

INQUEST INTO THE DEATH OF

L I S A   S H O R E

THE EVIDENCE OF DR. ROBIN WILLIAMS

TAKEN FEBRUARY 4, 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<br>Sick Children, et al | PATRICK HAWKINS, ESQ.<br>RENEE A. KOPP, MS. |
| Counsel for Dr. M. Schily and<br>Dr. M. Catre        | ANNE POSNO, MS.                             |
| Counsel for Corometric                               | VAN KRKACHOVSKI, ESQ.                       |

REPORTING PLUS  
(905) 477-0126

1 MS. BROWNE: The next witness is Dr.  
2 Williams.

3  
4 DR. ROBIN WILLIAMS, SWORN

5 EXAMINATION IN-CHIEF BY MS. BROWNE:

6 Q. Dr. Williams, I have a number of copies  
7 of several items, the first being your curriculum  
8 vitae. May I show one to you and have you indicate  
9 this is a correct copy?

10 A. Yes, yes.

11 Q. May that be marked as an exhibit?

12 CONSTABLE CULLETON: Exhibit 58.

13  
14 EXHIBIT NO. 58: C.V. of Dr. Robin Williams

15  
16 BY MS. BROWNE:

17 Q. Also, I have a number of documents  
18 called "Terms of Reference for the Pediatric Review  
19 Committee."

20 A. Yes.

21 Q. Could that be marked as an exhibit,  
22 also?

23 CONSTABLE CULLETON: Exhibit 59.

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EXHIBIT NO. 59: Terms of Reference for the  
Pediatric Review Committee,  
amended November 19, 1996

BY MS. BROWNE:

Q. And finally, Dr. Williams, a report, a  
final report of the Pediatric Review Committee. Is  
that correct?

A. Yes, thank you.

Q. May that be marked as the next exhibit,  
as well?

CONSTABLE CULLETON: Exhibit 60.

THE CORONER: Thank you.

EXHIBIT NO. 60: Pediatric Review Committee  
final report for Lisa Shore

BY MS. BROWNE:

Q. First of all, according to your CV, Dr.  
Williams, your business is in St. Catharines, correct?

A. Yes.

Q. You have a Bachelor of Science awarded  
in 1967 and a Doctor of Medicine awarded in 1970 from U  
of T?

1 A. Yes.

2 Q. You have done six months internship in  
3 paediatrics at Sick Kids?

4 A. Yes.

5 Q. And you have done Sick Kids internship,  
6 general medicine, at Toronto General, right?

7 A. Yes.

8 Q. You have been awarded the Gold Medal in  
9 1973, Public Health?

10 A. That's right, a diploma in Public  
11 Health, mm-hmm.

12 Q. And now you have been in pediatric  
13 residency from 1978 to 1980 at McMaster?

14 A. Yes, including rotations at Sick  
15 Children's in Buffalo, Children's Hospital.

16 Q. And right now, you are the Medical  
17 Officer of Health in Niagara?

18 A. Yes.

19 Q. How long has that been?

20 A. That's been since '95, 1995.

21 Q. You are a member of the Pediatric  
22 Coroner's Review Committee which I'll ask you to  
23 explain in a minute. You have been since 1989?

24 A. That's right.

25 Q. And you are in private practice in

1 consulting in paediatrics?

2 A. Yes, I was from January of '81 to 1995.

3 Q. You have been a past medical consultant,  
4 child abuse, for Family and Children's Services in  
5 Niagara and Child Development Centre?

6 A. That's right.

7 Q. You are now a member of the test  
8 committee in paediatrics at the Royal College of  
9 Physicians and Surgeons of Canada?

10 A. Yes. I've actually just stopped doing  
11 that, so that's still '99.

12 Q. And you are a physician for the  
13 Children's Core Residence ---

14 A. I was.

15 Q. --- in 1993 Chelsea Place? Where is  
16 that?

17 A. That's in Niagara, and that's -- I was.  
18 That was from '82 to '95.

19 Q. Are there any other particular entries  
20 in your CV that makes you particularly qualified to be  
21 on the Pediatric Review Committee that you can point to  
22 us?

23 A. There are some low-level things, like, I  
24 am associate clinical professor in the department of  
25 paediatrics at McMaster, which is quite a low level

1 appointment. I also co-ordinate the academic half-days  
2 for the residency program at McMaster, so I do have a  
3 little bit of an academic tie to the university there.

4 I'm involved in a variety of professional  
5 associations, and they are listed in the CV.

6 Q. All right. And can you just explain to  
7 us a little bit about the Pediatric Review Committee?  
8 We have the terms of reference in front of us. Can you  
9 explain what exactly it is and what it does?

10 A. Certainly. You have a copy of the  
11 terms?

12 Q. They have a copy.

13 A. Okay, wonderful, because that does  
14 explain that this is an advisory committee that advises  
15 to the Chief Coroner's office and it looks at a whole  
16 variety of cases. It first was put in place in 1989  
17 and originally was a core group of medical physicians  
18 and as life unfolded and more children that were in  
19 child welfare kinds of settings, those kinds of cases,  
20 were being referred to the committee, the Coroner's  
21 office decided to expand the committee, so it now  
22 functions in sort of two roles, one, the medically  
23 complex kinds of deaths where sorting out the technical  
24 pieces is important and so that's one of the main  
25 functions.

1                   Another function is to try to figure  
2                   out, looking backwards what happened and looking  
3                   forwards, what can we cause to have happen differently  
4                   that would prevent, you know, what can we learn from  
5                   the deaths that we're investigating, and so quite a bit  
6                   of energy is put into trying to look at how systems  
7                   could be changed.

8                   They're not inquests, because obviously  
9                   that's what you're going to be looking at in this  
10                  situation, but in a number of cases, there are minor  
11                  things that could be improved, changed or altered,  
12                  education that could happen, either broadly or  
13                  specifically to a hospital as a result of something  
14                  we've learned from the case.

15                  So it's a broad- functioning kind of  
16                  committee that gives its advice to the Coroner's  
17                  office. It's made up of a variety of disciplines and  
18                  it's sort of a virtual committee in that there is a  
19                  core group of physicians that meet regularly and they  
20                  are from a variety of backgrounds, a neonatologist, a  
21                  pediatric ICU, a community paediatrician, they come  
22                  from different areas of the province, so they're not  
23                  all downtown Toronto, although we do have, you know, a  
24                  good academic representation from Toronto. Gender,  
25                  we've got some gender variety on it.

1                   When we need advice or technical  
2 information that we're not able to, and obviously we're  
3 not experts in all areas or even many areas, we would  
4 then reach out and get the kind of information that we  
5 need, either by inviting someone to come to the  
6 Committee to help us dialogue, sort out, figure out  
7 what's happened in a particular case or we would seek a  
8 toxicological opinion or a radiology opinion or depending  
9 on what we need.

10                   So it's a core committee that meets  
11 monthly, prepares; one individual on the committee  
12 would do the initial case review, like what I did with  
13 Lisa's story, bring it back to the committee, more  
14 information sorted out, what's needed, go back out to  
15 get the information, come back to the committee and  
16 eventually you end up with a consensus report that is  
17 the general opinion of that committee. And so, for  
18 example, today I would be here speaking on behalf of  
19 the committee as a whole and not as myself, as an  
20 individual.

21                   Q.    How many are on the committee?

22                   A.    The expanded I think is about 10 or 12  
23 and the core committee, I think, is five or six  
24 physicians.

25                   Q.    And how busy is it?

1           A.    I did pull the numbers, and it's between  
2           60 to 80 cases a year that are reviewed.

3           Q.    How long would you -- is there an  
4           average time it would take to review a case? I know it  
5           would differ a bit from case to case, but ...

6           A.    It does. I mean, some are quite  
7           straightforward, it is a paper chart review. Others  
8           are considerably more complex and I think Lisa's is  
9           a good example of a very complex case and it went  
10          back ---

11          Q.    How long?

12          A.    Lisa's was many hours; it went back and  
13          forth to the committee on many occasions as we were  
14          able to get more information, sort out some questions,  
15          identify other questions, so Lisa's would be at the one  
16          end in terms of the amount of time. Others are as  
17          short as one or two hours of preparation time and then  
18          a 20-minute presentation at committee with everyone  
19          agreeing.

20          Q.    And you have produced today your final  
21          report? There have been a number of drafts before this  
22          final one that the jury members have and the Counsel  
23          have.

24          MR. HAWKINS:   Sorry, if I could just ask a  
25          quick question? The report that had been

1 given to us is six pages; the one you have  
2 produced today is seven.

3 MR. GOMBERG: It's the same. I went through  
4 it quickly, it's exactly the same, it's just  
5 printed out with a different font and ---

6 THE WITNESS: I believe there are two other  
7 corrections.

8 MR. GOMBERG: Oh, all right.

9 THE WITNESS: The titling of the committee  
10 at the top was changed because -- to be  
11 consistent with actual name of the committee  
12 and on the previously circulated, it said  
13 "October 20th" and it should have said  
14 "October 21st, 1998," the first paragraph  
15 under "background." And there was a charting  
16 error on one of the vital signs in the  
17 graphing, and that was corrected. The heart  
18 rate at 3:20 was improperly grafted, so there  
19 were three alterations made.

20 MR. HAWKINS: Okay, thank you. Sorry, I  
21 just wanted to clarify that because I  
22 didn't ---

23 THE WITNESS: And I'm sorry for that  
24 confusion.

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BY MS. BROWNE:

Q. We all have a copy now of the final report, Dr. Williams, and perhaps we could just look at the sources reviewed which seem to be extensive. You have 16 listed from registered Coroner's letters, correspondence from the family and lawyer, Hospital for Sick Children's chart, the post-mortem examination, the coroner's report, the ECRI evaluation reports, the inquest brief and that would take in quite a lot of paper, toxicology report from Dr. MacLeod, the post-mortem review of the myocardial slides, a report from Dr. Charles Smith, a Hospital for Sick Children report, November the 10th and letters from Mr. Bauer, Dr. Schily's report, the nurse educator report from Borden & Elliot, that is, the report of Mary Douglas; preliminary testimony that you heard in November. Did you have a transcript or were you ---

A. It was a transcript.

Q. And the Boston Children's Hospital chart with Lisa's background in it. You had a meeting with Mr. Hawkins, was it?

A. Yes.

Q. Of Borden & Elliot?

A. Yes.

1 Q. In December of 1999?

2 A. Yes.

3 Q. And you have a biopsy analysis report,  
4 December the 17th. You also spent a day here. What  
5 day was that?

6 A. It was Monday, this week.

7 Q. And that's the only day you've actually  
8 been here at the inquest?

9 A. That's correct.

10 Q. Now, can you tell us, just through your  
11 report and indicate -- first of all, you have the  
12 background of Lisa and you've got this -- well, the  
13 charts and from the letters from her family and the  
14 correspondence, am I correct?

15 A. Yes.

16 Q. You understood that she had been treated  
17 in Boston's hospital -- Boston's Children's Hospital  
18 and that it was there that the diagnosis of reflex  
19 sympathetic dystrophy came up?

20 A. That's right.

21 Q. Can you just tell us what that is?  
22 We've had it referred to a lot and I think maybe we  
23 need a, sort of, explanation.

24 A. Okay. Could I make just a couple of  
25 comments?

1 Q. Certainly.

2 A. The first being that the initial review  
3 was probably the first five items. Then, as more  
4 information came available, the draft was changed and  
5 altered, so a specific sentence, I would have to trace  
6 back where that source was, because this is a  
7 compilation of the final thinking of the committee.

8 I think it is important to note that  
9 Lisa was originally seen at Sick Children's in  
10 February, shortly after she had had her fractured leg  
11 and had presented at the hospital and had had --  
12 although the original treatment was done at another  
13 hospital, she had some complications with pain and  
14 presented at the Sick Kids Hospital.

15 She was then seen and followed over a  
16 couple or three admissions there with respect to the  
17 pain that she had, and eventually the family took Lisa  
18 to Boston Children's Hospital. The initial review did  
19 not include that chart, but subsequently in the  
20 interests of completeness, we did obtain a copy of that  
21 chart, actually, through Mrs. Shore and it was  
22 reviewed.

23 The overall focus, I think, of our  
24 review really concentrated very much on the final  
25 admission and although we did a broad look and a screen

1 and when we were trying to interpret some of the  
2 toxilological information, it became important to look  
3 back at the March admission to Sick Kids and also look  
4 at the Boston Children's admission. We really were  
5 concentrating on the final admission.

6 Q. Could you still just give us a little  
7 rundown of reflex sympathetic disorder (sic)?

8 A. Yes. Now, this is not a disorder I have  
9 seen in a child. I'm familiar with it in adults and I  
10 think it's only more recently become known in  
11 children's literature, and it's a well-known, now, pain  
12 syndrome, it's a complex pain syndrome. She had some  
13 atypical features, as I reviewed the Boston chart, but  
14 they felt quite firmly that the four features that she  
15 had confirmed that diagnosis and included the pain  
16 pattern that she had, she had some coarse hair growth  
17 on that leg, she had some loss of the bone mass on that  
18 leg, some osteopenia and those features were, although  
19 slightly atypical because she had paroxysms of pain,  
20 she added extra stabbing kind of pain on top of it,  
21 they felt that this was the appropriate diagnosis.

22 She did respond to therapies that are  
23 known to give relief with RSD and so I think they were  
24 quite comfortable with that diagnosis and managed her  
25 through the summer, I think long-distance by phone, and

1 then the Shore family brought Lisa back to Sick  
2 Children's in early October to transfer care because of  
3 the mechanics of the management, I guess, the long-  
4 distance management.

5 Q. And what therapy was she undergoing at  
6 the time that she went into the hospital for her last  
7 admission? What was she ongoing?

8 A. She was on, as I understand it,  
9 medication and also had restarted some physical therapy  
10 a couple of days prior to presenting on the 21st to  
11 Sick Children's, and I understand she had been doing  
12 some pool therapy and within a day she was starting to  
13 have difficulty with pain again and then the 48 hours  
14 later is when she presented at Sick Children's.

15 She was on three different kinds of  
16 medication ongoing and these were recommended and  
17 monitored from initially Boston Children's and had been  
18 reviewed October 9th when she presented at the pain  
19 clinic at Sick Children's. And they were gabapentin at  
20 a dose of -- I don't know whether you know -- want the  
21 doses, but -- if you've heard them before, so she was  
22 on three different medications, the amitriptyline, the  
23 carbamazepine and the gabapentin.

24 Q. We've heard the names of the drugs and  
25 we've heard, of course, of the administration of

1 certain drugs on October the 21st. But, basically,  
2 what's the purpose of gabapentin and the other two  
3 drugs, the amitriptyline and the ...

4 A. As I understand it, these are all known  
5 to give pain relief with this particular complex pain  
6 syndrome that she had. This is clearly where I am not  
7 an expert.

