those orders on January 26th,
16 right, so that's a very, very important issue
17 in terms of who looked at them. They may
18 have been looked at that night for all we
19 know, I don't know, and I suggest to you,
20 respectfully, that this is the wrong place to
21 be doing an investigation, right, it's crazy
22 to be doing that investigation here. That's
23 the first point.

24 The second point is this: There are

1 records available of other patients on ward
2 5A and 5B that were treated by Nurses
3 Doerksen and Soriano, and my submission is
4 that those records are relevant to determine
5 the level of monitoring that was done that
6 night by those nurses. Now, those records
7 can -- I'm aware of the fact, probably better
8 than any one, that there are privacy issues.

9 Those records can be made available without
10 identifying data; patient 1, patient 2, all
11 the way through to patient 8 or 9, however
12 many patients there were.

13 In my submission, the police
14 investigation, to the extent that the police
15 were seconded to look at this, was stymied
16 and the truth seeking function of the court
17 is severely compromised and remains
18 compromised by the absence of information.
19 How can the police possibly check the
20 veracity of any information that is sent to
21 Counsel, and to you, Deputy Chief Coroner, at
22 6:30 at night on January 14th, two months
23 after this inquest began. I'm talking now
24 about statements from Nurses Doerksen and

1 Soriano.

2 In my submission, and I may be corrected
3 on this, the police have taken statements
4 from two people -- two people -- my clients.

5 Those are the two points that I wanted to
6 make and I thank you for indulging me and
7 permitting me to make them.

8 THE CORONER: Do any other Counsel wish to
9 make comments on Mr. Gomberg's requests?

10 MR. KRKACHOVSKI: I've already raised it,
11 not so much a concern, but a question
12 privately, Mr. Coroner, about the date when
13 these orders from Dr. Schily were first
14 looked at and printed, and I discovered quite
15 late in the process as to when they were
16 provided to the Coroner's office, and I'm not
17 clear, still, as to why it took as long as it
18 did for the orders to come to light, (a); and
19 (b) have reported to the Coroner's office.

20 It's actually in part what Mr. Gomberg
21 is saying, that if someone from the hospital
22 can explain that, that's fine, but the other
23 thing we're interested in, as well, is did
24 anyone look at those orders between the time

1 of Lisa's death and January the 26th, which
2 is the date of the printout that we have
3 without necessarily printing the orders?

4 THE CORONER: Ms. Posno.

5 MS. POSNO: We have no further submissions
6 or any further information to be of
7 assistance, Mr. Coroner.

8 MR. CORONER: Mr. Hawkins.

9 MR. HAWKINS: As to the first point, at the
10 time and this has been what was explained to
11 the Coroner's office, I understand, verbally
12 in January of '99 was subsequently Ms. Warren
13 attempted to explain the process and in
14 discussions that I have participated in with
15 Counsel and yourself subsequently, we have
16 explained the process by which these orders
17 came to be produced to the Coroner's office
18 in January of 1999, as was explained, has
19 been explained, the discharge print that is
20 done did not include the suspended orders.

21 When the Coroner's office requested the
22 chart in December of 1998, the chart went
23 with the orders as printed on discharge, and
24 it's been explained why these suspended

1 orders did not print on discharge.

2 In January of 1999, as I understand it,
3 in the context of some of the physicians
4 reviewing the chart, they raised the question
5 of all of the orders not being there; those
6 orders were then accessed and sent to the
7 Coroner's office by the Hospital for Sick
8 Children. So it was the Hospital for Sick
9 Children, the people at HSC re-sent the
10 orders to the Coroner's office in January of
11 '99.

12 Through a misunderstanding or a mis-
13 communication, that information was not also
14 conveyed to the Shore family and I think
15 that's why we get to the problem today, but
16 certainly the hospital tried to clear up the
17 confusion or the misunderstanding in January
18 of 1999.

19 What I understood we had agreed to do
20 was that the hospital would put this in
21 writing to you to set out the chronology of
22 when, where and how these orders were
23 entered, printed and dealt with by the
24 computer system. Mr. Gomberg suggests that

1 we need a computer expert to check into these
2 issues. Ms. Warren has clearly testified
3 that the computer system does not track
4 looking at -- simply looking at something on
5 the screen, it tracks changes, it tracks --
6 it tracks doing something to the computerized
7 record, be it orders or something else, other
8 than looking at it. So on that point, I
9 think we have the evidence. I think the
10 explanation and the misunderstanding has been
11 explained.

12 As to the second point about other
13 patients, other patients on the ward are,
14 with all due respect, irrelevant to the
15 issues before this inquest, which is the care
16 provided to Lisa Shore. What care may and
17 may not have been provided to other patients
18 that night or at any other time is irrelevant
19 to the purposes of this inquest, and that's
20 quite apart from the confidentiality concerns
21 raised or averted to by Mr. Gomberg, and in
22 my respectful submission, simply removing the
23 identifying data does not change the fact
24 that those are confidential records and does

1 not change the fact that we would be going
2 far beyond the purposes of this inquest if we
3 were looking into care provided to other
4 patients.

5 THE CORONER: Ms. Browne.

6 MS. BROWNE: I've listened carefully to
7 Counsel and it's my submission, Mr. Coroner,
8 that as to the number of times the record --
9 the doctor's orders, the suspended orders
10 were printed out before it came to your
11 attention, I think that we can probably get
12 that from somebody, a computer person, other
13 than Ms. Warren at the hospital. I'd be
14 happy to check and see who the right person
15 is and ask her whether or not there -- her or
16 him, excuse me, whether or not there are
17 other printouts that occurred before the ones
18 that you received in your investigation.

19 As far as the finding out if there's a
20 record of people looking at them, the only
21 evidence we have is that it doesn't print
22 out, there's no way of tapping into the
23 computer and searching out when people look
24 at them. That's the evidence we have; if

1 there's anything further, I'd be happy to
2 hear it from anybody who can provide us with
3 that evidence, but I think you have to have
4 an evidential basis before you go into that.

5 The last point, I believe, was that the
6 other person -- the other patients' records,
7 I can't see any relevance to that, in my
8 submission, unless, of course, somebody
9 provides us with an evidentiary basis that is
10 -- that is relevant. I don't think just
11 saying it's relevant makes it admissible. At
12 least there should be some basis put forward
13 as to say that any other patients' records,
14 which are, of course, private, are admissible
15 in this court. Those would be my
16 submissions, sir.

17 THE CORONER: Any further comments by
18 Counsel?

19 MR. GOMBERG: Do I get to reply?

20 THE CORONER: Yes, certainly.

21 MR. GOMBERG: With regard to the -- you see,
22 there's tremendous confusion. Point one
23 deals with the -- with the computer, all
24 right. With the greatest of respect, I'm not

1 bound by what Carol Warren may think or may
2 not think. With the greatest of respect to
3 her, she was not the most impressive witness
4 that I ever saw, and she may be wrong.

5 Now I want to know, and I think we're
6 entitled to know, we ought to have been told
7 this a long time ago, whether or not those
8 orders, whether you can go into the computer
9 and determine whether they were looked at,
10 right, printed is another question, looked
11 at. For all we know, they may have been
12 printed earlier, but that's different from
13 looked at. Now, surely, we're not bound by
14 what she says on that, because if you were
15 bound by what people said, then when you do a
16 murder investigation, you go up to the
17 suspect, ask him if he did it, he'd say no,
18 and that would be the end of the
19 investigation, and I don't think it works
20 like that, with the greatest of respect.

21 Now with regard to other patients, this
22 is the evidentiary basis for that. Let's
23 just talk about blood pressure for a second.
24 They didn't take any blood pressure after

1 1:45. Now we're going to find out why,
2 presumably, but I'd like to know whether they
3 were taking blood pressure on each of those
4 other patients every half an hour, or 45
5 minutes or hour, because it raises a
6 different gloss on the blood pressure issue
7 and that's only one issue, there are others;
8 pain scale, sedation scale.

9 How can one possibly determine what was
10 going on here unless you know what was going
11 on there, and in my submission it's very
12 relevant for this reason. I've driven
13 through one stop sign, but I've never driven
14 through seven or eight of them in a row. In
15 terms of blood pressure, I can see missing
16 one or two, but I can't see missing six, or
17 seven or eight and I'd like to know what else
18 was going on that night, because it does
19 impact on this case. Was this just a
20 mistake, you missed -- forgot to take one
21 blood pressure, or was something else going
22 on, like, just so we're not guessing, this
23 patient's a nut, the family's a nut, we're
24 not going to be too worried about what's

1 going on here. Those are my submissions.

2 THE CORONER: Does Counsel have any other
3 submissions?

4 MR. HAWKINS: I don't think Mr. Gomberg has
5 come anywhere close to establishing a
6 relevance for the care provided to other
7 patients. The issue is the facts and
8 circumstances of Lisa's death and the care
9 provided to her by people at the Hospital for
10 Sick Children. Whatever was going on with
11 other patients was and remains and always
12 will be irrelevant to that investigation and
13 to the purposes of an inquest as defined by
14 the Coroner's Act, and that's quite apart
15 from confidentiality.

16 THE CORONER: What I would intend to do is
17 to reserve any decision I may make on this
18 matter at this time. I certainly will rule
19 on the request by Mr. Gomberg. I do not feel
20 that I am prepared to rule on it now, I'd
21 want to give it some serious consideration,
22 it's a serious matter and I think it deserves
23 that. I do not feel that it prevents us from
24 going ahead with today's evidence and I will

1 rule on it. It may well be that the evidence
2 we hear over the next day or two may also
3 help me in making that sort of decision.

4 MR. GOMBERG: Thank you, sir.

5 THE CORONER: Is that satisfactory with all
6 Counsel?

7 MR. GOMBERG: Yes.

8 THE CORONER: Mr. Hawkins, is that
9 satisfactory with you?

10 MR. HAWKINS: That's satisfactory.

11 THE CORONER: Ms. Browne, is that
12 satisfactory with you?

13 MS. BROWNE: Yes.

14 THE CORONER: Ms. Posno?

15 MS. POSNO: Yes, thank you.

16 MR. KRKACHOVSKI: Yes, Mr. Coroner.

17 THE CORONER: Thank you. If we could bring
18 the jury back in. Would you like to call
19 your next witness?

20 MS. BROWNE: Ms. Stinson is here and she is
21 -- I understand the jury wanted to hear --
22 ask her some questions and hear a little
23 more, and I believe that there's something we
24 can introduce to assist.