8 Q. Can you just go back, then, to that last  
9 week, you said she had pool therapy?

10 A. Yes.

11 Q. And that created some pain.

12 A. Yes. My understanding from the notes  
13 that I reviewed that she had done a one-hour pain --  
14 I'm sorry -- pool movement and the following evening,  
15 my understanding from the notes goes that she had  
16 developed increasing pain and then on the Wednesday  
17 evening, she was having terrific amounts of pain, and  
18 that's when her mother brought her down to -- actually,  
19 mother and father, I think, brought her to Sick  
20 Children's.

21 Q. I understand from what we've heard and  
22 what we've seen that the pain was both chronic and  
23 acute?

24 A. That's right, that she had a background  
25 of pain and on top of it, she would have these

1           paroxysms, these extra pulses of stabbing-type pain.

2           Q.    And we've heard about pain scale, 1 to  
3           10, they would be pretty -- she would be suffering  
4           pretty highly?

5           A.    The records from the Emergency  
6           Department indicated that she was 8 to 7, so she was in  
7           a significant amount of pain when she presented to the  
8           hospital.

9           Q.    What time did your committee see that  
10          she arrived at the hospital on that last admission?

11          A.    23:50, that's not right. I would have  
12          to look back, and we got it from the chart, there is a  
13          time. Do you want me to do that?

14          Q.    Perhaps, Dr. Williams, at Exhibit 3, we  
15          have the entire chart here, so you can refer to it.

16          A.    So 21:50 is the time.

17          Q.    21:50. Can you just briefly, then,  
18          review what your committee found about her initial care  
19          when she arrived at the hospital? What you reviewed  
20          and what you found?

21          A.    When we were initially presented with  
22          this, we did not have a cause of death, so there was a  
23          lot of energy and time that went into trying to  
24          determine from a variety of points of view had the  
25          amounts of the medication that had been ordered, were

1 they appropriate, were the drug levels that were done  
2 post-death, were they appropriate, what assessment had  
3 been done early in October in terms of drug levels,  
4 because she had an amitriptyline level and she had an  
5 ECG done. Were those normal? Yes, they were. So much  
6 of our initial discussion was focusing on what on earth  
7 had happened to her.

8 In final discussion, when all the bits  
9 and pieces were brought together, we ended up deciding  
10 that as a committee, we didn't have a cause of death,  
11 although we were certainly thinking along the lines of  
12 what I understand Dr. Stuart MacLeod presented to you  
13 that there was some as yet to be described unknown  
14 interaction that had occurred between the morphine in  
15 combination with the three other medications, that each  
16 individually were within therapeutic levels, except the  
17 gabapentin, and even that level had never been  
18 described as to be causative with this kind of picture,  
19 and so our feeling was that there was an interaction  
20 and in combination with the clinical picture we saw,  
21 which was from the vital signs that were recorded,  
22 stable initially and then this decreased respiratory  
23 rate and then the tachycardia that went on the rest of  
24 the evening. We thought it was most likely related to  
25 depression of the respiratory rate, depression of the

1 blood pressure and her attempt to try to compensate for  
2 that with the tachycardia.

3 Q. As you know, the jury will be asked to  
4 come up with some recommendations for future study,  
5 future care and I presume that one area might indeed be  
6 a study of the interaction of some of these drugs that  
7 you've mentioned.

8 A. That's right. And also because they are  
9 fairly new, alerting and canvassing for whatever  
10 information with respect to side effects that, you  
11 know, can be brought to bear.

12 Q. Absolutely. All right, if you could  
13 just go on with her treatment that day, October 21st?

14 A. So she was treated with a PCA -- no, I'm  
15 sorry, she was given two doses of morphine in the  
16 emergency department.

17 Q. We understand that added up to about  
18 four milligrams?

19 A. Four milligrams, that's right. She was  
20 seen by the pain service and I understand that Dr.  
21 Schily also came and testified and he was the physician  
22 from the pain service that decided to organize a  
23 patient-controlled pump so she could administer her own  
24 pain control through the rest of the admission, and ---

25 Q. Your committee looked at the nature of

1 the pain service ---

2 A. Yes.

3 Q. --- in the hospital and at the time, I  
4 understand there were no admissions that could be made  
5 to the pain service?

6 A. We did not actually question, we didn't  
7 go down that road, although I do understand there had  
8 been subsequent changes and I'm aware from some of the  
9 correspondence that I've reviewed from Sick Kids, that  
10 there had been changes now that in -- when Lisa was  
11 there, she was admitted to the orthopedic service, even  
12 though her management was going to be through  
13 anaesthesia, who are the experts in the pain control.

14 We did look at protocols, we did look at  
15 the kind of guidelines, the policies and procedures  
16 that support safe practice around the use of things  
17 like a PCA pump, the morphine administration, the  
18 monitoring, so we did look at that kind of thing, but  
19 not the admission practices.

20 So subsequent to the four milligrams,  
21 she was started on this pump and we did review the  
22 doses, the way it was set up, the amount of -- number  
23 of doses she was allowed to take for her weight, all of  
24 which were well within practice standards. Her  
25 therapeutic level of morphine was within acceptable

1 norms.

2 She was meant to be transferred to --  
3 upstairs to the ward when her pain control had come  
4 down to a 5 level, but mom, in conversation with the  
5 nurse, indicated that, you know, it would be very  
6 difficult for Lisa to settle in the emergency  
7 department and that the pain control would be much more  
8 likely to occur if she was transferred up, so my  
9 understanding was they paged Dr. Schily, he had left  
10 the hospital by then, he responded and said yes,  
11 indeed, put her where she's going to be most  
12 comfortable and transferred her up to 5A.

13 Q. You understood that she had already had  
14 two of her drugs, her night doses given to her by her  
15 mother; is that correct?

16 A. No, I understood it was all three, but I  
17 may be wrong on that.

18 Q. Two were before the hospital and one was  
19 in the hospital ---

20 A. In the Emergency Department.

21 Q. --- she gave her the amitriptyline.

22 A. The amitriptyline, which was her bedtime  
23 dose.

24 Q. So that would be between her arrival and  
25 the time she was transferred to the ward, all right.

1 If you could just go on from there? What exactly is  
2 involved in this PCA, what's the protocol, what has to  
3 be done when it's used?

4 A. Now, again, this is not something I have  
5 personal practice with. We did look at the protocols  
6 and we certainly were interested in Mary Douglas'  
7 review of other hospitals' practice patterns around  
8 this. I'm sorry, I've lost where you're taking me.

9 MR. HAWKINS: If I can just interject?

10 THE WITNESS: Yes.

11 MR. HAWKINS: That was Jennifer Stinson's  
12 review, so there is no confusion there.

13 THE WITNESS: So the confusion's here, is  
14 it?

15 MR. HAWKINS: The jury had it put with a  
16 different name, so I didn't want ---

17 THE WITNESS: I'm sorry.

18 MR. HAWKINS: --- to confuse that.

19 THE WITNESS: Sorry. Now you've really  
20 thrown me off, so ...

21  
22 BY MS. BROWNE:

23 Q. We were talking about the -- I know this  
24 is not your area of practice itself, but you have and  
25 the committee has looked at the PCA protocols. How

1 long has a patient-controlled analgesic pump been in  
2 action, from your review of it? Is it fairly recent or  
3 has it been around for a number of years?

4 A. Well, it's more recent than five years,  
5 because -- so it would be within the -- and certainly  
6 in terminal and adults, I think it's been around  
7 probably eight to ten years, but again this is not an  
8 area of expertise for me. I don't know how long it has  
9 been used in paediatrics.

10 Q. But when you think about it, to give a  
11 child control over dosing of a drug that can be quite  
12 powerful, must be hedged by a lot of safeguards.

13 A. Absolutely. And what we've learned is  
14 that up front pain control works way better than  
15 waiting until pain becomes, you know, to such a degree  
16 that it requires a lot stronger and harder  
17 intervention, so, you know, the use of patient-  
18 controlled medication, in fact, I think, gives overall  
19 better control and I think there are studies that show  
20 that you use less analgesic in those scenarios.

21 So by the time she'd gotten to the ward,  
22 she'd had a further ten milligrams, 10.2 milligrams,  
23 for a total of, I believe, 14.2 milligrams when she got  
24 to the ward. Subsequent to that on the ward, there  
25 were no more -- she did not use any more of the PCA

1 pump, and the PCA pump was removed from her around, I  
2 think, 2:50 in the morning when the nurse noted her  
3 respiratory rate dropping.

4 Q. You reviewed the orders of Dr. Schily  
5 that he made with regard to how many boluses in what  
6 time period and the lock-out periods?

7 A. And the lock-out periods, yes.

8 Q. All right. And during her time on the  
9 pump, how was she to be monitored? Did you review  
10 that, did your committee look at that?

11 A. Yes, we did, and there, indeed, was a  
12 lot of confusion for the committee initially around the  
13 materials we were provided with and trying to get a  
14 handle on the Kidcom orders, activated, suspended,  
15 where they input, who could take them off. There were  
16 a number of questions in the parents' letters with  
17 respect to this.

18 We got subsequent copies from the  
19 medical records department that had different  
20 activation dates on them than what we had been  
21 originally provided with, so there was a lot of initial  
22 confusion trying to figure out, but on balance, when we  
23 did examine the orders that had been input by Dr.  
24 Schily, they did seem comprehensive and appropriate and  
25 were very specific with respect to what was expected of

1 monitoring around this.

2 They included vital signs every four  
3 hours and they were specifically named; heart rate,  
4 respiratory rate ---

5 THE CORONER: Sorry, can I just ---

6 THE WITNESS: Yes.

7 MR. GOMBERG: You said every four hours.

8 THE CORONER: You said every four hours.

9 THE WITNESS: Hourly, thank you.

10

11 BY MS. BROWNE:

12 Q. Hourly for every four hours and then ...

13 A. For four hours, yes. And we interpreted  
14 that, because they had been written in the emergency  
15 department for use on the ward that it would be every  
16 hour for four hours when she came to the ward. If it  
17 were interpreted differently, it would still be only  
18 have had two of the four hours covered, because she was  
19 only down in emerg for two hours, but we had  
20 interpreted as -- that those orders were written for  
21 her admission to the hospital, which was technically  
22 when she came to the ward, so there were other things  
23 that were expected to be done, including a sedation  
24 scale, a pain scale and then oximetry, which would be  
25 continuous monitoring of her oxygen levels.

1                   We subsequently became aware that those  
2 orders had not been activated, although clearly there  
3 was a handwritten note on the emerg admission orders,  
4 which said "See Kidcom orders." However, the Kidcom  
5 does have, in our opinion, the advantage, it's very  
6 specific, it's very clear, there's no problem with  
7 legibility, you know, I think we felt there are  
8 terrific strengths to this system, when all pieces are  
9 there and working well, because it's very -- was very  
10 specific what was expected of monitoring.

11                   Q. Are you maybe aware that the lawyers,  
12 the jury, everybody was over at the Hospital for Sick  
13 Children ---

14                   A. Yes.

15                   Q. --- and had a demonstration?

16                   A. Yes.

17                   Q. It was, as you say, extremely specific  
18 and extremely careful and legible and very precise.  
19 What went wrong here, from your review, the committee's  
20 review?

21                   A. Many things went wrong. With respect to  
22 the Kidcom orders, they weren't activated, so the  
23 bedside nurse was not following the directions that the  
24 physician believed he had ordered, in spite of the "See  
25 Kidcom order" on the emergency admission orders.

1 Q. Did you find out and did your committee  
2 find out how long the Kidcom, the Sick Children's  
3 computer system had been working at Sick Children's by  
4 the time of Lisa's death?

5 A. The protocols go back to 1994, so I  
6 would assume it was from '94, and that protocol also  
7 suggested -- not suggested, but said that the physician  
8 was to call the ward, that Kidcom orders had been  
9 placed and actually Mr. Hawkins had questioned me with  
10 respect to the committee's opinion on that and I did go  
11 back to the Pediatric Coroner's Review Committee about  
12 that and the committee felt that the -- that it was an  
13 even stronger communication to have written it, "See  
14 Kidcom" than to have had a telephone conversation, so  
15 there was that one variance on the physician practice  
16 from the protocol as written, although the committee  
17 felt it was, you know, very reasonable that he had  
18 written "See Kidcom orders" as a flag for the nursing  
19 staff to activate those.

20 Q. Did your committee find in its studies  
21 that generally Kidcom orders when entered were  
22 activated?

23 A. We looked only at this, but this was a  
24 question that we did have, that were we running Kidcom  
25 at Sick Kids, we would have been interested to know was

1 this an exceptional thing that orders were not  
2 activated in a timely fashion, or is there a practice  
3 problem between when they're entered, when the child  
4 comes to the ward and when they're activated. And we  
5 felt that would be something worthwhile for Sick Kids  
6 to look at. Now subsequently this particular problem,  
7 I understand, will be solved by activated orders being  
8 printed in emerg and transferred with the child, so  
9 that I think is a very good failsafe.

10 Q. And we've heard that, too, and hopefully  
11 that will take care of a lot of problems.

12 A. I'm noticing scowls. Is that not right?

13 MR. GOMBERG: I'm not sure that that's  
14 exactly right, quite frankly.

15 THE CORONER: The suspended orders will be  
16 printed on the floor to which the patient  
17 goes at the nursing station on the floor  
18 which the patient goes. They will not be  
19 printed in emerg and go up as part of the  
20 chart.

21 MR. GOMBERG: Yeah, but Dr. Williams was  
22 talking about activated orders. Anyway, I  
23 guess we can deal with it after.

24 THE CORONER: And they're not activated,  
25 they're suspended.

1

2

BY MS. BROWNE:

3

Q. Can we go back to Lisa's care that night? What was her -- how did she proceed after she was taken to the ward?

6

A. I understand she was assessed, the chart indicates that she was assessed by one nurse, a second nurse was involved in a coverage period of about -- from 2:00 until after 4:00 and she was transferred into the -- from the stretcher onto her bed and there's some conversation, I understand, with the mother with respect to pillows and blankets and she has a skin sensitivity when sheets are put over her leg and that's important to pay attention to. She has an initial set of vital signs done, which included -- on the ward -- which included her temperature, her pulse, her respiration and her blood pressure. No specific recording with respect to the sedation scale or the pain scale or the oximetry.

20

Q. And you're looking at, I guess, the first chart that was attached to this report? The chart of physician orders, is that what you were looking at ...

24

A. That is what I was looking at, because that's my ...

25

1 Q. That's the first page after seven,  
2 right? Can you explain that to us, that chart, so that  
3 we can understand how it's constructed? First of all,  
4 the real time is 1:45 and then you have temperature,  
5 pulse, respiration, blood pressure, sedation scale,  
6 pain scale and oximetry, and you have little  
7 checkmarks. That means that initially when she was  
8 brought up there, her temperature was taken, her pulse  
9 was taken and respiration was taken and her blood  
10 pressure was taken.