1 THE CORONER: Ms. Stinson was sworn
2 previously, she does not need to be re-sworn.
3 Ms. Stinson, I think the jury specifically
4 have some questions for clarification from
5 your previous evidence, if you'll be kind
6 enough to help them out. I'll leave it up to
7 the members of the jury.

8

9 JENNIFER STINSON, PREVIOUSLY SWORN

10 CROSS-EXAMINATION BY THE JURY:

11 BY JUROR #2:

12 Q. We just wanted to clarify something that
13 was said. In your testimony, you explained the state
14 of arousal with sleep, that if a nurse puts a
15 stethoscope on a child's chest, there may be a natural
16 reaction, but from there a slight nudge, or push or
17 speaking the child's name may also cause a response.
18 What we were wondering is with this response, is that
19 what you would expect generally from a child, and when
20 a child is under the influence of morphine and several
21 other drugs, would they respond the same way or would
22 they require more -- more nudging or whatever? Would
23 they react to a stethoscope on the chest? Would they
24 react to a pulse being taken or would you have to go a

1 step further with that type of a child?

2 A. Okay, that's a very good question. As
3 I've said, in terms of assessing the level of sedation,
4 it's a global assessment, and what you do is you really
5 take a baseline when you first see that child. So, for
6 example, when Lisa came to the floor, the nurse would
7 take an assessment of her at that point and it's a
8 continual ongoing assessment, 'cause you need a base
9 line to see how her level of consciousness or their
10 ability to be aroused changes.

11 So when she comes to the floor, I don't
12 know, I think she was sleeping on a stretcher, but what
13 the nurse would do would be to move her to a bed, so
14 she would observe Lisa's behaviour in moving to the
15 bed. For example, if Lisa was able to move without
16 assistance at all, that would be a child that is alert.

17 She might be a little bit drowsy, but she follows
18 commands really well, Lisa, can you move to the bed,
19 and she moves to the bed on her own, okay, so she would
20 take a baseline assessment and so when she comes up she
21 would assess that she's fairly alert, and I'm just say
22 this is a hypothetical, I don't know if that's the
23 case. So she would assess that she's alert and from
24 there, she would make all her other assessments, so

1 it's a continual, ongoing assessment every time she
2 interacts with Lisa.

3 Q. Okay.

4 A. So it's always not one point in time, so
5 she may go into the room and she's made that baseline
6 assessment and maybe she's very alert and then -- but
7 wants to go to sleep, goes to sleep. The next time she
8 would come in, she would enter the room, she may be
9 using a flashlight, the light from the hall may be
10 enough for her to go in and do her assessment, or she
11 may turn on a light in the room, various options, and
12 you would observe her reaction to that.

13 Now most children, even if they've had
14 morphine, because I do rounds on a daily basis where I
15 go in and assess children, you enter the room and for
16 the most part, if they're sleeping, if you enter the
17 room and you just call their name or you even just
18 lightly touch them, they'll wake up. Now if they're a
19 little bit sleepy or drowsy what will happen is you
20 will talk with them or touch them and then they'll go
21 back to sleep again, so then you would want to touch
22 them and talk to them a bit more, okay.

23 Q. Okay.

24 A. Okay? So it's a gradual assessment.

1 When you come in you first see if they respond to
2 noise, then you would lightly touch them, and if they
3 don't respond to a light touch or a stethoscope on the
4 chest, you would go a bit further. You would try and
5 talk to them.

6 Q. Okay.

7 A. Okay?

8 Q. So to bring that around to the point
9 we're just trying to establish, if the child is on
10 morphine, or in this case, a combination of drugs,
11 there may be need to go a little further than ---

12 A. It depends on the baseline assessment
13 and it depends on your assessment. As I said, if the
14 nurse comes into the room, the child doesn't move,
15 she'd go over to the child and put her hand on her, put
16 her stethoscope on the chest, that would be touching
17 her.

18 Q. Right.

19 A. And if she moves a little bit, that
20 would show you that it's purposeful movement, so she's
21 moving because someone is touching her and people that
22 are very somnolent don't have purposeful movement.

23 Q. Okay.

24 A. Okay? So, for example, if you went in

1 and I think at one point they took her temperature, and
2 you'd say, Lisa, I'm going to take your temperature
3 now. If she opened her mouth, right, that means that
4 she has the cognitive ability and she's got enough
5 oxygen going to her brain that she can follow a command
6 without being told, Lisa, open your mouth, hold the
7 thermometer in, because you have to hold it in your
8 mouth for, you know, a good 30 seconds or so.

9 Now you'd be able to tell her level of
10 arousability then because if she was holding that in
11 her mouth and she couldn't keep her mouth shut, because
12 you have to keep your mouth closed or it will alarm
13 that it's not reading properly, I'm assuming that she
14 was arousable at that point because they were able to
15 take a temperature and she was able to keep her mouth
16 closed, which requires her doing purposeful movements,
17 okay, by closing her mouth, opening her mouth to have
18 the thermometer in it.

19 Q. Okay.

20 A. Those types of things.

21 Q. Okay. We have another question. In
22 conversation, there's been a lot of reference made to
23 clinical judgment.

24 A. Mm-hmm.

1 Q. And so what we want to know is if
2 there's a manual procedure, standard or protocol for
3 clinical judgement or if it is simply a discretionary
4 matter amongst the nurses? Is there any conferencing
5 involved or is it an independent decision to make a
6 clinical judgment?

7 A. In clinical ---

8 Q. I guess what we're looking for is
9 basically a standard, at what point clinical judgement
10 kicks in.

11 A. Okay. Nursing, any profession is really
12 an art and a science, so you have a knowledge base and
13 you have skills in order to do tasks, and then comes
14 the clinical judgement piece where based on your
15 experience, your knowledge and your clinical skills and
16 the context of the situation, so what's going on, you
17 decide when and where to carry out orders or whatever
18 it is you're doing. You have to prioritize; you may be
19 caring for five patients and they all need things done,
20 so you use your knowledge, your clinical skills and
21 then your judgment piece to put it together in terms of
22 when am I going to do this for which patient, and it's
23 all on prioritizing and determining what's in the best
24 needs of the patient, so there is no manual that says,

1 in this instance she will do that, that's the judgment
2 pieces. It's the independent thinking that nurse does,
3 or any other professional, based on your knowledge,
4 okay, so of the situation, the medications your
5 patient's on, their status, and then your clinical
6 skills in terms of caring for those patients to make a
7 judgment.

8 Q. Just to further that, if I could, can
9 clinical judgment be taken from the point of deciding a
10 need to -- a need to actually deal with the orders?

11 A. In terms of whether you would follow
12 them or not, or whether ---

13 Q. Follow orders, yeah.

14 A. Is that the question?

15 Q. That's the question.

16 A. Okay. Again, yes, clinical decision
17 would come into that. You would have an order and as
18 various people have already told you, the order needs
19 to be looked at by a nurse to determine, you know, for
20 example, if they're ordering a medication, is it the
21 right drug, is it for the right patient, is it the
22 right dose, so you would use your judgment to determine
23 all those things so see whether it is indeed safe to
24 give that medication to a patient, and then there would

1 be the orders for the monitoring and then you would --
2 again, they would be ordered every hour, but it may be
3 a little bit late 'cause you have five other patients
4 and someone else may be more sick, so you may go and
5 see them first and then ---

6 Q. Okay, that's fine.

7 A. Okay, so that's how ...

8 Q. Okay, and I think clarifies the few
9 little things I have. Thanks so much.

10

11 BY JUROR #1:

12 Q. A question has just surfaced for me
13 then ---

14 A. Sure.

15 Q. --- with this clinical judgment. Can
16 clinical judgment overrule an order?

17 A. Yes.

18 Q. It can? And in such a case where a
19 clinical judgment might overrule a doctor's order, does
20 the caregiver then have to conference with a supervisor
21 or someone else ---

22 A. You would speak with the physician that
23 ordered them.

24 Q. --- or is that arbitrary that one person

1 can overrule an order?

2 A. No, I think again it would go back to if
3 you had any concerns about an order, if, for example, a
4 medication that was ordered in too high of a dose,
5 obviously you would not administer that to the patient
6 if you knew it was not the appropriate dose for that
7 patient and you would contact the doctor to let him
8 know. And other things, for example, monitoring, if
9 you're not able to get a monitor, you'd be able to --
10 you would contact someone to let them know that, okay,
11 if they had ordered something.

12 Q. Yes.

13 A. And nurses can also use their clinical
14 judgment, even if they don't have an order, to put a
15 monitor on a child. Okay, so you don't always need an
16 order.

17 Q. Right, okay. So if a nurse should
18 choose not to follow a specific order, can she do that
19 without having a secondary opinion or permission of,
20 say, a nursing supervisor?

21 A. Yes.

22 Q. Thank you.

23

24 JUROR #5:

1 Q. Ms. Stinson, you said that you see
2 patients, children with morphine?

3 A. I do. I'm one of the nurse
4 practitioners on the Pain Service, so I make daily
5 rounds and I'm also able to order medications for
6 children, as well.

7 Q. Do you check to see the nurses has (sic)
8 followed these orders from the doctor?

9 A. We look at the flow sheets and often
10 times things like pain scores are not done at night
11 because we teach the nurses, for example, not
12 necessarily to wake a patient to do a pain score,
13 because not doing a pain score isn't life threatening,
14 but we do talk to the nurses during the day when we
15 come around to say if there's no sedation score or
16 respiratory rate, you'll ask them what that is, and
17 then their rationale for why it wasn't done.

18 Q. Okay, that's what I wanted to know.

19 A. And usually there's an explanation.

20 THE CORONER: Does the jury have any further
21 questions? I know there's going to be some
22 additional documents put in, but before that
23 there may well be that Counsel will have some
24 questions arising from the jury's questions

1 and I'd like to give you all the opportunity
2 to do that. Ms. Browne, do you have any
3 questions?

4 MS. BROWNE: No, not with regard to what Ms.
5 Stinson testified to.

6 THE CORONER: Mr. Krkachovski?

7 MR. KRKACHOVSKI: No, thank you, Mr.
8 Coroner.

9 THE CORONER: Ms. Posno?

10

11 RE-EXAMINATION BY MS. POSNO:

12 Q. Nurse Stinson, I just wanted to clarify
13 one comment you made.

14 A. Sure.

15 Q. As I understand, a nurse has the ability
16 to use her clinical judgment with respect to an order,
17 whether or not that order is appropriate, and the nurse
18 does not need to speak with her supervisor, for
19 example, to confirm her clinical judgment, is that
20 how ---

21 A. That's independent judgment that she's
22 made based on the knowledge of the facts that she has
23 for the patient she's caring for, the context of the
24 situation in which she's caring for the patient, and so

1 she makes a clinical judgement. If we have concerns
2 about that judgment, then we would go back and discuss
3 that with the nurse in particular, but she doesn't have
4 to check with the nursing supervisor. She may ask
5 other colleagues what they would do in a particular
6 instance, but there's no one that you check, there's no
7 protocol, that's something every health care
8 professional, whether you're a nurse, a physician, you
9 use your knowledge skill to make a judgement about a
10 patient.

11 Q. Right, and then based on the clinical
12 judgment that nurse has made a decision on, the
13 appropriateness of following the order, if in a
14 circumstance an order is not to be followed, then, for
15 whatever reason the nurse has decided, for example, you
16 said if a monitor is not available, for example, or if
17 medication is too high, the nurse then calls back that
18 physician and says, I've read your order, in these
19 circumstances and I've confirmed, based on my judgment,
20 this wouldn't be appropriate for these reasons, do you
21 agree, or do you have anything to add, so that the
22 physician will know that that particular order is not
23 being followed in the manner that that order was
24 written?

1 A. Yeah, and then they would make a
2 decision based on what the nurse has told them and
3 either say, okay, that's okay, just spot check them in
4 case of an O2 SAT, so there would be a dialogue between
5 the nurse and the physician.

6 Q. Okay. So the clinical judgement is
7 independent of the nurse, but then in terms of varying
8 the order, the nurse -- there's a second step, the
9 nurse then speaks with the physician with respect to
10 the order?

11 A. Correct.

12 Q. Okay, thank you.

13 THE CORONER: Mr. Gomberg.

14

15 RE-EXAMINATION BY MR. GOMBERG:

16 Q. I just want to try and bring this back
17 to what happened with Lisa, if I can.

18 A. Okay.

19 Q. Because I appreciate you're talking
20 generally now about what nurses are supposed to do when
21 they look at orders that they think may be flawed in
22 some way. Now let's just talk about the order -- do I
23 have that right, that's what ---

24 A. It's not necessarily "flawed;" the order

1 may not be "flawed," it may be she's using her clinical
2 judgment instead of doing it right on the hour to do a
3 vital sign, she may have to do it 15 minutes later, so
4 it's not always "flawed."

5 Q. All right. Well, it may not be
6 "flawed," the order may be fine, she may not be able to
7 do it right then and there ---

8 A. Exactly.

9 Q. --- or in the alternative, the order may
10 order something that's unavailable, like a monitor?

11 A. Yes, that's correct.

12 Q. Okay, so I was using "flawed" in a
13 generic sense that it couldn't be carried out.

14 A. Okay.

15 Q. But let's just talk about this case
16 because I think that's what the jurors are particularly
17 interested in. Dr. Schily made orders at 11:48 at
18 night which were put onto the Kidcom, right?

19 A. Correct.

20 Q. Now, I take it, you'd agree with me that
21 neither Nurse Doerksen, nor Nurse Soriano nor anyone
22 else could have exercised any clinical judgment about
23 those orders and whether they were appropriate or
24 inappropriate; we're talking about the orders made at

1 11:48, because as a common sense matter, they didn't
2 know about them? I take it you agree with me?

3 A. I would agree that they did not know
4 about the orders, but they know in general the order
5 set for monitoring patients on PCAs.

6 Q. I'm talking specifically about these
7 orders that he made ---

8 A. They did not see those orders, that's
9 correct.

10 Q. All right, and therefore they couldn't
11 question the specifics of these specific orders because
12 they didn't know about them?

13 A. That's correct.

14 Q. Those are my questions.

15 THE CORONER: Mr. Hawkins.

16

17 RE-EXAMINATION BY MR. HAWKINS:

18 Q. Ms. Stinson, just picking up on what Mr.
19 Gomberg said, I think you've heard most of the evidence
20 that's been given to this point?

21 A. Yes, I have.

22 Q. There's been some suggestion in the
23 questioning, in the answers that it's shocking that
24 nurses did not look at orders, and that it's shocking

1 that they didn't take particular vital signs at
2 particular points in time. In reference to what you've
3 heard, can you tell us if you consider that shocking or
4 what it's about?

5 A. I wouldn't use the word "shocking." I
6 think what happened to Lisa is extremely tragic and my
7 heart goes out to every member of her family, but I
8 think what happened is there was some error in human
9 judgment and there was a snowball effect from my
10 listening to, anyway, the testimony, of various things
11 that happened throughout the night.

12 For example, this is the first time
13 we've ever had a patient admitted through the Emergency
14 Department who had a chronic pain syndrome who needed
15 an acute management of that episode. We had just
16 started our Chronic Pain Service, so we've never had
17 these types of patients admitted before, we've never
18 had admitting privileges, so we had to admit this
19 patient through ortho.

20 I've been trained on Kidcom and I know
21 Marcus received the same training that I received and
22 we -- never was there any mention that when you enter
23 these orders that they're suspended or that, really,
24 the call from the physician in emerg to the floor is

1 really the red flag, the same as in the chart when you
2 pull out the red flag to say there's doctor's orders,
3 so I don't know if Marcus did that in terms of letting
4 the nurses know that -- all the different medications
5 she was on and maybe that she was at a high risk for
6 sedation.

7 The nurses not activating the orders on
8 the floor, you know, they didn't get the call. I can't
9 explain that, again, that's an error in human judgment,
10 people are human -- it just seems to be there was just
11 a snowball of things, a cascade. That's my opinion.

12 Q. And what do you, as a nurse, or what
13 have you done as a nurse since this incident to try to
14 deal with that "snowball effect," as you called it?

15 A. I think we've done several things. As I
16 said before, we now have admitting privileges which I
17 think we can bring these patients in on a planned basis
18 and not have them coming in through emerg, to help
19 manage their pain. We've -- I've been to 5A and 5B
20 where we're going to have the chronic pain patients
21 come in to do extensive in-servicing with the nursing
22 staff about what it's like for children to have chronic
23 pain, what are some of the medications these children
24 are on, because I'm not sure that the nurses would be

1 familiar with these types of medications because they
2 don't see them that often, and then the doses that
3 they're on.

4 Other things that we've done is we've
5 looked at -- I wasn't directly involved with this, but
6 the Nursing Practice Committee has looked at monitoring
7 of children in general on morphine or any sort of
8 opioid infusions, to have standard monitoring with
9 that, which would now be the O2 saturation monitor and
10 I know that there is in-servicing going on, it has
11 already occurred on 5A and 5B, about monitors,
12 recording the actual serial number on the monitor,
13 what alarm limits you set -- what other things we've
14 done ...

15 And then as a nurse on the Pain Service,
16 we reviewed our own sort of monitoring guidelines and
17 I'm actually the liaison with the Kidcom people for
18 revising the Kidcom protocols, and we need to look at
19 things on there that clearly tell nurses when to call a
20 physician, and we're going to change it from being a
21 sedation score of 3 to a sedation score of 2, to let
22 them know that they are frequently sleepy and that
23 maybe we need to keep a closer eye on them versus
24 having them call when it's sedation score of 3.

1 Other things that we're doing is going
2 to be re-looking at the whole order related to pain
3 scores and whether it's appropriate to wake children at
4 night for a pain score. So those are just some of the
5 things that we're doing based on hearing the testimony
6 that we've heard here to try to think -- make things
7 clearer.

8 MR. HAWKINS: And, Dr. Cairns, I have one
9 question for Nurse Stinson that doesn't quite
10 arise out of what the jury said, it's about
11 Dr. MacLeod's evidence about gabapentin and
12 the possible interaction with morphine. I
13 just want to ask Nurse Stinson, as the Pain
14 Nurse, if that's something that she and her
15 colleagues are aware of, were aware of, at
16 the time?

17 THE CORONER: I think that's fair.

18

19 BY MR. HAWKINS:

20 Q. Nurse Stinson, you heard, I understand,
21 much of what Dr. MacLeod was saying and he talked about
22 that there's a possible interaction between gabapentin
23 and morphine. Is that something that you are aware of?

24 A. Well, gabapentin is an anticonvulsant

1 and an anticonvulsant similar to morphine can cause
2 your central nervous system to be depressed, so that
3 they would both act together to depress that. Now, I
4 was not aware of his testimony regarding the difference
5 in labelling from the US monograph to the Canadian
6 monograph about the eight episodes of sudden death.
7 What we've always heard and we went to a world congress
8 this summer in Vienna on pain, and there were world
9 experts there speaking on gabapentin and gabapentin
10 basically is considered one of the safest
11 anticonvulsants in terms of its side effect profile.
12 We weren't aware of that. We were aware, obviously,
13 that it, in combination, can cause more CNS depression,
14 but not that it would potentiate the morphine to a
15 higher level, which I think is what he was referring
16 to.

17 Q. So not that it might potentiate the
18 respiratory effects of morphine?

19 A. It would, because it would -- if it
20 depresses the respiratory -- your central nervous
21 system is where your respiratory centre is housed, it
22 may depress that as well, but she had been on these
23 drugs, from what I understand, for several months with,
24 I don't think, a lot of -- any side effects that I was

1 aware of in terms of excess sedation.

2 Q. Specifically he talked about the
3 difference between the warnings put on in Canada versus
4 the United States; were you aware of the US warning at
5 all?

6 A. No, we were not aware of that.

7 THE CORONER: Ms. Browne, you had some other
8 documents, I think, that you wanted to
9 introduce through this witness?

10 MS. BROWNE: Yes.

11

12 RE-EXAMINATION BY MS. BROWNE:

13 Q. I'm going to show you -- Ms. Stinson,
14 you indicated that you are connected with the Pain
15 Service.

16 A. I am.

17 Q. Right. And we have copies of some of
18 the records of the Pain Service and perhaps if I could
19 ask Detective Culleton (sic) to give you what amounts
20 to about one -- three pages of the Pain Service that
21 was -- you can tell us something about it. I've made
22 copies for Counsel so we don't have to go to the big
23 one.