11 A. Yes. This chart was an attempt to try  
12 to sort out what had been ordered and what was actually  
13 done and so although it doesn't record the actual  
14 numbers, all it does was clarify for us if she came to  
15 the ward at 1:45 and she was to have hourly, for four  
16 hours, when would those hours be, so that's why there's  
17 a lapsed time column and it was to try to give us a  
18 picture of what monitoring was done versus what was  
19 ordered.

20 Q. From the chart that you have, it looks  
21 as if the temperature was done at 1:45 and then at  
22 5:00?

23 A. That's right.

24 Q. Is that part of the vital signs taken?  
25 Temperature is, obviously.

1 A. Yes.

2 Q. The pulse, you saw that that was taken  
3 1:45, 3:24, 4:15?

4 A. I don't know, I need to check, because I  
5 am not certain that -- I don't think temperature was  
6 ordered Q hourly for four hours. I need to look at  
7 that, excuse me just one minute.

8 Q. Okay. We have -- some of the exhibits  
9 have blow-ups if the charts, if that would be any  
10 assistance to you.

11 A. So this chart is correct, temperature is  
12 not requested hourly for four hours. The vital signs  
13 that were required hourly for four hours were heart  
14 rate, blood pressure, respiratory rate, pain scale,  
15 sedation scale, and the oximetry.

16 Q. All right. And when you found the  
17 pulse, was that taken as requested?

18 A. It was on admission and it was monitored  
19 a number of times throughout the night, as was the  
20 respiratory rate, there were extra respiratory rates  
21 recorded. The orders of the physician would be the  
22 baseline and the addition of extra recordings would be  
23 where there was worry or concern and when her  
24 respiratory rate fell during the night, extra  
25 recordings were taken.

1 Q. Blood pressure?

2 A. The blood pressure was only done on  
3 admission. It had been done two previous times in the  
4 emergency department, but only on the ward on one  
5 occasion.

6 Q. Sedation scale, apparently not at all?

7 A. I couldn't find specific numbers. There  
8 are references, however, to, you know, that she's  
9 sleeping, that she's drowsy, that -- but there wasn't  
10 the actual scale.

11 Q. Pain scale?

12 A. There are a couple of references to,  
13 again, that she's sleeping or she's -- that could be  
14 broadly interpreted as indicators of, you know, whether  
15 she was comfortable or not, but they were not the pain  
16 scale as ordered.

17 Q. All right. The oximetry?

18 A. That was not done.

19 Q. Do you know why it wasn't -- is there a  
20 problem with the number of oximeters available?

21 A. I don't know that, but if there were,  
22 that should have been sorted out, recorded and  
23 negotiated with the physician, we can't get one or  
24 whatever. The problem as I see it here is these were  
25 not activated or suspended or the -- the nurse who was

1 at the bedside was not practising by these orders.

2 Q. She ---

3 A. I'm mixed up now in the terminology and  
4 so I'm nervous about what I'm saying, but what I'm  
5 trying to say is I don't think she read, either of the  
6 nurses, read these and was being guided, their practise  
7 was not being guided by these orders, because they  
8 weren't ---

9 Q. They weren't activated?

10 A. Is that it?

11 Q. They were still suspended.

12 A. Suspended, okay.

13 Q. All right, now how did the course of  
14 Lisa's (inaudible) go, her night, early morning?  
15 You've heard, of course, that she -- and you can see  
16 from the charts that she had a respiratory depression  
17 that continued throughout the night, and you have made  
18 a chart with regard to that?

19 A. Yes.

20 Q. Can you explain that to us and tell us  
21 what it is?

22 A. And, again, we were trying to chart in a  
23 way to see what it might tell us and, I mean, it is  
24 quite impressive from her baseline readings in the  
25 emergency department and on the ward that her

1 respiratory rate did fall and at the same time, her  
2 heart rate, she became very tachycardic, very. She  
3 became tachycardic, 120 and then 130 and then 134.

4 Q. And tachycardia is a rapid heart rate?

5 A. Heart rate, yeah, a fast heart rate.

6 Q. And indicates what?

7 A. Well, that's the problem, isn't it?

8 Because there are a variety of reasons for high heart  
9 rate and from her being in pain would be one hypothesis  
10 from -- temperature is another thing that traditionally  
11 gives, often gives children high heart rates. Neither  
12 of those seem to apply here, so then you would be  
13 looking for the heart trying to compensate for other  
14 problems, probably related to falling blood pressure in  
15 response to the morphine, falling oxygenation because  
16 her respiratory rate was being depressed, so it was the  
17 heart's response to those things having happened.

18 Q. I don't know, maybe you can't answer  
19 this, but when your committee reviewed the course of  
20 her respiration rate which went down and then  
21 fluctuated, and the heart rate, which went up, did you  
22 come to any conclusion as to whether or not timely  
23 medical intervention would have assisted here? Would  
24 it have helped her? What kind of intervention?

25 A. In retrospect, we felt if the drug

1 interaction were the cause of death, which we believe,  
2 in the end, that is what happened, that removing the  
3 effect of the morphine in a timely fashion would have  
4 prevented this outcome, so, yes, we believe -- and, you  
5 know, at what point it was irreversible, we don't know.

6 I mean, clearly it was irreversible when they started  
7 at 7:15. We did carefully review the resuscitation,  
8 everything at that point that could be done, was done,  
9 but it was too late.

10 So we did feel that intervention  
11 earlier, you can never say for sure, but my goodness,  
12 here was an 11-year-old who came into hospital  
13 basically healthy on some medications who dies on the  
14 ward with her mother beside her. My, goodness.

15 Q. Did your committee review the supposed  
16 use of any monitor, Corometric monitor that you heard  
17 about and read about?

18 A. I mean, that was another whole issue of  
19 back and forth with the hospital with letters, trying  
20 to sort out was it on, was it being monitored and  
21 watched when it was on and it was very difficult to  
22 know. Clearly, there were some recordings from the  
23 mother that she hadn't been aware of it. It should  
24 have been ringing and certainly should have rung when  
25 she arrested and it didn't, so we did bring a

1 Corometric monitor to the committee.

2 We, you know, checked whether you could  
3 independently stop the apnea versus the heart rate and,  
4 yes, you could. We understood the apnea part had been  
5 turned off, so, again, there was a lot of confusion  
6 back and forth about had that, in fact, been in place  
7 and it was difficult to know. The initial admission  
8 note by the nurse did not say a Corometric was on. The  
9 subsequent post-death entry did say it was on.

10 You know, I did hear the testimony and I  
11 -- I don't think the committee had a clear opinion.  
12 There was differences of opinion from what we read and  
13 where we read it and I don't think it was "sort-out-  
14 able" by us. Clearly, though, it did not ring when she  
15 arrested, so it was not on at the end.

16 Q. And I gather that your review of the  
17 charts and the brief indicated there was a difference  
18 of opinion as to what conversations were held between  
19 the nurses and the doctor that night and when and what  
20 was said?

21 A. I'm getting mixed up between what I  
22 heard and what I read. I did read Dr. Schily's CMPA  
23 statement and he had dictated that within a day of  
24 Lisa's death and had registered it with, I think, a  
25 credible organization in terms of trying to nail down

1 the facts. He might have dictated it and had it added  
2 to the chart and that would have also been an  
3 acceptable thing to do that, that where something goes  
4 very wrong, it is important to put down as best you can  
5 all of your thinking, what you were thinking, how you  
6 analyze something and so I did read that, and he  
7 clearly indicated that he had not received a first  
8 page, he had received a second page.

9 When he spoke with the nurse, the PCA  
10 monitor had already been removed and that he was told  
11 the vital signs were -- I think his actual word is  
12 "good." The nurse says that she gave him the specific  
13 vital signs. I did note in a couple of places in the  
14 chart that where there are written references to the  
15 vital signs, they are saying vital signs "stable," they  
16 are not saying the specifics, so again it's a -- the  
17 committee felt it was a he said/she said; we really  
18 couldn't sort out what had happened.

19 Q. Now, the ---

20 A. What didn't happen, though, was a level  
21 of concern either relayed or received by the physician  
22 that prompted the appropriate interaction,  
23 intervention, in the middle of the night, which would  
24 have been to come in, assess her and administer narcan,  
25 in retrospect, so there was some problem with the

1 interaction.

2 Again, the committee did discuss do you  
3 accept when a nurse calls you in the middle of the  
4 night and says vital signs are stable, is it the  
5 responsibility of the physician to say, "What are those  
6 vital signs?" And there was quite a bit of dialogue  
7 back and forth, because that was one of those what ifs.  
8 What if he had said, "What are the vital signs and what  
9 was the oximeter reading?" It would have picked up  
10 then that the monitoring wasn't in place. There are a  
11 whole variety of what-ifs and all of them add up to  
12 this final outcome.

13 Q. In your committee's review, did you look  
14 over at all any of the methods of charting used? We've  
15 heard evidence that sometimes vital signs or some  
16 things were written on pieces of paper and they were  
17 later discarded and so on and so forth. Did your  
18 committee look at optimum methods of charting vital  
19 signs or anything?

20 A. No, no, but I certainly -- I can  
21 empathize with busy nurses who, I mean, I would hate to  
22 have us do anything that makes their job harder in  
23 terms of no, you must not write on a piece of paper,  
24 and, I mean, I've been around wards long enough and  
25 they're busy enough that that's a better thing to do

1 than to try to remember it in your head and do three  
2 others and then run up and chart it. So I think that  
3 some of the prompts that we need to use to do our work  
4 well are absolutely appropriate.

5 On the other hand, the discussion that I  
6 heard about incident recording that the covering nurse  
7 feeling no progress note was -- I'm not exactly sure  
8 how she said it, but, you know, I really question that  
9 when there was significant unfoldings with respect to  
10 this child during those three hours of coverage, that I  
11 think there is an onus on that nurse to make an  
12 incident record on the chart and, you know, what if  
13 there had been a clearer description of the interaction  
14 that she'd had with the physician, that she'd called on  
15 two occasions, she told him these vital signs, it would  
16 be a very different picture than what we're looking at  
17 by the review that we did do. So ...

18 Q. I guess your committee's very basic  
19 purpose is to study these matters, these tragedies in  
20 order to prevent future tragedies. Are there any steps  
21 that your committee thought should be taken that would  
22 assist the jury in making recommendations?

23 A. We thought -- we certainly supported the  
24 move to inquest, because we felt that there were a  
25 whole variety of things that needed discussion in front

1 of -- that there were opportunities for a number of  
2 interventions. You know, the whole issue around the  
3 monitoring, because really, when everything was teased  
4 out, examined and looked at, it really came down to the  
5 monitoring, not only what was ordered, but the  
6 monitoring that was done, the interpretation of that  
7 monitoring and the moving to get a timely intervention,  
8 the understanding of the tachycardia, what it meant,  
9 and, you know, seeking help and support from a young  
10 nurse in interpreting it and getting appropriate  
11 intervention was another part -- another problem.

12 And so then that leads to the whole  
13 thinking of my goodness, how does a, you know, a young  
14 nurse like this who is covering through these few hours  
15 or the two nurses together, how is the system not  
16 supported? So there are a whole variety of those kinds  
17 of questions, you know, to do with training and  
18 orientation and all those kinds of questions.

19 There is also, given what happened, I  
20 think the whole coroner's investigation, there were  
21 concerns about what was seized, what was taken at the  
22 time, what kind of an investigation was carried out. I  
23 think the timely dialogue with the family was  
24 problematic, both from the hospital's point of view and  
25 there were times that the coroner's office, as well,

1 that there were problems with getting appropriate  
2 support and information backwards and forwards for the  
3 family.

4 I think there were -- I mean, I am  
5 hopeful we're going to hear from Sick Kids before the  
6 day is out with respect to the kinds of interventions  
7 they have taken as a result of their understanding of  
8 what's happened. I did find it very disconcerting to  
9 listen to the nursing testimony and still have  
10 misunderstanding about the Kidcom orders.

11 Now, it's a little hard for me today,  
12 having just blown my own understanding of the Kidcom  
13 orders, but I'm not using it day by day, so I do -- I  
14 have concerns that the way in which staff were  
15 debriefed, supported, and, you know, there's a whole, I  
16 mean, a whole list of what-ifs that would have made a  
17 difference, I think, could have made a difference to  
18 this terrible outcome.

19 Q. And you think there are still changes  
20 that can be made?

21 A. I'm only privy to what we've been given  
22 in hard copy with respect to what Sick Kids has done in  
23 response to this. And there are a number of things  
24 that they did do that I think are absolutely  
25 appropriate, you know, changes to -- so that oximeter

1 is automatic on anybody that's -- I mean, there have  
2 been a variety of things that I think they did look at  
3 and try to change. More orientation, or, at least  
4 ongoing education on the 5A ward with respect to a  
5 whole variety of things. It is disconcerting, though,  
6 to then have a nurse come that ...

7 Q. Those are my questions, but you are  
8 going to hear from four other Counsel. Thank you very  
9 much, Dr. Williams.

10 THE CORONER: Mr. Krkachovski?

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

12  
13 CROSS-EXAMINATION BY MR. KRKACHOVSKI:

14 Q. Dr. Williams.

15 A. Good morning.

16 Q. I gather from your evidence and the  
17 Pediatric Review Committee report, as well, that  
18 insofar as the monitoring equipment is concerned,  
19 whether it's a Corometric monitor or a pulse oximeter,  
20 the issue here isn't the equipment itself but rather  
21 the failure of the nurses to use the equipment; would  
22 that be fair?

23 A. I would agree with that.

24 Q. That's all I have. Thank you.

25 THE CORONER: Ms. Posno?

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CROSS-EXAMINATION BY MS. POSNO:

Q. Dr. Williams ---

A. Good morning.

Q. --- I'm Anne Posno, we represent Dr. Schily and also Dr. Wright, who testified here. And as you know, Dr. Schily is the physician who prescribed the morphine in the emergency department. Before I get into some of my questions, I wonder if we could turn up, please, your vital signs chart, the graph, that has the movement in a line diagram of the respiration rate and heart rate? I'm looking at this chart and one of the things that may be helpful for the jury to understand when things were up and down, is could you give some guidance for us as to where we draw the lines of a normal heart rate and normal respiration rate along this chart so we can see when it goes above and below an acceptable range?

A. That is a challenge, and it's related to as one gets older, one's heart rate drops, the normal baseline level drops, so a heart rate of 120 in a newborn would be just fine, and below 80 would be a worry; whereas in an 11-year-old, which is a transitional age, clearly what appears to be her baseline, even when she was having pain, is what

1 happened -- is what her readings were in the emergency  
2 department, so that her heart rate was running, I  
3 think, the first couple of readings were the baseline  
4 readings with respect to her heart rate, and her  
5 respiratory rate may have been up a little at 20 and  
6 probably more normally, 14 to 16, something like that.

7 Clearly the cut-off this physician ordered with  
8 respect to respiratory rate was 11; if it falls below  
9 11, call me, so that's what he believed the normal  
10 lower limit to be in this situation.

11 There are, however, a variety of things  
12 that will move those up and down. If a child is  
13 anxious or nervous, your respiratory rate can go up and  
14 your heart rate can also go up. You've heard children  
15 in pain, the heart rate can go up, the temperature or  
16 the heart rate can go up, so it is interpretation,  
17 given her age, when children sleep, normally the, you  
18 know, they drop back to their resting levels, so that I  
19 would interpret an 11-year-old that's asleep not  
20 showing pain, not crying, not -- with a heart rate of  
21 120 and then up in the 130's, I would be concerned  
22 about, that is elevated, significantly elevated, and  
23 it's also a change from and it's also a change from  
24 what the previous picture was.

25 Q. So to assist the jury because again they

1 don't have the medical background and don't appreciate  
2 how all the different factors fit together to give the  
3 overall picture, is a good comparison for the heart  
4 rate, then, to use the baseline ---

5 A. The first three readings, I think.

6 Q. The first three readings?

7 A. Yes.

8 Q. So in the range of the 90 or below 100,  
9 between 80 and 100 as the baseline range?

10 A. That would be reasonable; below 100, for  
11 sure, I would think.

12 Q. And for the respiratory rate, a level to  
13 at least alert concern would be the level indicated by  
14 Dr. Schily, around 11?

15 A. Which was 11, yeah. And there were only  
16 two readings, and they were 8 and 10 and they were  
17 taken back to back, as I understood, that she would  
18 have timed for a minute and then checked it again for a  
19 minute and that is when she said she initially called  
20 him, which would have been appropriate.

21 Q. In your report, and I was looking for  
22 one of your previous reports ---

23 A. Yes.

24 Q. --- so let's see if I can figure out.  
25 There's a reference to the 8 and 10 at 2:50. Yes, it's

1 on page three of your report, the one that the jury  
2 will have. It's the large paragraph in the middle.

3 A. Yes.

4 Q. Okay, the third sentence -- what the  
5 committee has done here is given a bit of a factual  
6 background at 2:50, the respiration rate dropped to 8  
7 and 10, the pain management on call person was paged by  
8 the nurse who removed the analgesic delivery button,  
9 which is the PCA pump, the doctor on call did not  
10 respond according to the nursing notes, but he  
11 indicated he received no page from the ward until 4:00  
12 a.m.

13 Looking at that, my understanding of the  
14 way this is written is that somewhere in the nursing  
15 notes it indicates that the doctor did not respond to a  
16 page at 2:50. When I read the notes, I didn't see  
17 anything to that.

18 A. No, no, and actually that nursing note  
19 is a response letter of a meeting at Sick Kids, I  
20 believe, because I did go back also to the chart last  
21 night to find that reference.

22 Q. Okay.

23 A. It is not in the chart, it is not  
24 charted that there were two calls made that I could  
25 find. That is from, I think, a March response letter.

1 Q. Written by one of the nurses?

2 A. I think it was written by a risk manager  
3 who did a consensus.

4 Q. This is the letter from the Hospital for  
5 Sick Children that responded to questions ---

6 A. I can check that.

7 MR. GOMBERG: This is the anonymous letter.

8

9 BY MS. POSNO:

10 Q. Maybe if we could just confirm which  
11 letter this is.

12 A. Okay, I will look that up.

13 Q. Because I just want to make sure ---

14 A. It is not in this record.

15 Q. There is nothing in the contemporaneous  
16 chart that indicates that a page was made and that the  
17 doctor failed to respond, and that we do know.

18 A. I know his reference is his CMPA letter.

19 Q. Now, as you know, through the letter of  
20 Dr. Schily, the doctor indicates he did not receive a  
21 page and we have -- I'm not sure if this was made  
22 available to the committee, but we had produced during  
23 the course of the inquest a piece of information from  
24 the chart that was in the pain service department that  
25 indicated that no page was received by Dr. Schily's

1 pager at 2:50 in the morning. For the jury, what I'm  
2 referring to is ---

3 MS. BROWNE: If I could just maybe assist,  
4 maybe Dr. Williams could be assisted by  
5 seeing Exhibit 51A?

6  
7 BY MS. POSNO:

8 Q. Okay, we'll back up to that, first.

9 A. Is this the nursing note?

10 Q. The nursing note we were just discussing  
11 about, Dr. Williams, referred to a letter and I wonder  
12 if this is the letter that ---

13 MS. BROWNE: This is the question, also, Ms.  
14 Posno; is that those are responses, these are  
15 questions.

16 THE WITNESS: Could we get copies, sometime,  
17 because I could do this -- because I need to  
18 concentrate ...

19 MS. POSNO: Oh, I'm happy to take a short  
20 break.

21 THE WITNESS: I could delay it until ...

22 THE CORONER: That's fine.

23 THE WITNESS: I don't want to waste  
24 everyone's time, but I want to make sure  
25 I ---

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MR. HAWKINS: I'm not sure, what is the question, or I'm not sure what the issue is.

THE WITNESS: The question is where did the Pediatric Coroner's Review Committee get the nursing note notation that a page had been put in at 2:50.

THE CORONER: It came from the response to the questions asked by the family, which was part of all the detailed material that they reviewed, the committee reviewed.

MR. HAWKINS: Well, yeah, I don't think there's any dispute that it's in that document.

THE CORONER: Correct.

MR. HAWKINS: So I don't know that that needs to be reviewed.

THE CORONER: No, there's no dispute, I don't think there's any dispute, it's not on the actual chart. This report is a report that is taking into consideration all the information that was available and I do agree with you, the way it's written there, it appears it's from the chart.

MS. POSNO: Right.

THE CORONER: But we're all in agreement

1           it's not from the chart, it's from a response  
2           from the hospital.

3           MS. POSNO:    Okay, and that's what I just  
4           wanted to clarify for the jury when I read  
5           it, that they weren't looking through the  
6           chart and that we somehow missed that  
7           information, so it's in that response letter.

8  
9  
10          BY MS. POSNO:

11                 Q.    And what I was going to now, I'll show  
12           the jury and I'll come back to you, Dr. Williams ---

13                 A.    Okay.

14                 Q.    --- was this one page we reviewed that  
15           indicated the history on the pagers and I think a copy  
16           of this page was provided to the jury.  I don't know if  
17           the committee had an opportunity to see that document.

18                 The evidence we heard today is that when Dr. Schily  
19           the next morning reviewed the history of his pager,  
20           that was what was indicated on it, which does not show  
21           a 2:50 page at all.

22                 A.    And, you know, there was again some  
23           discussion at the committee about this and I think the  
24           issue has more to do with the not getting a response.  
25           It's not unusual on a pager to get someone else's page,

1           it's a misplaced number, it's transmitted wrong, the  
2           issue really is how long do you wait when you've got a  
3           concern before re-paging again or going down the chain  
4           of command in terms of -- so it's the timeliness of  
5           response as opposed to was it placed or not, was the  
6           approach our committee took.

7           Q.     Perfect, that's exactly where I was  
8           going with that is whether or not the page was placed,  
9           if it was placed, a timely response was required in  
10          terms of if the physician didn't call back, the nurse  
11          should have paged again within a reasonable time.

12          A.     Yeah, and I guess the issue is was the  
13          hour and almost, I guess, hour and ten minutes, twenty  
14          minutes, enough -- a short enough time.

15          Q.     And did the committee have a view on  
16          that?

17          A.     Even at 4:00, there was lots of time for  
18          intervention in terms of the outcome, we believed.

19          Q.     Turning back to the flow sheet -- if we  
20          could place the flow sheet, actually, up so the jury  
21          can follow along.

22          MS. BROWNE:   Constable Culleton will help  
23          you get it up there.

24          CONSTABLE CULLETON:   Exhibit 8.

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BY MS. POSNO:

Q. I think your testimony earlier today was that it certainly was appropriate for the nurse to call or to page Dr. Schily at 2:50, based on the respiration rates?

A. Yes.

Q. Now ---

A. And given that she hadn't read the orders, because that was on the Kidcom order, but that was absolutely appropriate.

Q. Right, whether she read the orders or not, it was appropriate?

A. Yeah.

Q. The testimony that -- you heard some of the nurses' testimony, but not all of it. I think it's a clear understanding that the orders, the Kidcom orders were not looked at. The handwritten page that says "See Kidcom orders?"

A. Yes.

Q. That handwritten document was looked at ---

A. Right.

Q. --- by Nurse Doerksen. I don't believe it was looked at by Nurse Soriano, who was attending to

1 the patient ---

2 A. Initially and at the end.

3 Q. --- on the flow sheet from the 2:30 to  
4 the 4:00 times. I take it it's fair for a doctor to  
5 assume that when he writes his orders or enters his  
6 orders on Kidcom, that those orders will be followed  
7 unless he's advised otherwise?

8 A. Yes.

9 Q. So when Dr. Schily was paged at 4:05, it  
10 was very reasonable for him to assume that there was an  
11 oximetry monitor on this child and that the vital signs  
12 had been taken every hour up to that period of time?

13 A. That, I think, would be a reasonable  
14 assumption. And, I mean, it would be very helpful if  
15 there had been an incident, what Nurse Soriano was  
16 saying is an incident, that that's when she would have  
17 put something on the chart, on the progress note, an  
18 incident progress note, it would be very helpful if  
19 there had been a recording, you know, cataloguing some  
20 of this, because we, the committee, certainly could  
21 understanding the unfolding, being wakened at 4:00 in  
22 the night, being told that her respiratory rate had  
23 dropped at 2:50 to 8 to 10, the monitor, the PCA had  
24 been taken from her and that her vitals now were  
25 stable, that seemed perfectly reasonable interaction,

1           okay, continue to monitor, which is as it was dialogued  
2           in Dr. Schily's note, so the recording of it seemed to  
3           us a perfectly reasonable interaction.

4                   Q.    So if a physician is given that amount  
5           of information and says to the nurse, thank you for  
6           calling, keep a close eye on her, from the committee's  
7           perspective, based on that information, Dr. Schily's  
8           conduct was reasonable, not attending to the hospital  
9           at that time?

10                   A.   Yes.  Now, I mean, normally we're not  
11           deciding on reasonableness, but Mr. Hawkins had  
12           questioned me about it and so I did go back to the  
13           committee and there was a considerable dialogue, should  
14           the physician at 4:00 in the morning have not accepted  
15           a nurse saying if, in fact, she did say that the vital  
16           signs were stable, should he be specifically asking for  
17           the vital signs, and the feeling was that in general,  
18           if she wasn't, you know, given an urgency about it or  
19           something and had dealt with it by taking the PCA away,  
20           that it would be reasonable, so there was that dialogue  
21           around it.

22                            But it's another one of those what-ifs;  
23           what if he had asked for the vitals, what if he had  
24           asked what was the oximeter, has the oximeter been  
25           going, how low did the oximeter dip when her

1 respiratory rate dipped, it might have been a very  
2 different picture.

3 Q. We certainly know that there is some  
4 dispute on exactly what was said to Dr. Schily and  
5 discussed with the nurse at that time. If we turn to  
6 the flow sheet at that time of the call, which was, the  
7 call was placed based on the paging history we have at  
8 4:06, so it was just after the 4:05 respiration rates  
9 would have been taken and at that time, the  
10 respirations were 14 and 12?

11 A. Right.

12 Q. Do you have the flow sheet in front of  
13 you, Dr. Williams? It's just behind you.

14 A. Do you want me to look at that one?

15 Q. Whichever one is easier for yourself.

16 A. I'll -- to be honest, I'll look at the  
17 one I can read. Is that okay?

18 Q. Absolutely.

19 A. So I'm looking at?

20 Q. At 4:05.

21 A. Okay.

22 Q. The respiration rates were 14, 12.

23 A. 14, 12, mm-hmm.

24 Q. If the physician is told that at 2:50, a  
25 respiration rate went to 8 and 10, that the heart rate

1 was in the range of 120 to 130 and the moment that the  
2 nurse is calling, the respiration rate is 14 and 12, is  
3 that enough information for a physician to even make an  
4 assessment, if he was told those specific numbers and  
5 only those numbers?

6 A. Yes, I think he should be alerted to  
7 something's going on, something's very different.  
8 Hers's a child that's asleep with a tachycardia and  
9 she's had one respiratory depression, so, yes.

10 Q. So if a physician was told those  
11 specific numbers, would one expect that a physician  
12 would ask more information ---

13 A. Yes.

14 Q. --- or have a level of concern raised?

15 A. Yes.

16 Q. And this may seem self-evident, but I'll  
17 ask the question anyhow: If the physician had asked  
18 for more information such as a blood pressure and the  
19 level of saturation, oxygen saturation, based on the  
20 information on the flow sheet, the nurse would not have  
21 been in a position to give that information to the  
22 physician at that time?

23 A. That's right.

24 Q. Looking at the 4:15, a heart rate of 134  
25 and respiration rate of 10 and the 10 is below the 11

1 that was on the order, whether it was looked at or not,  
2 if the physician had indicated to the nurse, "keep a  
3 close eye on this child" and these vitals were taken at  
4 4:15 at 134 and the respiration rate of 10, did the  
5 committee consider what the nurse should have done at  
6 that time?

7 A. The order is clear, respiratory rate  
8 under 11, so more tachycardia and, again, a depressed  
9 respiratory rate subsequent to the call back, that  
10 would have required another call to the physician.

11 Q. And that didn't happen?

12 A. No. I mean, clearly there is concern  
13 here because many readings are being taken, so the  
14 nurse was having enough concern to do that. The  
15 problem was the interpreting of it, the actions taken,  
16 as a result of it. And even at 5:00, the temp was not  
17 ordered to be repeated and, you know, one can't help  
18 but wonder whether the 126 twigged, gee, I wonder if  
19 she's running a temperature, that there was at least,  
20 you know, this is a bit unusual for an 11-year-old, I  
21 better check the temp is what I was thinking would have  
22 been responsible for taking an oral temp on a child  
23 that was asleep.

24 Q. One of the things, not being medical  
25 people, it's difficult to put the whole picture

1 together at times, or maybe more than just at times.

2 A. And more than being -- it's difficult  
3 for physicians, too, to put the -- and nurses, to put  
4 the whole picture together.

5 Q. And what we're hearing, or what we did  
6 hear a little bit from the nurses is the primary  
7 concern is that the risk of being on morphine was  
8 respiratory depression and so if we focus only on the  
9 respiratory rates, they are a little bit erratic, but  
10 while they did go down to the 8 and 10 level on a  
11 couple of occasions, they did go back up to the 16 and  
12 14 level. Can you offer an explanation to the jury or  
13 to the rest of us, how could the respiration rate  
14 remain within a level of 14 and 16 with the heart rate  
15 still going up? I mean, because she's still breathing  
16 at a proper rate, but her heart rate is going up and  
17 then ultimately she had no vital signs, just sometime  
18 after 7:00. What was going on with this child, in  
19 hindsight, if you can tell us?