24 CONSTABLE CULLETON: Exhibit 32.

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EXHIBIT NO. 32: Pain service meeting notes
taken on the morning of Lisa's
death

BY MS. BROWNE:

Q. Do you have it front of you?

A. Mm-hmm.

Q. All right. Can you just tell us then, please, the first page there, it's got "page 3" written up at the top, what is that? Who wrote that and when was it written and what can you tell us?

A. Okay. That was Dr. Harvey Huang, he was the Anaesthesia Resident on that night and he was actually involved in her resuscitation, he's the Anaesthesia Resident. As to when this was taken, what happened is, I arrived -- I was the Nurse Practitioner on the Pain Service that week so I arrived that morning, I think it was Thursday morning, anyways I arrived at about ten to 8:00 and in the hallway when I got off the elevator were Dr. Huang, Dr. Desparmet, which was the visiting professor from Montreal at that time, she was helping with the Chronic Pain Service, and I met them in the hall and then they -- they told

1 me that Lisa had died, and obviously I was in -- in
2 shock and disbelief, we all were, and like anyone in
3 this situation, what you need to do as a team is meet
4 to sort of debrief and say is there anything we need to
5 do immediately, or can we determine anything
6 immediately so that we can make changes. So we met in
7 my office and that's when Dr. Huang made this brief
8 note. He was sort of describing what had happened and
9 he was jotting down notes.

10 Q. When you had this meeting, do you know
11 what time it was, approximately?

12 A. I got off the elevator just before 8:00,
13 so I'm assuming at 8:15, 8:30, something like that.

14 Q. All right. And who was there beside
15 yourself and Dr. Huang?

16 A. Dr. Desparmet, Lori ---

17 Q. The visiting Professor from Montreal?

18 A. The visiting Professor. Lori Palozzi,
19 who's the other Nurse Practitioner, and Dr. Schily.

20 Q. And this note that was written by Dr.
21 Huang, was that intended to cover from the code onwards
22 or ---

23 A. Just the code. He was called up and I
24 think he arrived there a couple of minutes after they

1 had started the resuscitation.

2 Q. So this note that we have here from Dr.
3 Huang, it's basically what was done after the code was
4 called?

5 A. At the point of his arrival to the code.

6 Q. And I think we've heard most of this
7 before, but it indicates that he arrived on the scene,
8 she was intubated already.

9 A. Yeah.

10 Q. That CPR was being administered and
11 multiple doses of epinephrine and so on were being
12 given to her.

13 A. Yeah.

14 Q. But the code was (inaudible).

15 A. That's correct.

16 Q. The next page that you have, it's "P4"
17 at the top.

18 A. Yeah.

19 Q. Can you tell me, what is that? Who made
20 that note and when? It says "October the 22nd."

21 A. Yeah.

22 Q. And it's -- I think it's Dr. Schily and
23 your signature appears there, too?

24 A. Yeah, and Dr. Cagney, who's another

1 Anaesthesia Fellow.

2 Q. And when -- who made -- was that made at
3 the same meeting?

4 A. It was.

5 Q. By Dr. Schily?

6 A. It was.

7 Q. And what exactly was he indicating here?

8 A. He was going through, basically, his
9 bellboy calls. He had just documented down the two
10 times that he had -- well, that were written on his
11 pager anyway. You can get a numerical readout of the
12 time the call was made and the number.

13 Q. Sorry, I'm just trying to get ---

14 A. That's okay.

15 Q. Can you tell us when the page calls came
16 through?

17 A. Well, he showed me two calls, one was at
18 4:06 and that was 6948, which is 5A, and the other one
19 was at 7:52 and that was, again, the same floor, 5A.

20 Q. And the 7:52 one would be after ---

21 A. After the code, mm-hmm.

22 Q. The 4:06a, what is the "a" mean? A.M?

23 A. A.M.

24 Q. A.M., okay. The 6948, that's the code

1 number for ---

2 A. That's the floor number.

3 Q. Floor number.

4 A. So if you phone the floor, that would be
5 the number.

6 Q. And can you tell me how the bellboy
7 calls work? I mean, if somebody does want to page Dr.
8 Schily, what exactly will they do?

9 A. They would basically -- it depends on
10 what type of pager you have. There's various different
11 pagers, but the Fellow's pager is basically a number
12 that's the same for every -- they carry the pager and
13 they rotate it, so it's always the same number. They
14 would dial 9 and then 235-8912, I think is the number,
15 and you have to actually put in the exact number.
16 Like, if you make a -- enter a wrong number, whatever,
17 the page won't go through.

18 Q. And we've heard some evidence and we'll
19 probably hear more about a page at 2:50 in the morning;
20 that's not recorded here, is it?

21 A. No, the only two pages I saw were the
22 two pages. That's it.

23 Q. What does that mean, that -- the
24 significance to you that there's no "2:50 a.m., 6948"?

1 A. Well, I'm not sure what significance I
2 attribute it to. It's not uncommon that the Fellows,
3 when they go home, just like I do, I clear my pages and
4 then if I'm leaving it on, then when you're flipping
5 back, you won't get confused if you have whole bunch of
6 pages on there, so it's not uncommon when you leave the
7 building to clear your pages and leave it on so then
8 any incoming pages you'd know what they related to, so
9 in the middle of the night you wouldn't have to look.
10 That's what some people do, I'm not -- that's not
11 everyone.

12 Q. Was there any discussion at this meeting
13 about any pages at around 2:50 or 3:00?

14 A. No, there's no discussion about that.

15 Q. And, finally, the next page which looks
16 as if it's really two pages, can you tell us who's
17 writing that is?

18 A. That's Dr. Desparmet.

19 Q. All of it?

20 A. Yeah.

21 Q. Both pages?

22 A. Yeah.

23 Q. And the one, it looks as if -- the one
24 on the right, is that -- does that come first, on the

1 right?

2 A. Yes, the right-hand side column comes
3 first and then she moves over to the other side, and
4 it's basically her taking notes as Dr. Schily and Dr.
5 Huang sort of talk about what happened that night.

6 Q. So these are notes taken by Dr.
7 Desparmet ---

8 A. Desparmet, just to sort of see if you
9 could ---

10 Q. --- at that meeting?

11 A. Yes.

12 Q. And it indicates that Lisa came in at
13 9:30 in the ER?

14 A. Mm-hmm.

15 Q. Checked by Marcus ---

16 A. Marcus.

17 Q. --- between 10 and 11?

18 A. Yeah, in pain, 10 out of 10.

19 Q. 10 out of 10, unbearable, she's
20 screaming ---

21 A. Screaming, stabbing pain, constant.

22 Q. --- stabbing pain that's constant?

23 A. Mm-hmm.

24 Q. Mother wanted an epidural?

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A. Yeah.

Q. Said that the last time it helped?

A. Mm-hmm.

Q. I can't read the next.

A. And then he says, "said she will be kept in ER until pain less than 5" on that pain score of 1 to 10, 0 to 10.

Q. And this information is coming from ---

A. This is what Marcus is saying ---

Q. --- Dr. Schily to ---

A. Dr. Schily to ---

Q. --- his recorder?

A. Yeah.

Q. Okay, go on. Can you just read the rest, I can't read it?

A. Sure. "PCA started" and again it's the constant solution, it would be 1 milligram per cc. He's just talking about how he prepared it with Nurse Matthews in terms of using the 4 ampoules. "Explained" -- it's supposed to be Marcus with the "M", "explained only LS" would be Lisa Shore, "can push button. Two milligram bolus given by nurse." "Query," I don't know what that word says, "given." "The PCA was used by Lisa. Between 12:20 and 12:40 she was awake, in pain,

1 screaming, not sleeping. The ER was told to discharge
2 patient only if pain score was less than 5 and well
3 after PCA started."

4 After 1:00, a.m. Marcus got called that
5 Lisa Shore was in pain and screaming, and that's when
6 he gave them permission to transfer her to the floor.
7 The next call was from ward saying "resps decreased to
8 10, arouseable, told to stop PCA, check SAT and inform
9 if low. Asked if should come, said no need for it.
10 Call at 4:00."

11 Q. Is that -- does that note "call at 4:00"
12 refer to the next call from the ward?

13 A. No, he's just talking about that call
14 that he's talking about right there was at 4:00, the
15 one I just described.

16 Q. Right. That's what I was getting at.
17 Okay.

18 A. Yeah.

19 Q. And then there's a line, can you read me
20 the next part?

21 A. Yes. These are the PCA settings, so
22 again, "PCA 1 milligram per cc, mixed in 50 cc's" which
23 is the normal, and he's just going through the
24 settings, so the bolus dose was 1.5 milligrams every

1 six minutes for a maximum of 20 milligrams in two
2 hours. Okay, "Anti-reflux was flushed. Infusion, out
3 of sight of Y connector," so it was just that connector
4 I was telling you about from the patient's normal
5 saline line to the PCA pump, and then we were just
6 trying to figure out how many cc's were left in the
7 pump if she had used 10.5 milligrams, and basically
8 there was, I think, 36 cc's left in it, so that would
9 be appropriate, 3 cc's for the flush, plus the 10.5 for
10 the -- what she had used.

11 Q. So you ---

12 A. Just making sure the pump hadn't given
13 her too much medicine.

14 Q. Right. And I gather you were here and
15 you heard that the last time she received any was at
16 1:08 ---

17 A. That's correct, yes.

18 Q. --- and some seconds.

19 A. Mm-hmm.

20 Q. It's been summarized, got seven doses?

21 A. Yeah, seven doses, 37 demands for a
22 total of 10.5 milligrams.

23 Q. Right.

24 A. And then ---

1 Q. I can't read it.

2 A. I think it -- I don't know if it says
3 7:10 or -- I don't know, but anyways it says "at 6:10
4 patient asleep, vital signs normal, found dead at
5 7:20."

6 Q. And over here, 4 milligrams -- what's
7 that?

8 A. Four milligrams, 100 mikes** (Sharon?)
9 -- oh, we were just working out basically how many
10 mikes** per kilogram she would have gotten with the
11 10.5, and it was in ---

12 MR. HAWKINS: Sorry, just if I can ---

13 THE DEPONENT: Sorry.

14 MR. HAWKINS: --- assist there, we're cut
15 off at the left-hand end or the bottom end of
16 that page, and on a better copy it is 5:10
17 and 6:10.