20 A. One possibility is a problem with the  
21 readings, that the readings weren't accurate and that's  
22 always a possibility, and especially with respiratory  
23 rates, you have to wait a long time. A minute, it goes  
24 by in a flash sometimes, but when you're standing at a  
25 bedside and if you're doing a 15 second, I don't know

1           whether you asked the nurse, or a 30 second recording  
2           and multiplying, so there can be that maybe responsible  
3           for some of the variability and ten breaths over 60  
4           seconds is not that different from 11, if you slip one  
5           in just before the 60, or if you glance away or -- so I  
6           think the recording of respiratory rate is probably the  
7           most variable.

8                           The heart rate, I mean, clearly she was  
9           running a tachycardia through most of the night, trying  
10          to compensate for something that was going on and the  
11          issue is the thinking, I think, that was going on  
12          around what was being seen. I mean, even given that  
13          the order, the Kidcom orders weren't accessed,  
14          activated, whatever, weren't followed, even given that,  
15          the PCA protocols weren't followed in terms of the  
16          monitoring, even given all of that, the monitoring that  
17          was done, there was significant red flags there that  
18          somehow was not translated into action and whether it  
19          was within the nurse, within the nursing team, within  
20          the interface between the nursing team and the  
21          physician, I mean, these are all questions, but  
22          clearly, in retrospect, there was a lot of time for  
23          intervention that would have, we think, made a  
24          difference to the outcome for Lisa.

25                        Q.    Although a respiration rate may be in

1 the range of 14 to 16, is it a possibility that a child  
2 may be breathing very shallow and not getting enough  
3 oxygen into the blood anyhow, which could cause a heart  
4 rate to go up? Would that be a consistent scenario?

5 A. I don't know that. My understanding was  
6 -- I'm not an expert on morphine. I mean, my  
7 understanding is it's a central depression and I would  
8 have expected the dipping to be the petering out in  
9 terms of the respiratory rate. Now, whether you then  
10 become acidotic and that stimulates you to breathe more  
11 and I understand she was also snoring, which would say  
12 to me it was a deeper breath that was being taken, so  
13 to be honest, I'm not a ---

14 Q. So we don't know.

15 A. --- respiratory physiologist nor a --  
16 there are a whole bunch of things I'm not, so I'm not  
17 sure how to interpret that.

18 Q. Okay. Well, thank you very much. Those  
19 are my questions.

20 THE CORONER: I think it's a reasonable time  
21 to take morning recess. We'll recess for 20  
22 minutes. I would remind everyone that Dr.  
23 Williams is on the stand and should not be  
24 talked to during break.

25

1 --- A BRIEF RECESS

2  
3 THE CORONER: Mr. Hawkins?

4  
5 CROSS-EXAMINATION BY MR. HAWKINS:

6 Q. Dr. Williams, you mention in the cover  
7 part of your, or the initial part of your report and  
8 you've commented a couple of times, but we met to  
9 discuss this case in December?

10 A. That's right.

11 Q. And you understand that before I met to  
12 discuss it with you, I asked the permission of Dr.  
13 Cairns and received his permission to talk to you?

14 A. Right. And I he as well, so, yes.

15 Q. And I asked you some questions and you  
16 took those questions back to the Pediatric Review and  
17 they are reflected in your report?

18 A. That's right.

19 Q. This is a little bit out of sequence,  
20 but since Ms. Posno was questioning you on the  
21 telephone conversation at 4:00 and in the break, I've  
22 checked my notes and I've also reviewed the transcript  
23 and I think Ms. Posno may have inadvertently mis-stated  
24 Dr. Schily's evidence and so looking at Dr. Schily's  
25 version of the 4:00 conversation, I'd like to ask you

1           some questions about it.  When Ms. Posno asked you the  
2           question, as I understood the way she put the questions  
3           to you, she said that Dr. Schily was told about a past  
4           situation of decreased respirations, but the  
5           respirations were now fine; was that your  
6           understanding?

7           MS. POSNO:  Just so I can clarify, I wasn't  
8           trying to paraphrase Dr. Schily's evidence.  
9           What I was doing was just going to the flow  
10          sheet and saying if he were told this  
11          information, okay?  So I wasn't trying to  
12          suggest this was what specifically was said.

13          MR. HAWKINS:  But there's a distinction  
14          here, Dr. Cairns, that I'd like to ask Dr.  
15          Williams about.  As Ms. Posno put the  
16          questions to Dr. Williams, it was on the  
17          basis that Dr. Schily had been told a past  
18          situation of diminished respirations, vital  
19          signs are good.  As I understand Dr. Schily's  
20          evidence and as I read the note Dr. Schily  
21          wrote, Dr. Schily's version of the  
22          conversation is he was told a current  
23          situation of decreased respirations.

24          THE CORONER:  That's fine.  Go ahead and ask  
25          your question, no problem.

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BY MR. HAWKINS:

Q. So, Doctor, if Dr. Schily at 4:00 is told a current situation of decreased respirations as opposed to a past situation of decreased respirations, would you expect him then to ask specifically what is the heart rate, what is the blood pressure, what are the oxygen saturations?

A. Yes, I think so.

Q. And so as we read Dr. Schily's note that he sent to the CMPA:

"... At about 4:00, I was phoned from 5A. The nurse reported that Lisa's respiratory rate was just above 10 per minute ..."

So, again, I read that and certainly Dr. Schily's evidence is he's being told a present situation of respirations of about 10.

A. And I think the committee's confusion relates to the charting of when the pain service was aware the respiratory rates that are recorded were 14 and 12.

Q. Okay. But then if Dr. Schily takes from the conversation, as he's recorded there, that this is

1 a present situation where the respiratory rate is down,  
2 in that circumstance, you'd expect Dr. Schily to ask  
3 specifically what is the heart rate, what is the blood  
4 pressure, what are the oxygen saturations?

5 A. Mm-hmm, I think that would not be  
6 unreasonable, yeah.

7 Q. And so if he's told a past situation of  
8 respiratory depression ---

9 A. Yeah, 8 to 10 at 2:50.

10 Q. --- it's perhaps then in the committee's  
11 opinion acceptable to take vital signs are normal and  
12 nothing further?

13 A. Yeah, and especially when at 4:05 they  
14 were -- the respiratory rate was now up to 14 and 12,  
15 yeah.

16 Q. But if Dr. Schily's interpretation of  
17 the nurse's call, as recorded there, is it's a present  
18 situation of diminished respirations, you'd expect him  
19 to go further?

20 A. I would, and also given that his action  
21 was to remove the pump and the pump had already been  
22 removed, so the committee, I think, was thinking that  
23 he thought he was past the respiratory depression, the  
24 pump had been removed, this was almost a retrospective  
25 of a past situation.

1 Q. But as certainly as he reports it there,  
2 he's being told a present situation, so in that  
3 circumstance, he should go further?

4 A. Mm-hmm, but it wasn't the present  
5 situation.

6 Q. No, no, I didn't -- no ---

7 A. All right.

8 Q. It wasn't a present situation at that  
9 point, but as Dr. Schily has written his note and as  
10 he's testified, he thought it was a present situation  
11 and so if that's the case, he should go further and ask  
12 some questions.

13 A. I think it wouldn't be unreasonable to  
14 expect, but that's my opinion; I didn't take that  
15 particular question back to the committee.

16 Q. Okay, thank you. Going back to and I'd  
17 just ask you a few questions about your curriculum  
18 vitae.

19 A. I'm the lowest of the low, so I agree to  
20 that. No, I'm not an expert on so many things,  
21 Patrick.

22 Q. Okay. You've probably, then,  
23 anticipated some of my questions.

24 A. Yes. Okay.

25 Q. You are a paediatrician, but you're not

1           presently practising paediatrics; is that correct?

2           A.     That's right, I'm not practising  
3           clinical paediatrics, although I do advise  
4           pediatrically on a whole variety of provincial  
5           programs, health department programs. I mean, I'm  
6           already starting to be a little defensive about this,  
7           but you're right, I'm not clinically seeing children.

8           Q.     And you personally have no direct  
9           experience with the use of PCA pumps in children?

10          A.     That's right, that's right.

11          Q.     And no direct experience with RSD or  
12          chronic pain in children?

13          A.     That's right. Oh, chronic pain, yes, I  
14          would be aware of not this particular diagnosis, yes.

15          Q.     Not this brand of chronic pain?

16          A.     No. And, actually, I'm not sure anyone  
17          on the committee had, either, but ...

18          Q.     Okay, that perhaps anticipates some of  
19          my further questions, but -- so you personally didn't  
20          have the expertise or had no experience with reflex  
21          sympathetic dystrophy?

22          A.     That's right.

23          Q.     And you said nobody else on the  
24          committee had that expertise?

25          A.     I don't know that for sure, but I have,

1 I mean, we aren't experts down tiny slices (sic) and I  
2 don't recall anyone having particular expertise on that  
3 diagnosis.

4 Q. And in terms of yourself, I take it as  
5 well you're not personally familiar with, sort of, the  
6 precise actions and interactions of the drugs that Lisa  
7 was on?

8 A. That's right.

9 Q. Then if I can ask you, the Pediatric  
10 Review Committee and we've received the terms of  
11 reference for the committee and I do have some  
12 questions about who was on the committee, their  
13 background and their expertise when they reviewed this  
14 case. I understand Dr. Cairns is the chair of that  
15 committee?

16 A. That's right.

17 Q. In addition to yourself, the other  
18 committee members, I understand, there's a Dr. Ted  
19 Kormode (ph.) ---

20 A. Yes.

21 Q. --- and he's a paediatrician who  
22 practices in Orillia?

23 A. That's right.

24 Q. And his pediatric background, I guess,  
25 would be fairly similar to yours?

1                   A.    Except that he's a real live one  
2                   currently ...  
3                   Q.    Yes.  
4                   A.    He's clinically still in practice.  
5                   Q.    Okay, you're still a real live  
6                   paediatrician, I don't mean to imply that, but you and  
7                   he both practice community paediatrics?  
8                   A.    That's right.  
9                   Q.    And your practice was at Greater Niagara  
10                  General Hospital?  
11                  A.    Yes.  
12                  Q.    And that would be similar to Dr.  
13                  Kormode's practice in Orillia?  
14                  A.    Yes, I think so.  
15                  Q.    There is also a neonatologist on the  
16                  committee?  
17                  A.    Yes.  
18                  Q.    And that's Dr. John Watts out of  
19                  McMaster?  
20                  A.    That's right.  
21                  Q.    And neonatologists as a sub-specialty,  
22                  practice in the care of critically ill newborns?  
23                  A.    Yes, in part. He's not a general  
24                  paediatrician, he certainly has -- I mean, I can't  
25                  speak to all his experiences, but he would have

1 experience with use of morphine, analgesic, so there  
2 are some crossover slices, if that's what you're  
3 looking for. But his general focus is neonatology.

4 Q. His focus is the neonatal period ---

5 A. That's right.

6 Q. --- which is the newborn period?

7 A. That's right.

8 Q. And, as well, I understand that the  
9 committee ordinarily has two physicians from the  
10 Hospital for Sick Children, but that they did not  
11 participate in this review?

12 A. That's right. The intensivist was  
13 replaced with another ICU physician from another centre  
14 who came and did a consultation session with the  
15 committee.

16 Q. Right. Okay, so the intensivist from  
17 Sick Kids who is normally on the committee was replaced  
18 by one from London?

19 A. That's right.

20 Q. And he participated in -- well, your  
21 report indicates that there were three meetings of the  
22 committee. Did that intensivist participate in all  
23 three meetings of the committee?

24 A. No, he was only on-site on one occasion.  
25 There were a number of telephone conversations with

1 him.

2 Q. Okay.

3 A. Maybe a couple or three in terms of  
4 sorting out some of the issues that he had flagged for  
5 us.

6 Q. Okay.

7 THE CORONER: To be fair, Mr. Hawkins,  
8 although Dr. Charles Smith from Sick Kids,  
9 the pathologist, is a member of the  
10 committee, did not initially review this, it  
11 was necessary to bring him in purely from the  
12 pathology section in terms of doing those  
13 extra tests.

14 THE WITNESS: He reviewed the myocardial  
15 slides, yes.

16 THE CORONER: So we did ask him and we  
17 thought it was appropriate to ask him to  
18 consult on the issue when Dr. MacLeod brought  
19 up that there may be myocarditis. We asked  
20 Dr. Smith at that time to join the committee,  
21 pure and simply, to answer that question.

22 MR. HAWKINS: Okay.

23

24 BY MR. HAWKINS:

25 Q. So that the other physician from Sick

1 Kids who was ordinarily a part of the committee is  
2 Charles Smith?

3 A. That's right.

4 Q. And in this case, he participated in the  
5 committee only insofar as the, sort of, extra  
6 myocardial testing was concerned?

7 A. That's right. He was not present at the  
8 clinical discussions. He did report, and I can't even  
9 remember whether he verbally reported on the  
10 myocarditis issue, but he did examine the slides and  
11 provide us with information on that.

12 Q. But in terms of the discussion you did  
13 on the clinical piece, Charles Smith didn't participate  
14 in that?

15 A. That's right.

16 Q. But you relied on his expertise in terms  
17 of the ---

18 A. Ruling out the ---

19 Q. --- myocardial testing and the pathology  
20 testing, that end of things?

21 A. Yes.

22 Q. Okay. I think way back when, when the  
23 Pediatric Review Committee first came up, Dr. Cairns  
24 described it as a multi-disciplinary committee and you  
25 described it as an inter-disciplinary committee. As

1 you've described it to me, there are only physicians on  
2 the committee?

3 A. There are two components to the  
4 committee; one is the core medical group that you've  
5 just named, but then there's also a broader group,  
6 including child welfare, police, crown attorney. I  
7 think that's the other members that make up this bigger  
8 group, especially when we're looking at children who  
9 have died in child welfare care, it would involve that  
10 broader committee.

11 Q. Right, okay, so the core committee is  
12 physicians.

13 A. Mm-hmm, that's the one that meets at the  
14 end of the other meeting regularly every two -- one  
15 Tuesday a month.

16 Q. Okay. And then there is also a  
17 designated expanded committee in child welfare ---

18 A. Police, crown.

19 Q. --- the police, those types of cases?

20 A. Mm-hmm.

21 Q. But the committee that studied Lisa's  
22 case was only the core committee of physicians?

23 A. Yes.

24 Q. With the addition of the physician from  
25 London?

1                   A.    As needed.  And there were, you know,  
2                   the ECRI, the pump mechanics, the -- I mean, it's a  
3                   virtual committee in that it sends out for opinion on a  
4                   whole variety of things; the toxicologist, we asked for  
5                   an opinion on, so it expands as needed, as directed by  
6                   the -- and as directed by the case and depending on  
7                   what's required and Lisa's was complex enough that we  
8                   actually brought another ICU person in to go through it  
9                   with us.

10                  Q.    Okay.  Then, that, I guess, leads me to  
11                  two specific questions.  Firstly, a lot of your report  
12                  comments on nursing issues.  Was there a pediatric  
13                  nursing expert on your committee?

14                  A.    No.

15                  Q.    And a lot of your report on Lisa's case  
16                  deals with reflex sympathetic dystrophy.  Was there an  
17                  expert in reflex sympathetic dystrophy on your  
18                  committee?

19                  A.    No.

20                  Q.    And you had an intensivist, who I assume  
21                  was familiar with the use of PCA devices in an ICU  
22                  environment or in an intensive care environment?

23                  A.    I don't know what his specific  
24                  background is.  I would assume at least all of that.

25                  Q.    So you'd assume he'd know about PCA

1 devices in an ICU or intensive care environment?

2 A. I don't know. I would assume at least  
3 that and I guess my question is whether he would have  
4 broader experience, what kind of coverage he does on a  
5 -- I mean, I don't know that.

6 Q. Yeah, then my next question would be as  
7 far as you're aware, was there an expert on your  
8 committee familiar with the use of PCA devices outside  
9 of an ICU environment?

10 A. I don't know Ted's experience, I don't  
11 know John's experience and -- I mean, yeah, I think I  
12 could say no, they would not say they were experts in  
13 -- I think they would describe themselves as I do,  
14 that, you know, we're the facilitators to try to get to  
15 outcomes and we would tap into the expertise. There's  
16 not a radiologist on the committee, for example, but  
17 there are times that we need to go out for that kind of  
18 expert opinion.

19 With respect to the nursing piece, and I  
20 mean, I think you bring up a very good point; our view  
21 was that the orders were ordered and not carried out  
22 and if there is a nursing practice issue, I mean,  
23 that's a College issue, just like if we identify a  
24 medical issue that is a College issue, we would refer  
25 it to the College. So it wasn't as though there

1 were judgments around nursing practice, what we  
2 identified ---

3 Q. No, but ma'am ---

4 A. Sorry.

5 Q. --- your committee makes some comments  
6 on nursing monitoring issues and the appropriateness or  
7 not of nursing responses to certain things. Don't you  
8 think it would have been helpful to your committee to  
9 have input from somebody with expertise in pediatric  
10 nursing?

11 A. I mean, it's a very good point and we  
12 need to pay attention to that thread. On the other  
13 hand, the review, and you know, went through eight  
14 different drafts and we teased away issue after issue  
15 after issue as we made our way through and it ended up  
16 boiling down to what was ordered, what was responded to  
17 and how those responses were interpreted and  
18 transferred to the physician. So ---

19 Q. But, Doctor, a pediatric nursing expert,  
20 I would suggest to you, would have some expertise in  
21 looking at nursing responses, how and why nurses  
22 respond as they do.

23 A. And this is a good forum for that. I  
24 mean, an inquest is a good forum.

25 Q. But you didn't think it was necessary to

1 have that on your committee?

2 A. Well, I mean, we teased through many,  
3 many, many issues. At the end ---

4 Q. I accept that you teased through many  
5 issues, but you didn't tease through the issues with  
6 the assistance of a pediatric nursing expert?

7 A. Because if it's a practice issue, it's a  
8 College issue, just like if it's a physician issue  
9 about practice or interpretation of practice, it would  
10 be a College issue.

11 Q. I know that Dr. Cairns is aware of this,  
12 but are you aware of an inquest that was held, I guess,  
13 about two years ago in Hamilton that dealt with the  
14 issue of composition of the coroner's expert review  
15 committees?

16 A. If I was, I forget, so ...

17 Q. Okay. Well, maybe -- and I have  
18 provided this to Counsel and I'd like to ask about a  
19 couple of the recommendations that that jury made.  
20 This is a copy of the jury verdict into the death of  
21 Tricia Yeboah which was rendered on the 2nd of March,  
22 '98 and I'd like to ask you specifically, Doctor, there  
23 are two recommendations that deal with the composition  
24 of the expert review committees of the coroner's office  
25 and I understand and I take it there is no issue, Dr.

1 Cairns, that these two recommendations were consented  
2 to in the context of that inquest by the Coroner's  
3 office?

4 THE CORONER: I have no problem with that.

5 MR. HAWKINS: Okay.

6 MS. BROWNE: Do you have another copy, Mr.  
7 Hawkins? I don't appear to have one.

8 MR. HAWKINS: I'm, unfortunately, down to my  
9 last copy unless I can find one. I  
10 apologize. Sorry, I do have another one.  
11 Could we perhaps mark that as the next  
12 exhibit?

13 CONSTABLE CULLETON: That would be Exhibit  
14 61.

15  
16 EXHIBIT NO. 61: Inquest verdict and  
17 recommendations from the death  
18 of Tricia Yeboah, dated March  
19 2, 1998

20  
21 BY MR. HAWKINS:

22 Q. Just to read the first recommendation  
23 which is 2(A) to the Chief Coroner's office, that:

24 "... The Expert Review Committee, when  
25 reviewing a death at the request of the

1 Coroner, consult with a person whose  
2 qualifications are the same as the  
3 person whose care is being scrutinized,  
4 if such person is not already a member  
5 of the committee.

6 Reason: All parties should be  
7 fairly represented as each party has  
8 their own area of expertise ..."

9 Dr. Williams, as a general principle,  
10 would you agree with that recommendation?

11 A. Yes, absolutely, mm-hmm.

12 Q. And as a general principle, when your  
13 Pediatric Review Committee is considering a case that  
14 involves both medical and nursing issues, you'd agree  
15 as a general principle that it would be helpful to have  
16 the input of a pediatric nurse?

17 A. Yes. I guess what is interesting is I  
18 can't recall that we've come to nursing practice issues  
19 before, but I, you know, I support the principle,  
20 you're right.

21 Q. And I guess similarly that that would  
22 apply when we're dealing with reflex sympathetic  
23 dystrophy, the use of PCA devices for that condition,  
24 that it would be helpful to the Committee to have that  
25 expertise in scrutinizing what happened?

1           A.    If it were relevant to outcomes or  
2           issues that we identified, I would agree.  I do not  
3           think that we needed, on those two issues, an expert in  
4           RSD to come and join the committee.  I don't think it  
5           was relevant to the issues we were looking at, but  
6           those are judgments that we need to be open and aware  
7           of and I, you know, I do agree with the principle and  
8           I'm sure the Coroner's Office does, too.

9                        We do try to call the best expertise  
10           across the breadth that we need in order to move it  
11           forward.  This was lapsed by an inquest.  I think if it  
12           hadn't gone to inquest, perhaps we would have either  
13           invited a nursing practice person or probably we would  
14           have done that prior to referring it to somewhere else  
15           for resolution.

16           Q.    Okay.  Then ---

17           A.    But I think that's perfectly reasonable.  
18           I don't know how the Chief Coroner's office would feel  
19           about it, but ...

20           Q.    Well, they've consented to that  
21           recommendation a couple of years ago, so I would assume  
22           that that's -- they have a similar position today.  The  
23           second recommendation says that:

24                        "... The reports of an expert review  
25           committee be released as soon as

1 possible to the appropriate persons,  
2 parties, when release of such reports to  
3 such parties may promote public health  
4 and safety.

5 Reason: All parties should be notified  
6 as soon as possible so that any  
7 recommendations can be reviewed and  
8 implemented promptly ..."

9 Again, as a general principle, would you  
10 agree with that recommendation?

11 A. Yes. Yes, I would.

12 Q. And in this case, as I understand it and  
13 looking at your final report, the Pediatric Review  
14 Committee first met and considered this case in March  
15 of 1999? Sorry, do you not have your final report in  
16 front of you?

17 A. I have my final report.

18 Q. And I take it from that, that the first  
19 meeting that considered this case was March of '99?

20 A. I don't know that. It would be around  
21 then. I don't know whether I was given the case in  
22 January or ---

23 THE CORONER: No, I can confirm that it was  
24 March.

25 THE WITNESS: Okay, thank you.

1 MR. HAWKINS: Okay, thank you, Dr. Cairns.

2  
3 BY MR. HAWKINS:

4 Q. And then we have the first draft of your  
5 report, which I take from the fax signature at the  
6 bottom was produced March 23, 1999?

7 A. I'm at a real disadvantage. If you tell  
8 me that, I would believe it.

9 Q. I don't know that it necessarily has  
10 to be made an exhibit, but the first draft, I take it,  
11 was produced in March simply because the copy that we  
12 have ---

13 A. That would be reasonable, mm-hmm.

14 Q. And that report, for the first draft of  
15 your report, as I look at it, essentially raises more  
16 questions than answers.

17 A. That's right.

18 Q. And, in addition, one of the things that  
19 you had when you wrote this report and it has been  
20 marked as an exhibit, was a letter written by the  
21 family following on the hospital's response?

22 A. I did review a number of letters from  
23 the family, both copies, letters to Sick Children's and  
24 copies to the Coroner's Office and I may not have all  
25 of those sequences right, but I did review a large

1 number of -- or a number of letters.

2 Q. No, this reference is the -- and just so  
3 Counsel know, I'm reading from page 287 of the brief:

4 "... The HSC response to questions regarding  
5 Lisa Shore was reviewed, dated March 3, '99,  
6 faxed March 11, '99 by the family and it  
7 generated further questions, faxed March 17,  
8 '99 ..."

9 That, I believe, has been made an  
10 exhibit but I did not write down -- Exhibit No. 50.  
11 Does that -- I'm showing the witness Exhibit 50. Does  
12 that refresh your memory as being something that you  
13 reviewed or that the committee reviewed in coming to  
14 its report?

15 A. Yes, this is the -- yes, I've read this,  
16 mm-hmm.

17 Q. And then so your first draft of the  
18 report raised a lot of questions and the family there  
19 raises a lot of questions.

20 A. Mm-hmm.

21 Q. Would it surprise you, ma'am, that the  
22 questions you raised, the questions the family raised,  
23 were not provided to the hospital to try to assist in  
24 answering, but they weren't provided to the hospital  
25 until November?

1 A. Would I be surprised at that?

2 Q. Yes.

3 MR. GOMBERG: By who, please?

4

5 BY MR. HAWKINS:

6 Q. By anybody.

7 A. My, I mean, this is a working draft ...

8 Q. But you would have hoped that somebody

9 would either send this working draft ---

10 A. No, not the draft.

11 Q. Okay.

12 A. No.

13 Q. Or would certainly convey the questions  
14 to the hospital?

15 A. Once we know they're questions for the  
16 hospital -- I mean, obviously we want to provide timely  
17 information when it's thorough, credible, accurate.  
18 There certainly are times when we're part way through  
19 an investigation around a death where we have grave  
20 concerns about the child that's left at home in their  
21 care and we haven't completed our investigation and the  
22 Coroner's Office would contact the child welfare  
23 agency, for example.

24 But in this situation, it was a, you  
25 know, very complex trying to pull it all together, so

1 do I feel badly about what you view to be appropriate  
2 information that Sick Kids could have acted on not  
3 getting to them, of course I would. I mean, anything  
4 that we -- any way in which we could have helped Sick  
5 Kids to identify what the issues were in a timely  
6 fashion to have appropriate interventions, of course it  
7 would be appropriate.

8 I would have assumed that they would be  
9 carrying out their own even better investigation  
10 internally, having access and understanding of all of  
11 the things you've brought up, including Kidcom, et  
12 cetera, but yes, of course, that there would be timely  
13 communication.

14 One of the problems, as you know, is  
15 that people run for cover once we have lawyers involved  
16 and it's a very difficult interface between all these  
17 systems to try to make sure that in a timely fashion  
18 we've got, you know, good, honest problem-solving so  
19 that this kind of thing doesn't happen again. And I  
20 know on Sick Kids side, they want that, too; you know,  
21 they don't want to have this kind of failure of the  
22 system on behalf of ---

23 THE CORONER: Mr. Hawkins, I also do want to  
24 add that the first draft of this, which  
25 raised many, many questions, there were many

1 subsequent meetings between myself and people  
2 from Sick Kids to try and understand many of  
3 these issues.

4 In those meetings and discussions, these  
5 issues were brought up, they were not sent by  
6 letter, but the people at Sick Kids were  
7 aware of the questions we were asking, aware  
8 of some of the information that the committee  
9 needed to get with regard to suspended  
10 orders, with regard to PCA protocols, et  
11 cetera.

12 MR. HAWKINS: I am certainly aware of that,  
13 Dr. Cairns, and I know that you and I  
14 participated in those discussions. The point  
15 I wish to make with Dr. Williams, which is  
16 addressed in the first report, is we've heard  
17 an awful lot about the investigation that was  
18 done at Sick Kids and suggestions of  
19 inadequacies there. I'm content to leave the  
20 point with your acknowledgement, as well,  
21 that there were inadequacies in the  
22 investigation at the Coroner's Office, as  
23 well, and that that was addressed by the  
24 Pediatric Review Committee in its first  
25 report.

1 THE CORONER: I don't think anyone would --  
2 everyone would agree that the first time as  
3 far as our office is concerned, this was  
4 being addressed in what I consider a most  
5 appropriate and most serious matter was when  
6 it was referred to me in March and I had a  
7 meeting with the Pediatric Review Committee  
8 within three weeks of that being brought to  
9 my attention, and yes, I would have liked to  
10 have known about the issues the day of the  
11 death, so I don't disagree with you at all.

12 MR. HAWKINS: Thank you. Then I ---

13 THE CORONER: If you say that there was not  
14 an adequate investigation after March, then I  
15 would obviously take exception to that  
16 comment.

17 MR. HAWKINS: I am not in any way suggesting  
18 that, Dr. Cairns, I'm just -- simply wish to  
19 highlight which you have agreed with me that  
20 before March, there were problems or  
21 inadequacies both at the Hospital for Sick  
22 Children and at the Coroner's Office.

23 THE CORONER: Yes, and I think I've already  
24 indicated that to the jury, that one of my  
25 suggestions to the jury and whether they make

1 the suggestion or not, I've already indicated  
2 that it is the intention of our office and  
3 certainly my intention following the inquest  
4 to meet with high level officials at the  
5 Hospital for Sick Kids so that they  
6 understand what we want and we understand  
7 what they want and that this, in terms of  
8 what the hospital will be expected to do in a  
9 death like this and what we will be expected  
10 to do will be clearly understood so that it's  
11 not a situation of "I thought, they thought,  
12 she thought," whatever. I couldn't agree  
13 with you more.