18 THE DEPONENT: Oh, 5:10, okay. Thank you.

19

20 BY MS. BROWNE:

21 Q. And the vital signs "normal" and that's
22 at 6:10, do you think?

23 A. 5:10 and 6:10.

24 Q. So it's indicating vital signs were

1 apparently taken at 5:10 and 6:10?

2 A. Yeah, and that's what Dr. Schily is
3 saying, he thought by looking at them, that they were
4 normal.

5 Q. Do you know where the information came
6 that the vital signs were ---

7 A. I think -- I'm not sure. I'm just
8 surmising now, I would assume that Marcus went up to 5A
9 and what he would have done is probably looked at her
10 flow sheet because he had pretty precise detail in
11 terms that she had only pressed it seven goods,
12 30-however many demands, so that's what I'm assuming,
13 he had gone up to -- I'm not sure.

14 Q. He didn't say, and he ---

15 A. He didn't say.

16 Q. He didn't say?

17 A. No.

18 Q. Did anybody at this meeting try to
19 contact the ward and talk to the nurses who had been on
20 there?

21 A. My understanding was that Marcus had
22 been up there, Dr. Huang had been involved. I know
23 that Dr. Desparmet and Lori Palozzi went up to speak
24 with Mrs. Shore, I think some time after 10:00, I can't

1 remember, but I had to go and do pain rounds and see
2 other patients so I know I didn't go up.

3 Q. I wonder if I could ask Constable
4 Culleton to put up the flow chart? That's, I think,
5 Exhibit 8, am I right? Just have a look at this Ms.
6 Stinson, you're indicating that the vital signs were
7 reading as normal at 5:10 and at 6:10. Can you
8 indicate where that's recorded on the flow chart?

9 A. I'm assuming it refers -- oh, okay, I'm
10 assuming it refers to here, it says "5:00" here and
11 then "6:10," it looks like, so 6:00 there.

12 Q. And what's checked at that time, at
13 5:10?

14 A. Temperature, heart rate and resp rate --
15 respirations.

16 Q. Is that your understanding that vital
17 signs be checked?

18 A. Is that my understanding?

19 Q. Was that your understanding of what Dr.
20 Schily wished to be checked?

21 A. I'm not sure what he wished to be
22 checked at that point in time. All I know is he was
23 referring to those two times as the vital signs being
24 normal.

1 Q. No blood pressure apparently was taken
2 then?

3 A. No blood pressure.

4 Q. And, at 6:10, no change at all?

5 A. No, basically the only difference is the
6 resp rate is 14 instead of 16, and no temperature was
7 taken.

8 Q. And it's recorded on the chart that on
9 both of those occasions she appeared to be asleep? She
10 was asleep?

11 a. I'm sorry, over here it says "asleep,
12 asleep."

13 Q. So that I would assume that if she was
14 asleep, that she wasn't -- nobody checked to see if she
15 was raisable, am I right or wrong?

16 A. I don't think you can assume that from
17 there. You'd have to ask the nurses. If it was in a
18 column that said "sedation score" and that that said
19 sleep there, I would assume that meant that it was
20 normal sleep and that she was arouseable.

21 Q. And that would be, as I've sort of
22 picked up along the way, that would be marked by an
23 "S"?

24 A. Exactly.

1 Q. Right?

2 A. Yeah.

3 Q. All right, those are my questions, Ms.
4 Stinson, I'm sure there'll be others.

5 THE CORONER: Mr. Krkachovski.

6 MR. KRKACHOVSKI: Yes, Mr. Coroner.

7

8 RE-EXAMINATION BY MR. KRKACHOVSKI:

9 Q. Ms. Stinson, the temperature reading at
10 4:20 or 5:10, just a point of clarification, because
11 the reading straddles the line between those two times.
12 Can you help us at all in terms of when that
13 temperature was taken?

14 A. Yeah, I think I you're referring to
15 right here. I would take from this that it was taken
16 at --- whether that's 5:00 or 5:10, and the "PO" just
17 above it is to say that is was taken per os or by
18 mouth.

19 Q. All right, so we can read that, at least
20 from your interpretation, is having been taken at 5:10
21 or ---

22 A. Yeah, 5:10.

23 Q. --- 5:00, whatever that is?

24 A. Yeah.

1 Q. Okay. And then with respect to the
2 meeting that took place shortly before 8:00, do you
3 have a memory of the chart being looked at during the
4 course of your discussion?

5 A. We had no access to the chart.

6 Q. And when you say you "had no access,"
7 was it restricted or just no one bothered to get it?

8 A. No, it was because they were still --
9 this was during the arrest, you know, just after the
10 arrest upstairs, so people were using the chart to make
11 notes, to put in the arrest record, things like that,
12 so it wasn't appropriate at the time for us to go up
13 there. We were having it in our office which is three
14 floors down.

15 Q. I just want to be clear. Do you have a
16 recollection of Dr. Schily at some point checking the
17 chart in order to make the comments that the vital
18 signs were normal at 5:00 and 6:00?

19 A. I can't recall, it's a year and a half
20 ago, but to the best of my recollection, he must have
21 seen the flow sheet because he could tell us what --
22 that her vital signs were normal, how many demands she
23 had used, how much morphine she had used. He knew it
24 was 10.5, so I'm assuming the only way he could have

1 known that is if he had either talked to someone or
2 went to the floor.

3 Q. Now, did he express any concerns or make
4 any comments about the level of monitoring that was
5 being carried out through the night; that is, what was
6 being done according to the flow sheet versus what he
7 had ordered?

8 A. No, my only recollection to the -- in
9 reference to the monitoring was that he had ordered
10 them, that he had ordered both of them and I think it
11 was his assumption that they were on her.

12 Q. I'm sorry, I used a bad word. When I'm
13 talking about monitoring, I'm talking more globally
14 than equipment; I'm talking about vital signs,
15 everything, not just a pulse oximeter and a Corometric
16 monitor. Did he express any concern or did he make any
17 comment about the fact that seemingly the orders were
18 not being carried out, let me put it that way?

19 A. No, he did not make any comments with
20 respect to that.

21 Q. Were you involved in a subsequent
22 meeting with Dr. Schily in attendance where Dr. --
23 first of all, let me stop the question there. Was
24 there such a meeting afterward?

1 A. I was involved in a couple other
2 meetings, but they were at the departmental level in
3 the Department of Anaesthesia where we sat down and
4 reviewed all our PCA policies, dosing guidelines with
5 respect to this case and monitoring.

6 Q. Are there notes arising from those
7 meetings?

8 A. I think Dr. Roy has notes from that
9 meeting; he's the Chief of the department.

10 Q. Can we get those notes, Mr. Coroner?

11 THE CORONER: Dr. Roy is going to be
12 testifying and, yes, it would be useful if we
13 had the notes, if there were any meetings
14 with regard to policies that were arising
15 from this that Dr. Roy is aware of. We
16 should have those notes in advance of Dr.
17 Roy's testimony.

18 MR. HAWKINS: I can ask Dr. Roy.

19 THE DEPONENT: And I think a lot of the
20 suggestions that came from that meeting are
21 already in this sheet of recommendations that
22 were passed out in terms of the dosing
23 guideline, identifying children at high risk,
24 getting admitting privileges, those types of

1 things.

2

3 BY MR. KRKACHOVSKI:

4 Q. And just so that I'm clear, was Dr. Roy
5 designated to be keeping notes of those meetings or
6 could someone else in addition to Dr. Roy have kept
7 notes?

8 A. I think Dr. Roy had taken notes and the
9 secretary could type them up. I don't -- I was not
10 taking notes and I wasn't aware that other people were.

11 Q. And can you help us at all in terms of
12 when these meetings took place, approximately?

13 A. I have to say, I think some time in
14 January, I can't -- either in November, or December or
15 January, I guess. I can't remember. It would be
16 dated, I would assume.

17 Q. Your recollection is there were two?

18 A. I think there were two meetings, yeah.

19 Q. Okay. Do you recall it being said at
20 either of these meetings that Dr. Schily's orders, for
21 some reason, were not followed during that night?

22 A. I can't remember. I can't honestly
23 remember. I could be guessing and I don't think it's
24 good.

1 Q. Do you recall any mention being made of
2 a Corometric monitor?

3 A. I know there was some mention, obviously
4 Dr. Schily said that he had ordered those, too, and I
5 know there was some mention of confusion about whether
6 there was a monitor on her or not.

7 Q. Anything more than that?

8 A. That's all I can recall.

9 Q. And, I'm sorry, what was the purpose of
10 these two meetings?

11 A. The purpose of these two meetings is
12 whenever anyone, whenever there's a risk to a patient
13 or a patient dies, the department has rounds to sort of
14 go over the case, sort of identify any areas that maybe
15 need to change and come up with some potential
16 recommendations.

17 Q. Quite apart, then, from Dr. Roy's notes,
18 did these meetings give rise to a report or written
19 recommendations that went somewhere?

20 A. The recommendations in the letter have
21 come here. So in terms of dosing guidelines, we've
22 changed our hand-outs that we give out to Fellows, so
23 we've incorporated those suggestions into our education
24 and teaching of the Fellows.

1 Q. But ---

2 A. Other than that, no.

3 Q. I'm sorry, I didn't mean to cut you off.

4 A. Okay.

5 Q. What we have in our documentation, were
6 those the recommendations arising from these two
7 meetings or was there something else that the meetings
8 generated which then gave rise to the document that we
9 have? In other words, are we missing another document
10 that we should be looking for?

11 A. No. No. I understand those are the ---

12 Q. So we'd just be looking at Dr. Roy's
13 notes?

14 A. Exactly; it's the only ones I'm aware
15 of.

16 Q. Do you recall whether either Dr. Wright
17 or Dr. Lobo was present during either of these
18 meetings?

19 A. No. It was the Department of
20 Anaesthesia.

21 Q. And I'm sorry if I asked you this
22 already, but were there any meetings that you know of
23 where Dr. Schily was in attendance that you were not in
24 attendance?