14 MR. HAWKINS: Okay. And that has certainly  
15 been, I believe, conveyed to you by the  
16 Hospital for Sick Children that they are just  
17 as interested in having that meeting and  
18 sorting out these miscommunications that  
19 unfortunately occurred in this case.

20  
21 BY MR. HAWKINS:

22 Q. Then, Doctor, if I can ask you to turn  
23 to the report that you have in front of you, I would  
24 take it, and maybe you don't remember the specific  
25 dates, but that the Committee met to review this case

1 on three occasions.

2 A. That's right. There was dialogue and  
3 activity between times and I wouldn't have necessarily  
4 a paper trail on any of that, but it was brought to the  
5 Committee on three occasions.

6 Q. Okay. And in between times, there was  
7 some dialogue between the members of the committee and  
8 Dr. Cairns?

9 A. No, these -- it was only reviewed twice  
10 at the committee. Those dates are dates when drafts  
11 were redrafted or there was substantive change, so the  
12 January 2000 was after the meetings and the -- to  
13 incorporate items 15 and 16.

14 Q. Okay.

15 A. I'd have to look back in the minutes,  
16 I'm sorry, I don't know how many times it went to the  
17 committee.

18 Q. Okay, but just so that I understand, the  
19 committee last, sort of, considered this case either in  
20 December or early January?

21 A. It was actually, I think it was as a  
22 committee -- you know, I don't know. I've written  
23 November 20th, but it may have been a December meeting.  
24 I'd have to find out.

25 Q. So the committee's last consideration of

1 this before finalizing the report was either November  
2 or December?

3 A. That's right. As a group, the final  
4 report was circulated to them.

5 Q. And that would be the circulation date  
6 would be ---

7 A. January.

8 Q. --- sometime in early January, okay.  
9 And if I can ask you to turn in your report to the  
10 issues identified and the first issue identified by the  
11 review team relates to the cause of death. In coming  
12 to the committee's opinion on the cause of death, you  
13 had access to all of the pathology information done by  
14 Dr. Glen Taylor, Charles Smith and also by Dr. Peter  
15 Liu at the Toronto Hospital?

16 A. Yes. The only pathology information we  
17 didn't have at that point was the actual viral studies  
18 on the myocardium.

19 Q. And those were subsequently done, then,  
20 by Dr. Peter Liu at the Toronto Hospital and reported  
21 in ---

22 A. December.

23 Q. --- December ---

24 A. Mm-hmm.

25 Q. --- as negative for the myocardial

1 virus?

2 A. That's right.

3 Q. I'd like to ask you about two things  
4 that the committee decided on there. The first  
5 sentence,

6 "... The committee noted that a clinical  
7 history suggested a respiratory  
8 depression leading to cardiac arrest,  
9 poor cardiac arrest secondary to an  
10 arrhythmia ..."

11 I take that to mean that one of the  
12 things the committee couldn't sort out was whether this  
13 was a respiratory event leading to arrest or a cardiac  
14 event leading to arrest.

15 A. We considered a number of possibilities,  
16 and those are two of them. The cardiac arrest  
17 secondary to arrhythmia sent us back to look at the ECG  
18 that had been done in October and our feeling was that  
19 there wasn't any absolute on/off test that would tell  
20 us which of those theories was most likely, but we  
21 ended up believing that it was the complex drug  
22 interaction as yet undescribed to be the most likely,  
23 but we didn't feel that we could, should or would be  
24 the ones to say that.

25 Q. Then the opinion that the committee

1 gives is:

2 "... The review committee did not feel  
3 there was sufficient evidence to  
4 determine the cause of death. A number  
5 of theories were discussed and explored,  
6 including some complex drug interaction  
7 as yet undescribed, but no cause was  
8 confirmed from the evidence reviewed  
9 ..."

10 That, I take it, is the opinion of the  
11 committee, that there's insufficient evidence to  
12 determine the cause of death?

13 A. From our level of ability and expertise.

14 You know, I could go back to the committee with a copy  
15 of the testimony of Dr. MacLeod, he's highly respected  
16 by our committee and he seems to feel in balance that  
17 this is the cause of death, so ... But we didn't feel  
18 there was, you know, add up the check-marks and come  
19 out with a yes or a no, we didn't feel that it was ...

20 Q. Okay, so from your perspective and you  
21 had Dr. MacLeod's report ---

22 A. Yes.

23 Q. --- you could not, as a committee, come  
24 to a conclusion on the cause of death?

25 A. That's right.

1 Q. And we know and in Dr. MacLeod's report,  
2 I think it's fair to say that he identifies drug  
3 interaction as a possibility or a strong possibility?

4 A. And he also raised the concurrent viral  
5 infection which sent us into the loop of doing the  
6 myocardial and, you know, to try to actually identify  
7 whether there was an isolatable and the review of the  
8 post-mortem slides on the myocardium to see what was  
9 the significance of it and, again, by the time we were  
10 looking at this in, whether it was the end of November  
11 or December, it was felt those were ruled out, so we  
12 were then back to the complex drug interaction as  
13 opposed to a concurrent viral.

14 Q. Okay, but ultimately the opinion your  
15 committee came to, and that's what's reported here ---

16 A. Yeah, it's carefully worded.

17 Q. --- is, "We don't know."

18 A. That's right.

19 Q. And that's the opinion of your committee  
20 is, "We don't know."

21 A. Yeah. I hate to say it that way; what  
22 we said was that "we couldn't confirm."

23 Q. Well, the committee did not feel there  
24 was sufficient evidence to determine the cause of  
25 death.

1           A.    Yeah, within our ability to say that,  
2           yeah. We thought the most likely was a complex drug  
3           interaction, but we didn't know. You're right, we  
4           didn't know.

5           Q.    But you didn't know.

6           A.    Mm-hmm.

7           Q.    Okay. And ---

8           A.    We went through a lot of work to be able  
9           to say we didn't know.

10          Q.    No, I accept that you left no stone  
11          unturned to come to, unfortunately, "We don't know."  
12          And that was the opinion that your committee came to.  
13          And I take it that the committee, I know that Dr.  
14          MacLeod, when he testified, went from "possibility" to  
15          what he said was "probability," but that issue has not  
16          been re-reviewed by your committee?

17          A.    That's right.

18          Q.    And so the opinion of your committee  
19          that you're presenting today is as stated in the  
20          report?

21          A.    Yeah, most likely, but not definite,  
22          yeah.

23          Q.    Well, ma'am, no, the report that you've  
24          written does not say "most likely drug interaction," it  
25          says:

1                    "... A number of theories were discussed  
2                    and explored, including some complex  
3                    drug interaction, as yet undescribed  
4                    ..."

5                    A.    But no cause was confirmed from the  
6                    evidence reviewed.

7                    Q.    Okay.

8                    A.    That's what we said.

9                    Q.    So your committee's opinion that you're  
10                    presenting today is ---

11                    A.    Is what's written there.

12                    Q.    --- no cause of death confirmed?

13                    A.    What's written there.

14                    Q.    And dealing with the drug interaction  
15                    theory and I think this goes to, sort of, the  
16                    investigation or the research that's being recommended  
17                    into it, and I think it's important to highlight. Now,  
18                    I've provided Counsel with a copy of this. I can  
19                    certainly give the jury a copy, if they wish, but it's  
20                    an article from Canadian Family Physician published a  
21                    few months ago on use of gabapentin in treating  
22                    neuropathic pain. I think marking one copy is probably  
23                    sufficient. If you'd like a copy, I can certainly give  
24                    you one, but I think marking one copy is probably  
25                    sufficient.

1 JUROR #1: It's available now?

2 MR. HAWKINS: It is available afterwards.

3 If you'd like one now, I can give you one  
4 now.

5 JUROR #1: Yes, I would.

6 MR. HAWKINS: Okay. I don't want to confuse  
7 things by giving too much stuff.

8

9 BY MR. HAWKINS:

10 Q. Now, this is an article from Canadian  
11 Family Physician in September of 1999, which, are you  
12 familiar with the publication ---

13 A. Yes.

14 Q. --- Canadian Family Physician?

15 A. It comes to a person that I happen to  
16 live with, quite regularly. I am familiar with it.

17 Q. And then I understand that that's a  
18 publication that goes out to maybe not all family  
19 physicians in Canada, but certainly close to all family  
20 physicians in Canada? Is that correct?

21 A. I don't know whether you need to be a  
22 member of the College in order to get it, but it goes  
23 to a large number of family physicians.

24 Q. And this particular article notes at the  
25 bottom that it is peer reviewed?

1 A. Yes.

2 Q. So that means that in addition to it  
3 being the opinion of the authors of the article, it has  
4 been reviewed by some sort of external committee to be  
5 sure it's correct?

6 A. Yes.

7 Q. What that article talks about and I'd  
8 like to just review it with you, is the main message  
9 that it says in the abstract,

10 "... Gabapentin is an anti-convulsant  
11 medication used recently as an effective  
12 adjuvant agent for treating neuropathic  
13 pain ..."

14 And then skipping a sentence,

15 "... Gabapentin has desirable  
16 pharmacokinetic properties and  
17 acceptable side-effects, which simplify  
18 its use. There are very few  
19 interactions between gabapentin and  
20 other medications. Gabapentin is well  
21 tolerated ..."

22 The conclusion,

23 "... Gabapentin could be an effective  
24 adjuvant agent for many neuropathic pain  
25 states ..."

1                   Is that sort of a summary of the general  
2 prevailing opinion on gabapentin, that it is a safe  
3 medication with very few known interactions?

4                   A.    Was this presented to Dr. MacLeod,  
5 because that would be my -- my need would be.  I mean,  
6 this, I don't know when it was accepted.  When I scan  
7 the basis on which it's written, there are '97  
8 references, I don't know what's happened since '97.  If  
9 this is about whether or not gabapentin could be a  
10 contributor to the interaction, I mean, I'm not the  
11 person to -- I know I'm not the person to answer that.

12                  Q.    Okay.

13                  A.    And I would be, if it came to the  
14 committee, this is the kind of thing we would refer  
15 for ---

16                  Q.    To Dr. MacLeod?

17                  A.    Yeah.

18                  Q.    Okay.  And so as far as ---

19                  A.    So was he presented with this?

20                  Q.    No, that was not presented to Dr.  
21 MacLeod.

22                  MR. GOMBERG:    Why not?

23                  MR. HAWKINS:    We didn't have it at the time.

24  
25                  BY MR. HAWKINS:

1 Q. So I take it then from the perspective  
2 of your committee and this is commented on, you're not  
3 aware of any literature that defines or that concretely  
4 documents an interaction between gabapentin and any of  
5 the other medication that Lisa was on?

6 A. No. What we were aware of was that the  
7 high levels that she had, had not been known in the  
8 literature to contribute to, in and of itself. We were  
9 not aware of any interaction literature on the  
10 gabapentin, and that was one of the reasons it was  
11 referred for an opinion on that.

12 Q. And one of the things that you'd  
13 recommend or that your committee would recommend is if  
14 there is an interaction between gabapentin and other  
15 medication, that should be studied?

16 A. Absolutely, especially when this now is  
17 sort of an endorser for using it in, you know, family  
18 practice environments, so ...

19 Q. Right. And that's really my point, is  
20 that this was a mailing to family physicians, generally  
21 endorsing gabapentin.

22 A. Mm-hmm.

23 Q. And certainly if that's what the medical  
24 community is doing, there should be considerable  
25 research into gabapentin.



1 things in relation to the emergency department care.  
2 First, you testified and the committee's understanding  
3 is that the Kidcom orders, and specifically the  
4 monitoring orders, were for use when Lisa arrived on  
5 the ward?

6 A. That's my understanding.

7 Q. And then I take it you're aware that  
8 there were no monitoring orders written for Lisa while  
9 she was in the Emergency Department?

10 A. That's right. The only orders I saw are  
11 that short version. There were orders written for  
12 monitoring for the ward, but not for the emergency  
13 department. I didn't see any, anyway.

14 Q. No, I'm not aware that there were any  
15 orders written for monitoring in the Emergency  
16 Department.

17 A. She was monitored, however, she did  
18 get ...

19 Q. I accept that she was monitored, Doctor,  
20 but my question was you're not aware that orders were  
21 written for that monitoring in Emerg?

22 A. That's right.

23 Q. And would you agree with me that when a  
24 patient is started on a new treatment, particularly  
25 something like morphine, the need for monitoring starts

1 with the start of the treatment?

2 A. That's right.

3 Q. And here, while it was done by the  
4 Emergency Room nurse and I guess I'll ask you if it was  
5 done appropriately by the Emergency Room nurse?

6 A. Well, I would be afraid to answer that  
7 after the conversation we've just had.

8 Q. Well, I take it the committee didn't  
9 identify any monitoring issues with respect to the  
10 Emergency Department?

11 A. No, she was there for two hours and  
12 forty minutes and she had two sets of blood pressure,  
13 two sets of heart rate, respiratory rate and sedation  
14 scale and a lot of dialogue written by the Emergency  
15 Room nurses.

16 Q. Okay, but the ---

17 A. And the other pieces we weren't sure of  
18 was in and out of the physician, how much he was there,  
19 what he administered, what he was monitoring and doing,  
20 but, again, what isn't recorded?

21 Q. Then certainly for that monitoring in  
22 Emergency Department, while the nurse did it, the  
23 physician didn't write orders for that monitoring?

24 A. That's right, that's right.

25 Q. And would you agree with me that if a

1 doctor wants specific orders for specific monitoring  
2 for a patient, it's his responsibility to write the  
3 orders?

4 A. That's right. If it's -- that's an  
5 interesting question, because -- in general I would  
6 agree, but I think there are circumstances where a  
7 person enters the system, hasn't seen a physician, they  
8 would be assessed, triaged, monitored and that would be  
9 with either standing orders, protocols, so I'm not  
10 sure ---

11 Q. Then once the physician has seen the  
12 patient, you'd ordinarily expect him to write orders  
13 for the monitoring that he wants?

14 A. Yes.

15 Q. And particularly in this case, as Nurse  
16 Matthews testified and I think as everyone has  
17 testified, that the staff in the Emergency Department  
18 were unfamiliar with the use of PCA pumps, it would be  
19 even more important to write monitoring orders for the  
20 Emergency Department?

21 A. That may be.

22 Q. And particularly when roughly the first  
23 hour and half or more of Lisa's treatment on a PCA pump  
24 is in the Emergency Department, it would be important  
25 to write orders for that monitoring in the Emergency

1 Department?

2 A. I mean, my dilemma is I don't know what  
3 the standing protocols are for monitoring, I don't know  
4 whether she has her own nurse, I don't -- no, I don't  
5 know the context, but in general, I agree that he would  
6 either verbally be coaching, telling, talking. He did  
7 write a very clear set of orders for when she moved to  
8 the ward.