1 A. I don't -- I'm not aware.

2 Q. All right. And, similarly, were there
3 meetings taking place within the hospital that you know
4 of to discuss what happened with Lisa's care at which
5 you may not have been present?

6 A. There may have been; I don't think so.

7 Q. For example, was there a type of meeting
8 to try and investigate what went wrong in the same way
9 that we're trying to do here?

10 A. It was the meeting that I had just spoke
11 to you about, the one right after her death, and then I
12 think the two subsequent to that; one in, sort of,
13 November and one, I think again in January.

14 Q. All right. You don't know of any
15 others?

16 A. I don't know of any others.

17 Q. Thank you.

18 THE CORONER: Ms. Posno.

19

20 RE-EXAMINATION BY MS. POSNO:

21 Q. Thank you. I have just a few questions
22 for you, Nurse Stinson. If I understood your evidence
23 correctly, at the meeting in your office the morning of
24 Lisa's death, Dr. Schily made a number of comments that

1 are recorded on this handwritten page and these notes
2 were written by Dr. Desparmet at that meeting?

3 A. That's correct.

4 Q. And based on your recollection now, do
5 these notes accurately describe what was discussed at
6 that meeting in particular by Dr. Schily?

7 A. They do.

8 Q. And you've indicated that Dr. Schily had
9 a significant number of details and particulars
10 regarding the PCA pump in terms of dosage, number of
11 demands, number of good demands and medication
12 received.

13 A. Mm-hmm.

14 Q. Can you get that information by
15 reviewing the pump itself and taking a history from the
16 pump?

17 A. Yes, you can.

18 Q. So you don't need to look at the flow
19 chart to get that information, you can get that
20 directly from the pump?

21 A. That's correct.

22 Q. And at that meeting, did Dr. Schily make
23 any reference that he specifically reviewed the flow
24 sheet?

1 A. I can't -- I can't recall.

2 Q. You can't talk to that?

3 A. No, I can't.

4 Q. Okay. And there was nothing mentioned
5 at that meeting regarding a 2:50 page that may or may
6 not have been made?

7 A. No.

8 Q. Nothing at all. And there was nothing
9 said at that meeting regarding a concern that perhaps
10 orders had not been followed the way that Dr. Schily
11 had written them or input them into the system?

12 A. No, there wasn't.

13 Q. When you were describing or reading
14 these notes, on the bottom of the page on the right,
15 which I understand is the first page, and then the
16 left-hand side is the second page, you read that bottom
17 line "next call from ward, breaths decreased as
18 respiration rate decreased to 10."

19 A. Mm-hmm.

20 Q. You were at that meeting; is that what
21 was said, because it's difficult to interpret that?

22 A. Yeah.

23 Q. Is that what was said at the meeting?

24 A. Yeah. Yeah, he said he basically got a

1 call other than one from emerg and that at that point
2 her resp rate was 10.

3 Q. Was 10, okay. So we can interpret that
4 arrow, that that's what that means?

5 A. The arrow means down.

6 Q. Okay, down to 10?

7 A. Decreased to 10.

8 Q. Okay. Now, we have, as well, a single
9 page here and I don't think the jury has this document
10 yet, which is unfortunate, but -- is there any extra
11 one that the jury may have access to while we're doing
12 this discussion, because we're talking about
13 particulars on a sheet they don't have?

14 MR. GOMBERG: These are the page times, I
15 think.

16 MS. POSNO: Actually, you know what ---

17 THE DEPONENT: They can have mine.

18 MS. POSNO: --- they can have mine, I've got
19 one in my Pain Service chart.

20 THE CORONER: Fine.

21 MS. POSNO: If I may approach the jury?

22 THE CORONER: Certainly, Ms. Posno.

23 MS. POSNO: Thank you. Just for -- you
24 know, we were speaking a minute ago, this is

1 the handwritten sheet of Dr. Desparmet, made
2 at the meeting, and it starts on this side
3 and you read it down there, and then you go
4 to this side and read it there, and what I
5 was just speaking of in terms of interpreting
6 "respirations decreased to 10" was this
7 little mark here that says "resp" and there's
8 an arrow down and then it says "10," okay, so
9 you can have this. And now I'm going to be
10 speaking of this sheet which apparently --
11 I'll confirm again with the witness, that is
12 what was recorded on the pager.

13

14 BY MS. POSNO:

15 Q. So looking at the one page which
16 indicates the history of the pagings received by Dr.
17 Schily, we have a reference, as you've indicated, to
18 4:06 and 7:52, and those are the pages Dr. Schily's
19 hand-held page machine records as historically having
20 been received by him.

21 A. Mm-hmm.

22 Q. After that was erased, we don't know
23 when it was erased, is from your comment?

24 A. That's correct.

1 Q. Okay. Now, given that -- assuming Dr.
2 Schily erased historical pages, as you've indicated you
3 do and it's not uncommon to do when he either got home,
4 or went to sleep or at some point. There's no
5 suggestion on this sheet that a page was received by
6 his pager at 2:50?

7 A. No. The only two pages were the two
8 that are documented here.

9 Q. Okay. And at that time, no one even
10 raised as a concern that perhaps a page had been
11 missed?

12 A. No, because we didn't know that there
13 was another page.

14 Q. Right. And that's because, one, it's
15 not indicated on the history of the pager?

16 A. That's correct.

17 Q. And second, no -- nobody who was on the
18 floor that night had indicated that they had -- by this
19 time, that there was a concern that a page was made at
20 that time and never went through or ---

21 A. We hadn't ---

22 Q. --- was received?

23 A. We hadn't talked to any members of the
24 nursing staff on the floor, so we were not aware.

1 Marcus told of the calls that he received in Emergency
2 Department and these were the only two calls that were
3 on his pager.

4 Q. So when this document was made, it was
5 just made as a matter of historical reference keeping?

6 A. Mm-hmm.

7 Q. It wasn't made for the purposes of
8 illustrating whether a page was missed or not?

9 A. No.

10 Q. Okay.

11 A. Not to my knowledge.

12 Q. Just one last line of questioning here,
13 Nurse Stinson. When you had indicated to Mr. Hawkins
14 this snowball effect of errors that resulted in the
15 tragedy of Lisa's death, you made a comment about the
16 Kidcom system and that you did not know as of that
17 time, so October of '98, that the orders input in
18 emergency remained as suspended orders. You didn't
19 know that at that time?

20 A. No, because our department never
21 admitted patients from emerg, so we received no
22 training on that. We're a consult service, we only see
23 patients once they're in the hospital, we've never been
24 responsible for admitting patients.

1 Q. Okay. So you certainly received
2 training to use the Kidcom system?

3 A. Exactly, yeah.

4 Q. And all patients in the hospital had
5 orders only put on the Kidcom system ---

6 A. Except for emerg.

7 Q. --- except for the in-patient ---

8 A. That's correct.

9 Q. --- only had their orders on Kidcom? So
10 you knew how to use the system that way?

11 A. Mm-hmm.

12 Q. But you weren't familiar with the fact
13 that when the orders were input in the Emergency
14 Department, they remained as suspended until they were
15 activated on the ward?

16 A. No, I had no knowledge of that.

17 Q. And you've explained that the reason you
18 didn't know that at the time is because the Department
19 of Anaesthesia did not admit patients directly from
20 emergency as in-patients to a ward?

21 A. That's correct.

22 Q. And that would include Dr. Schily, as
23 well, I take it?

24 A. Yeah, it would include him.

1 Q. And I've have a bit of an explanation
2 here with respect to the phone call, that is a
3 procedure of the hospital in terms of the Kidcom system
4 as one of the check points or a safe mechanism that a
5 physician would call from emerg to advise the ward, by
6 the way, we've got a child arriving and they have
7 Kidcom orders. Now you may or may not be able to
8 assist me with this because it sounds to me your
9 department wasn't directly involved in the practice of
10 admitting patients from emerg, but bear with me if you
11 can.

12 A. Mm-hmm.

13 Q. I had understood from speaking with a
14 number of physicians now that that was put into
15 practice initially, when the Kidcom system was new and
16 people were just learning the system and not every
17 patient was necessarily on Kidcom orders, it was the
18 procedure and it was generally followed that physicians
19 would call from the emerg to advise the ward that a
20 child is being admitted and they have Kidcom orders.
21 Can you confirm for me that that was the procedure when
22 the Kidcom system was first implemented?

23 A. I don't have any knowledge of that
24 because I don't have admitting privileges and that

1 wasn't taught to me.

2 Q. Okay. I'll just ask you my next
3 question, as well, because it follows from there, but
4 from the sounds of it you might be able to help me. I
5 understand that by 1998, Kidcom had been in place for
6 six or seven years by that time and every child who was
7 an in-patient on a ward at Sick Kids would have Kidcom
8 orders, those are the only place the orders arrived, or
9 only place where orders exist, and that the practice
10 had developed by that time that because every child who
11 comes from the Emergency Department and is admitted to
12 a ward would have Kidcom orders, that it was no longer
13 a general practice that physicians would call up in
14 each and every case, it just didn't happen any more
15 because it was unnecessary. Can you -- I've been
16 advised that, can you confirm from your knowledge?

17 A. I know from just speaking with nurses
18 that it does not happen routinely in terms of
19 physicians calling any more. I know from our service
20 that we --- when we make changes on a daily basis we
21 always communicate with the nurses what those changes
22 are.

23 Q. And that's the red flag system so they
24 know when an order has been changed or added to ---

1 A. Exactly. So whenever we put orders into
2 the computer, we always go and speak to the nurse and
3 say these are the changes we've made, this is the
4 patient you're getting, so to communicate to them a
5 little bit about the patient.

6 Q. So in terms of a check point or a fail-
7 safe mechanism where physicians to call from emerg up
8 to the ward, your understanding is in general that
9 doesn't happen, and I wonder if you can assist the jury
10 in whether or not that's any kind of effective approach
11 to this. Now maybe given your involvement in this,
12 it's not within your field, but if that's anything that
13 the nurses could, and all be relying upon, whether Sick
14 Kids should consider a different type of fail-check
15 point system on that?

16 A. From my understanding from the
17 presentation by the Kidcom, it still is a mechanism
18 that's in place, it's just not being used, and I think
19 that whenever there's a patient being admitted, if
20 they're sort of out of the ordinary, it would be
21 reasonable to expect a telephone call to inform the
22 nurses a little bit about that patient. Now whether
23 happens from a physician or the nurse caring for that
24 patient in emerg, I think that's part of the

1 communication process.

2 Q. Right. And I think we heard from Nurse
3 Matthews that she definitely did speak with the ward
4 nurse and gave the ward nurse an update on Lisa's
5 arrival and her condition at that time. Were you here
6 for that testimony?

7 A. Yes, I was. I heard that.

8 Q. And that did happen in this case?

9 A. Mm-hmm.

10 Q. Those are my questions. Thank you,
11 Nurse Stinson.

12 MR. GOMBERG: Mr. Coroner, I have probably
13 ten minutes of questions and I have an urgent
14 need to use the facilities; would it be
15 appropriate to take a break now, please?

16 THE CORONER: I'll give you a 20 minute
17 break, that should suffice.

18

19 --- A BRIEF RECESS

20

21 THE CORONER: Mr. Gomberg.

22 MR. GOMBERG: Thank you, Mr. Coroner.

23

24 RE-EXAMINATION BY MR. GOMBERG:

1 Q. Nurse Stinson, I want to ask you about
2 this meeting. I can't remember what time you said it
3 was, around 9:00 or quarter to 9:00, or something like
4 that?

5 A. Mm-hmm.

6 Q. Is that right?

7 A. That's correct.

8 Q. All right. And the people at the
9 meeting, if I got your evidence right, were Dr.
10 Desparmet, Ms. Palozzi -- Nurse Palozzi, you, Dr.
11 Schily and Dr. Huang?

12 A. That's correct.

13 Q. Anyone else?

14 A. No.

15 Q. Do you know whether Lori Palozzi made
16 any notes about what happened at that meeting?

17 A. No, she didn't. Joelle was the only --
18 Dr. Desparmet.

19 Q. Was the only person who made notes?

20 A. Yeah.

21 Q. All right. Now I take it that that
22 meeting was to discuss, at least in general terms, what
23 had happened?

24 A. That's correct.

1 Q. Was any consideration given to asking
2 Nurses Doerksen and Soriano to attend the meeting?

3 A. No, and I don't think that would have
4 been appropriate. They were still upstairs, they had
5 to write their notes, it was just after Lisa had died.

6 I'm sure, as we've heard, that they were already
7 distressed, so this was just a debriefing of the people
8 in the Department of Anaesthesia that work on the Pain
9 Service.

10 Q. All right. Now are you aware of the
11 fact that the family found out about that meeting for
12 the first time this morning?

13 A. No, I was not aware of that.

14 Q. All right, and certainly these notes
15 that were made by Dr. Desparmet have been available for
16 the better part of 14 or 15 months? You've had them?

17 A. These notes were in a file that we keep
18 in our office and when I met with Patrick Hawkins,
19 that's when I was asked ---

20 Q. Well, I don't want to get into the
21 discussions between you and Mr. Hawkins, but are you
22 aware of the fact that the family first saw these notes
23 last week?

24 A. No, I was not aware of that.

1 Q. Now, in terms of the -- in terms of the
2 meeting, Dr. Schily was there.

3 A. Mm-hmm.

4 Q. Did Dr. Schily, was he specifically
5 asked about the orders that he had made?

6 A. They are standard order sets, so the
7 only reference he made to the order set were the dosing
8 and that he had ordered apnea and O2 saturation monitor
9 for Lisa.

10 Q. Well, I just want to stop you on that
11 for a minute. Dr. Schily specifically said at the
12 meeting with these four other people present, that's
13 Dr. Desparmet, Lori Palozzi, you, and Dr. Huang that
14 he'd made orders in the Emergency Department. Forget
15 about what they are for a minute, he specifically said
16 he made orders, right?

17 A. He said he entered orders. I don't
18 remember if he said in the Emergency Department or
19 where, he said he had made orders, that's it.

20 Q. He said he entered orders?

21 A. That's correct.

22 Q. All right. Well did anybody ask him
23 where he'd entered the orders?

24 A. I don't recall.

1 Q. Did anybody ask him specifically what
2 those orders were?

3 A. The only thing that we discussed, as I
4 said again, were the PCA settings which are documented
5 here, and the only thing else I remember him saying was
6 the apnea monitor and the O2 SAT monitor is what he had
7 ordered.

8 Q. Well did anybody take it upon
9 themselves, either himself or herself, to make
10 inquiries during that meeting to find out whether or
11 not those orders had been complied with?

12 A. We assumed they had.

13 Q. All right. So the assumption, not only
14 made by Dr. Schily, but by Dr. Huang, you, Nurse
15 Palozzi and Dr. Desparmet was that the orders that were
16 made by Dr. Schily, wherever they were made, had been
17 activated and had been complied with?

18 A. Correct.

19 Q. All right. And that since at least the
20 Corometric monitor is a standard -- I can't remember
21 what you called it, but is standard for somebody who's
22 on a PCA, certainly the assumption was that the
23 Corometric monitor, regardless of whether it had
24 formally been ordered or not, had been applied?

1 A. The Corometric monitor and the 02 SAT
2 monitor are at the discretion of the physician, so it
3 would be up to Dr. Schily to decide whether he wanted
4 to order those for the patient or not. There was no
5 set protocol at that time; however, most people -- most
6 of the Fellows in the department and myself and the
7 other nurse practitioners would generally put an 02 SAT
8 monitor on the kids on a PCA.

9 Q. Well for the minute I'm not talking
10 about the 02 SAT, I'm talking about the Corometric;
11 wasn't that part of the nursing procedure manual at the
12 time?

13 A. It says "at the discretion of the
14 physician," if I recall correctly, I don't have it in
15 front of me, but ...

16 Q. Now in terms of Dr. Schily and whether
17 or not he saw the flow sheet, we're talking about the
18 flow sheet that's in back of you now.

19 A. Yes.

20 Q. I'm not sure whether you were entirely
21 clear on this, but I take it that you would defer to
22 Dr. Schily, if he swears under oath that he never saw
23 that flow sheet that night and only saw it when it was
24 provided to him from the Coroner's office, you would

1 agree that he probably knows better about that than you
2 do?

3 A. That's correct.

4 Q. Now in terms of the page at 2:50, I take
5 it that you'd agree with me that when you had that
6 meeting that morning, whether or not there was a page
7 at 2:50 hadn't become the major issue that it is now?

8 A. That's correct, it was not discussed.

9 Q. Well it wasn't discussed and it wasn't
10 -- as I said, I don't know that I can put it better, it
11 wasn't a major issue as to whether or not there was a
12 page at 2:50 or there wasn't a page at 2:50?

13 A. That's correct.

14 Q. All right. And I suppose that you'd
15 agree with me that at least at that point when Dr.
16 Schily went and looked at his pager, he had no reason
17 to be anything other than truthful; namely, to refer to
18 the recordings of whatever times were on that pager
19 including 2:50, if there was one?

20 A. That's correct.

21 Q. Now were the words "Kidcom" used in that
22 meeting?

23 A. To the best of my recollection, I cannot
24 recall. I know orders were entered and most orders are

1 put in Kidcom, so ...

2 Q. All right. And, I take it, implicit in
3 that answer, you can't specifically say -- you can
4 probably say that you didn't raise the issue of Kidcom,
5 but you can't ---

6 A. I didn't raise it.

7 Q. You didn't raise it, because that you'd
8 remember?

9 A. That's correct.

10 Q. But in fairness to you, you can't
11 remember whether any of the other four people at the
12 meeting raised the term "Kidcom"?

13 A. No.

14 Q. When did you personally first become
15 aware of those Kidcom orders?

16 A. Personally aware that they were entered?

17 Q. Yes. First of all, that they were
18 entered.

19 A. Well, I assumed from discussion with Dr.
20 Schily that he had entered orders on her, so that would
21 have been at our meeting.

22 Q. All right. Just to be clear on this,
23 now, because I don't think this has come up before, you
24 were on, let's say, alert, or at least you were alerted

1 of the probability that there were Kidcom orders
2 entered the morning of October 22nd?

3 A. Correct.

4 Q. Right. Can you talk about whether or
5 not the other people at that meeting would have been on
6 alert that there were Kidcom orders entered ---

7 A. Well, I don't think ---

8 Q. --- at that meeting?

9 A. Sorry, I cut you off, but I don't think
10 "alert" would be the word I would use. Most patients
11 have Kidcom order sets, so I don't think it would be
12 something we would be thinking about.

13 Q. All right. Well, just to be clear, to
14 get back to the answer that you gave with regard to
15 your consideration of the probability that there were
16 Kidcom orders made by Dr. Schily, what, if any
17 consideration did you give on October 22nd to going
18 into the computer either yourself or through somebody
19 else to try and see whether there were those Kidcom
20 orders entered?

21 A. It was not an issue of Kidcom orders at
22 that point in time. We assumed that the orders had
23 been entered and that they were followed, so it was not
24 an issue at this meeting; it wasn't discussed.

1 Q. All right. And when did it become an
2 issue, if at all?

3 A. The first I was aware it became an issue
4 was some time in January.

5 Q. So your evidence is that from October
6 22nd until January, I don't think the date in January
7 matters that much, the assumption, at least on your
8 part was ---

9 A. On my part.

10 Q. --- I'm only talking about you because
11 it's a sensitive issue.

12 A. Yes.

13 Q. The assumption on your part was that
14 Kidcom orders had been made and that those Kidcom
15 orders had been followed?

16 A. And that they had been in the chart.

17 Q. And that they had been in the chart?

18 A. Mm-hmm.

19 Q. All right. And when you found out in
20 January, whenever it was, that those Kidcom orders had
21 been made, had been in a suspended mode, were not in
22 the chart, you were surprised?

23 A. That's correct.

24 Q. Because that's not the way it's supposed

1 to be?

2 A. I had no idea that the Kidcom order sets
3 are suspended in the Emergency Department.

4 Q. Now, when you found out about that in
5 January, was there any discussion with Dr. Desparmet,
6 or with Nurse Palozzi or with Dr. Huang about that,
7 about the fact that they may have been labouring under
8 the same misapprehension?

9 A. No, because Dr. Desparmet had gone back
10 already to Montreal, and Dr. Huang had left the
11 department, he was only there for a three or six-month
12 rotation.

13 Q. All right. Well at least as far as
14 Dr. Desparmet is concerned and I don't mean to be mean
15 about this, she could have been phoned, right? I mean,
16 this was a pretty surprising thing, wasn't it?

17 A. Phoned regarding that the Kidcom orders
18 had ---

19 Q. Regarding that she, presumably, was
20 labouring under the -- she can speak for herself, I
21 guess, but she must have been labouring under the same
22 misapprehension that you apparently were labouring
23 under and that is that the Kidcom orders had been made,
24 had been entered, had been activated and had been

1 followed?

2 A. I can't speak to what Dr. Desparmet may
3 think. I know I did not communicate that information
4 to her.

5 Q. All right. Now, the only other question
6 I have and it's sort of a common sense type question is
7 this: Is there any reason, and you may be the wrong
8 person to ask this question of, it may be a computer
9 question, but is there any reason why if Kidcom orders
10 are made, as they were in this case, and aren't
11 activated within a certain time period, that an alarm
12 can't go off, or something can't go off, or a page or
13 something to alert people to the fact that there are
14 Kidcom orders there and that they haven't been
15 activated?

16 A. To my knowledge, there is no such system
17 like that.

18 Q. Right. But to take it to the next step
19 and that is whether that system is practical or
20 practicable or whatever the word is, you don't know?

21 A. No, I'm not the person to ask.

22 Q. The court's indulgence just for a
23 minute, please? Thank you very much, Deputy Chief
24 Coroner, those are my questions.

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THE CORONER: Mr. Hawkins.

RE-EXAMINATION BY MR. HAWKINS:

Q. Just a couple of questions, Ma'am. The pager sheet, is that something that's common, that physicians write down the times from their bellboy?

A. I've not seen it done before.

Q. Have you ever been asked to do that before?

A. No, I've not.

Q. And when Dr. Schily showed you his bellboy, it showed pages at 4:06 and 7:52, and that's all that was on the bellboy?

A. That's correct.

Q. We know from --- well, we know from Dr. Desparmet's note and from other stuff that Dr. Schily was paged after 1:00 a.m. Did that page show up on the bellboy?

A. No, it was not on the bellboy.

Q. And you've been asked about the note that Dr. Desparmet made, and on that note it says "5:10 and 6:10 patient asleep, normal vital signs." Is that your recollection of what was said by Dr. Schily at the meeting?

1 A. That's correct.

2 Q. And while I recognize you don't know
3 whether Dr. Schily had reference to the flow sheet or
4 not, from your knowledge of the records, are Lisa's
5 vital signs at 5:00 and 6:00 recorded anywhere other
6 than the flow sheet?

7 A. The flow sheet is all I've seen, so I
8 don't know if there was another note made by the nurses
9 regarding her vital signs, but that's the only one I
10 know of.

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

13 THE CORONER: Does the jury have any
14 questions that have arisen from this new line
15 of questioning?

16

17 RE-EXAMINATION BY THE JURY:

18 BY JUROR #1:

19 Q. Yes, you said just a moment ago that
20 you've never known a doctor to take his pager in a
21 meeting, or to (inaudible) such as the one you held
22 that day on October 22nd, with the doctors that we were
23 discussing, Desparmet and so on.

24 A. That's correct.

1 Q. How many meetings -- hopefully, you
2 don't attend too many meetings of that nature?

3 A. Not on the Pain Service, I've not been
4 involved ---

5 Q. So it's not a frequent thing then to ---

6 A. That's correct.

7 Q. --- to assess anything that goes on in
8 that meeting as to its likelihood or frequency of
9 occurring, is it?

10 A. Sorry, I'm not sure I understand your
11 question.

12 Q. I'll leave that question. I'll leave
13 that question. You said earlier that sometimes doctors
14 will clear their pager?

15 A. Doctors or anyone else that ---

16 Q. Doctors, caregivers?

17 A. Yeah.

18 Q. Workers in the hospital. Upon leaving
19 or upon going home, they'll clear their pager?

20 A. Or if it reaches a limit. I think, for
21 example my pager, it only holds 12 pages in it and then
22 I have to clear it. It gives me a little ...

23 Q. Okay. So would it be possible, then,
24 that he did what you suggested other workers do, that

1 he cleared his pager when he went home to rest for the
2 night and that pager was then clear until the -- I
3 believe it was a 4:20 page?

4 A. That's correct, that's one possibility.

5 Q. Okay. And another -- could I -- could I
6 clarify something we spoke about before? I'm so sorry,
7 but I'm grappling with this, and we collectively have
8 discussed it since we spoke with you earlier this
9 morning. When a nurse uses clinical judgment, I know
10 some of the areas where she uses it, I know some of the
11 areas where she may contact a doctor, but there are
12 times when a nurse can use clinical judgment
13 arbitrarily without contacting anyone, right?

14 A. That's correct.

15 Q. Without contacting the doctor, without
16 contacting a nursing supervisor, just simply ---

17 A. That's correct.

18 Q. --- with her own judgment?

19 A. Mm-hmm.

20 Q. Thank you very much.

21 THE CORONER: Yes.

22

23 BY JUROR #5:

24 Q. The pager Dr. Schily used, who owns that

1 pager? Whose property is it?

2 A. It's the Department of Anaesthesia's
3 pager, it's a bellboy that is transferred from one
4 Fellow to the next as they rotate through the Pain
5 Service.

6 Q. So you can't give ---

7 A. It's got the same number.

8 Q. Can you get the records of all the pages
9 that went through that morning? No records?

10 A. My understanding is the only record
11 would be the visual display that's on the pager that
12 Dr. Schily showed me, outlining the pages.

13 Q. Thank you.

14 THE CORONER: Yes, please.

15

16 BY JUROR #3:

17 Q. When the nurse was not able to access
18 the Kidcom on that night, so she was working on her
19 clinical judgement for the whole night?

20 A. I'm not sure the nurse wasn't able to
21 access the Kidcom. She can access Kidcom.

22 Q. But then it was not -- it was suspended
23 all the time.

24 A. That's correct.

1 Q. So it was not activated?

2 A. She wasn't aware of the orders being in
3 the computer.

4 Q. Okay, so if she was not aware of the
5 orders, so was she then taking -- giving all her
6 clinical judgment to everything because since she was
7 not -- she was not reading all of the orders?

8 A. That's correct, what -- because these
9 nurses have had these patients with patient controlled
10 analgesia pumps on their ward since we started in 1992,
11 the nurses are familiar with the monitoring guidelines
12 for those patients and the typical type of order sets,
13 and so she would be using her clinical judgment in
14 determining the care for that patient if she wasn't
15 aware of the orders.

16

17 BY JUROR #1:

18 Q. Yes, I wonder if you'd happen to know,
19 Ms. Stinson, if the outgoing calls from the telephone,
20 the Toronto -- the Sick Children's Hospital telephones,
21 if they are monitored? If they are monitored, if
22 they're recorded, if there's any records of every call
23 that leaves the hospital from a hospital telephone? I
24 don't mean a pay phone, but a hospital telephone.

1 A. No, there is not.

2 Q. There is no ---

3 A. But I'm not the one to ask about that,
4 but to my knowledge ---

5 Q. Who would I ask about that?

6 A. I'm not sure, but to my recollection
7 there is no recording of the numbers of outgoing calls.

8 Q. Thank you.

9 THE CORONER: I will check in to some of
10 that. There are many procedures in major
11 institutions where local calls that do not
12 involve any expense will not be recorded, but
13 many institutions, long distance calls will
14 be recorded and it will be the responsibility
15 of those staff to sign off that they were for
16 the purposes of business. We can check into
17 that, but I'm not aware of any major
18 institution that would keep a record of local
19 calls.

20 MR. GOMBERG: You'd have to check with Bell
21 as well, though, just to answer the jury's
22 question. Bell may have that information;
23 the hospital may not.

24 THE CORONER: Any further questions?

1 MS. BROWNE: Yes, I've got some
2 clarification.

3

4 RE-EXAMINATION BY MS. BROWNE:

5 Q. I've been reading over what's been
6 marked, I think it's Exhibit 31, the last one -- is
7 that 32?

8 A. The one I have ---

9 Q. Is that 32, exhibit? I just want to
10 make sure I've got the right one.

11 A. 32, yeah.

12 Q. I just want to clarify a couple of dates
13 on that.

14 A. Sure.

15 Q. This is on October the 22nd, that's
16 shortly after the call, the code call, right?

17 A. That's correct.

18 Q. Dr. Desparmet -- can I ask how that's
19 spelled, I have no idea?

20 A. D-E-S-P-A-R-M-E-T.

21 Q. Thank you. She was recording what was
22 going on in this discussion?

23 A. Yes, just generally recording the
24 discussion.

1 Q. At the bottom of what I believe is page
2 1 and the top of page 2, he records that there was a
3 call from the ward. At the top of the second page, it
4 says it was about 4:00, right?

5 A. Mm-hmm.

6 Q. And it indicated that the respiration
7 was going down below 10 or 10?

8 A. Resps decreased to 10, is how I would
9 take it.

10 Q. To 10. But you don't know whether it's
11 to 10 or below 10?

12 A. I don't remember the exact wording, but
13 my assumption was it was 10.

14 Q. And what Dr. Schily said was that he
15 told them she was arouseable, this was told also in
16 this call?

17 A. Yes. He told us that she was
18 arouseable.

19 Q. And he told them, to whoever made this
20 call, to stop the pump?

21 A. Yeah.

22 Q. To check the saturation rate, is that
23 right?

24 A. "Check SAT" which would be ---

1 Q. Saturation?

2 A. Correct.

3 Q. And what's the next one?

4 A. "And inform if low."

5 Q. So check saturation and inform if low,
6 and he asked if he should come, and they said no need
7 for that?

8 A. That's correct.

9 Q. Did he have any recollection as to what
10 he was told about any saturation rate or whether indeed
11 it was checked?

12 A. No.

13 Q. He just said these were my instructions
14 at four?

15 A. This is what he has said to the nurse at
16 4:00.

17 Q. And he assumed that whatever he said was
18 done?

19 A. That's correct, that her resp went down
20 to 10 and that she was arouseable is all he had said.

21 Q. All right, thank you.

22 THE CORONER: Any further questions of the
23 witness? Thank you, Nurse Stinson.

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a true and accurate transcription of my
recording and notes, to the best of
my skill and ability.

Barbara A. Pollard
Certified Court Reporter

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