9 Q. And I take no issue with that, but my  
10 question ---

11 A. And, in fact, the committee did not pick  
12 up on this, so ...

13 Q. My question is if he writes such a clear  
14 set of orders for the ward, wouldn't it be equally  
15 reasonable to expect a set of orders in the Emergency  
16 Department?

17 A. That would be an interesting audit of  
18 Emerg records. I'm not sure that ...

19 Q. Certainly, Doctor, in your practice, if  
20 you're consulting with patients in the Emergency  
21 Department and you want specific monitoring, you would  
22 write specific monitoring orders for your patients in  
23 the Emergency Department?

24 A. But in general you wouldn't hold  
25 pediatric patients in the Emerg, like, it's -- they're

1 on their way to being admitted. You would write  
2 admission orders. I mean, if they're going to be held  
3 in holding or you'd admit them to holding and put a set  
4 of orders, but if it's in transit ...

5 Q. Well, this patient was to stay in the  
6 Emergency Department until her pain stabilized.

7 A. Mm-hmm.

8 Q. So I think the expectation is that she'd  
9 be there for some amount of time. Wouldn't you agree  
10 that it's important in that circumstance ---

11 A. Yes.

12 Q. --- to write monitoring orders?

13 A. Yes. It wouldn't hurt to and is that a  
14 reasonable expectation? I suppose if protocols aren't  
15 -- that if a patient in Emerg is assessed on a regular  
16 frequency then yes, I would agree.

17 Q. Particularly ---

18 A. But this is out of context; I don't know  
19 the context of this for Sick Kids' department, but ...

20 Q. And particularly as we've heard where  
21 the Emerg staff are not familiar with PCA pumps,  
22 monitoring orders would be even more important for the  
23 Emergency Department?

24 A. I can understand that argument, yeah.

25 Q. And in this case, we've heard a lot or

1 an awful lot about nurses forgetting to check the  
2 Kidcom orders on the ward. Would you agree with me  
3 that a physician forgetting to write orders for care in  
4 the emergency department is an error or is a mistake of  
5 about the same magnitude as failing to check orders?

6 A. It doesn't feel equivalent to me, but, I  
7 mean, my view of even a busy emergency department is  
8 that the kids are there, awake, the parents are awake,  
9 they're waiting for transition to the ward, the nurse  
10 is in and out, there's easy accessibility to  
11 physicians. He may have been actually there. They  
12 don't feel equivalent to me.

13 Q. Okay. So while it's reasonable to  
14 expect a physician to write orders in the emergency  
15 department, forgetting's okay? Is that what you're  
16 suggesting?

17 A. No, that's not what I'm suggesting.

18 Q. The second issue, then, in respect of  
19 the Emergency Department care, you understand that the  
20 pain service physician wrote no notes respecting his  
21 assessment of Lisa in the emergency department?

22 A. Do I know that?

23 Q. I can tell you there is no note by the  
24 pain service physician for the emergency department.

25 A. Okay. There is a pain service note.

1 Q. But the pain service note, I believe,  
2 that you have relates to the October 9th assessment  
3 when Lisa was in the clinic a few weeks prior. There  
4 is no ---

5 A. Okay.

6 Q. --- pain service note for the Emergency  
7 Department.

8 A. There were a number of different  
9 writings, so I did see his orders, but it looked like  
10 there were a number of different -- for example, the  
11 meds, I wondered if that was where he -- the one that's  
12 written, "many." It was hard to know who had written  
13 what on this.

14 Q. Well, ma'am, I don't know that I need  
15 you to review ---

16 A. Okay.

17 Q. --- the chart, but Dr. Schily certainly  
18 confirmed that he did not write a note of his  
19 assessment that night in the emergency department, and  
20 everybody has described this situation as unique, where  
21 a chronic pain patient attends in Emerg and is placed  
22 on a PCA pump and sent to the ward. Would you agree  
23 that's a fairly unique or rare situation?

24 A. It would be unique to me.

25 Q. Okay. And when you're dealing with

1 something unique, would you agree with me that  
2 communication between health care professionals is  
3 especially important?

4 A. Yes.

5 Q. And that's doctor to nurse?

6 A. Yes.

7 Q. Doctor to doctor?

8 A. Yes.

9 Q. Nurse to doctor?

10 A. Written, verbal, all, yes.

11 Q. Written, verbal, all of the above?

12 A. Yeah, to mother, to child, to -- mm-hmm.

13 Q. And when a physician assesses a patient  
14 in the emergency department, particularly in a unique  
15 situation, would you agree with me that it's even more  
16 important for the physician to make a note?

17 A. Yes, that wouldn't be unreasonable.

18 Q. Because that, the note, is one of the  
19 primary ways for that doctor to communicate to  
20 subsequent doctors or to subsequent nurses involved in  
21 the patient's care?

22 A. Mm-hmm. The essence are the orders, but  
23 I agree, a note is important.

24 Q. And a note would document his assessment  
25 as a patient, his findings?

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A. Yes.

Q. And his plans for treatment?

A. Yes.

Q. And particularly, I guess -- and would you say, I guess, the note is the main method of communication or that's the most important method of communication?

A. It's the one you can track.

Q. Right. And in this case, we have no note written that night to track or to document for people subsequently caring for the patient, that physician's assessment, findings?

A. Yeah. I mean, our view was this was a combined note. His writing is the medications. There is a note and it may be the nurse's handwriting, but there is a synthesis here, so there was a handwritten piece ---

Q. Those are his orders, but he doesn't write a note saying here's my assessment, here's my findings?

A. That's right.

Q. And that would be something that you'd ordinarily expect and reasonable to expect a physician to do in the emergency department?

A. Yeah. The only proviso is that this

1 looked to us like a combined chart, his handwriting  
2 where the nurse has originally written "many meds" and  
3 he had carefully written in the medications, it led ---

4 Q. I don't believe that was Dr. Schily's  
5 writing.

6 A. Is that not right?

7 Q. That was another nurse doing that  
8 writing.

9 A. Okay, sorry. We thought that was his  
10 writing. But, I mean, you're right, what if? What if  
11 he'd written a really clear note with, you know,  
12 "Alert, Alert, Alert." No, I'm sorry, I don't mean to  
13 be frivolous, but you're right, that's another what if  
14 that might have made a difference.

15 Q. When dealing with a unique situation,  
16 communication is more important?

17 A. Yes. Yes, you're right.

18 Q. And in this case, the only communication  
19 that went from the emergency department to the ward in  
20 terms of the assessment and findings was nurse to  
21 nurse? And would you agree ---

22 A. And the orders, yeah.

23 Q. And the orders.

24 A. Yeah.

25 Q. But would you agree that in this

1 situation, as a unique situation, it would be helpful  
2 either through a note or a phone call to have a  
3 specific physician to nurse communication about  
4 assessment and findings and plans?

5 A. Other than the orders?

6 Q. Other than ---

7 A. It wouldn't hurt, you're right.

8 Q. Okay. And in this case, we've heard the  
9 nurses testify, the nurses on the floor testify that  
10 the message they got from the emergency department was  
11 that the two most important things were to manage the  
12 patient's pain and allow her to sleep and that the pain  
13 service would assess in the morning. So in that case,  
14 with that being the message they got from the  
15 communication, something was lost in communication?

16 A. Yeah, absolutely.

17 Q. And a reasonable recommendation for this  
18 jury to consider is that particularly when we're  
19 dealing with unique situations, highlight the  
20 importance of communication?

21 A. Yes.

22 Q. And specifically highlight the  
23 importance of direct physician to nurse communication,  
24 be it in writing or be it by a phone call?

25 A. Yeah. The high-level communication,

1           however, is the orders, so everything else embellishes  
2           that and I don't know what protocols and procedures or  
3           requirements there are at Sick Children's with respect  
4           to notations by physicians within time periods, but  
5           that's all important to be looked at.

6           Q.    And certainly in your own practice when  
7           you're dealing with unique situations or dealing with  
8           consultations in the emergency department, in addition  
9           to orders, you write a note of your assessment and  
10          findings?

11          A.    Yes.

12          Q.    So that that's there as a method of  
13          communication to people subsequently involved in the  
14          care?

15          A.    Mm-hmm.  Now would I ever at 1:00 in the  
16          morning exhausted not have done that?  I don't know;  
17          probably not, I mean ...  But there always are  
18          confounding ---

19          Q.    Okay.

20          A.    And I don't know whether you asked him  
21          and what he said and what the context was and what the  
22          rules are in Emerg, but, you know, I think you are  
23          making important points.

24          Q.    Okay.  And then if I can ask you to turn  
25          and I'd like to ask you some of the things about the

1 monitoring of Lisa on the ward and the criticism that  
2 you make, if I can summarize it, is not that the nurses  
3 did no monitoring but that they did insufficient  
4 monitoring?

5 A. My words would be one of the concerns we  
6 had is that the orders as written in the Kidcom system  
7 were not followed and that laid out the expectation of  
8 the physician with respect to monitoring.

9 Q. Right.

10 A. So it's not about us or we criticizing,  
11 it's about identifying what the gaps are and there was  
12 a gap between what was ordered and what was done.

13 Q. Okay. But certainly we see from the  
14 flow sheet that the nurses were monitoring this  
15 patient?

16 A. That's right, two parameters.

17 Q. Right, and they were actually checking  
18 those two parameters more frequently than the orders  
19 required?

20 A. That's right, and that was our next  
21 level of concern, was exactly that.

22 Q. So the nurses were not in any sense  
23 ignoring the patient?

24 A. No, that's right.

25 Q. And the nurses were monitoring parts of

1 her assessment ---

2 A. That's right.

3 Q. --- quite closely?

4 A. That's right.

5 Q. And when they became or with the concern

6 about diminished respirations, they continued to take

7 respirations very frequently?

8 A. That's right.

9 Q. And, again, more frequently than would

10 have been ordered?

11 A. That's right.

12 Q. And so ---

13 A. And that part was good, you're right.

14 Q. Okay. Then maybe you come to my next

15 point is that while we've heard a lot about clinical

16 judgments and the nurses have acknowledged that they

17 made some poor clinical judgments, but you'd agree that

18 they made, in addition, some good clinical judgments?

19 A. In terms of increasing the frequency of

20 those two parameters, yes, I agree.

21 Q. And that's a good thing to do ---

22 A. Yes.

23 Q. --- in these circumstances.

24 A. Yeah.

25 Q. And the ---

1           A.    And even the temperature at 5:00 in the  
2 morning, I mean, that was not ordered, that was, I  
3 think, about trying to figure out the tachycardia.

4           Q.    And that would be something -- or taking  
5 a temperature at 5:00 in the morning is not something  
6 that would be required by protocol or orders ---

7           A.    That's right.

8           Q.    --- but that's something extra?

9           A.    That's right.

10          Q.    And it shows, from your perspective,  
11 even if the nurses weren't making the right  
12 conclusions, they were at least thinking about it and  
13 trying to draw conclusions?

14          A.    Yeah.

15          Q.    And that's the process of clinical  
16 judgment, is thinking about it and trying to draw  
17 conclusions. The process of clinical judgment is  
18 looking at your patient, thinking about it, and trying  
19 to come to some conclusions about what to do next?

20          A.    Yeah. I mean, the dilemma is vital  
21 signs are vital and the interpretation of them is  
22 critical, and it is problematic in paediatrics because  
23 of the age swings because of things like fever, we get,  
24 I think, desensitized to red flags like this, so I  
25 don't know what the barriers were for this clinical

1 nursing situation to not translate into the action that  
2 was required to support Lisa, but -- and, I mean, I'm  
3 hesitant to call it "nursing judgment," I -- but  
4 something didn't happen because there were substantive  
5 changes. Obviously there was some concern on their  
6 part because they did, the one nurse in particular  
7 increased the frequency of the recording of the  
8 respiratory rates.

9 Q. And that, if we look at and we know that  
10 the respirations went down to 8 on a first recording at  
11 2:50 at that stage, and, again, we've heard that that  
12 assessment wasn't complete, but in terms of the  
13 assessment at 2:50, the nurse did some appropriate  
14 things and made some good clinical judgments in terms  
15 of the assessments that she did.

16 A. What's very unfortunate is that a blood  
17 pressure wasn't done, the oximeter wasn't on. You  
18 know, it's very unfortunate that all that was done was  
19 increase the frequency of the respiratory rate.

20 Q. Okay. Well, at 2:50 the nurse rechecked  
21 the respirations after it went to 8, and that's  
22 certainly something that is appropriate to do.

23 A. Yeah, because she was faced with whether  
24 she needed to page the physician or not, so ...

25 Q. But it's certainly appropriate to

1 recheck?

2 A. Confirm, oh, yeah.

3 Q. And in addition to rechecking the  
4 respirations, she did a chest assessment to look at the  
5 quality and depth of the respirations and that's  
6 something that's good to do or appropriate to do? She  
7 has noted there, "Chest clear, good air entry."

8 A. So, yes, that would mean that she has  
9 done -- she had looked at the chest or listened, I  
10 guess, for air entry and that's when she removed the  
11 pump, yeah, mm-hmm.

12 Q. So doing a chest assessment in response  
13 to diminished respirations, again, that's an  
14 appropriate or one of the responses you'd expect to  
15 diminish respirations.

16 A. And is that enough, is the question. I  
17 don't think it is.

18 Q. Okay.

19 A. And especially given the orders that ---

20 Q. No, I accept that, Doctor.

21 A. Okay.

22 Q. And that's the opinion of the committee?

23 A. Do you want me to stop saying that?

24 Q. No, I fully accept that it's not a  
25 complete assessment, as did the nurse, but I guess what

1 I'm getting at is the nurse didn't ignore the  
2 situation.

3 A. No, she paged the physician and she  
4 removed the PCA pump, which were appropriate things to  
5 do.

6 Q. And she made some effort to address the  
7 situation, even if not a complete effort?

8 A. Yes.

9 Q. And if we come back to the communication  
10 between nurse and physician at 4:00 and we've heard  
11 that there are two versions of the conversation, the  
12 nurse has said that she had the flow sheet in front of  
13 her when she called the doctor and if we deal first  
14 with the nurse's version, if the nurse tells the doctor  
15 the numbers for the respirations and the numbers for  
16 the heart rate as recorded in the flow sheet, you would  
17 expect the physician to respond to that?

18 A. If she told him the status at 4:05,  
19 which is that only the respiratory rate had been taken  
20 and it was 14 and 12 and that she was very drowsy and  
21 pain service aware and that she'd removed the PCA pump,  
22 that might give one kind of response. If she'd read  
23 each of the times and the respiratory rates and the  
24 heart rates, I would have expected another kind of  
25 intervention.

1 Q. So if we accept the nurse's evidence,  
2 which is that she told the physician of the decreased  
3 respirations to 8 and 10 at 2:50, that the heart rate  
4 was 120, 130 and that the respiration rate was now 14,  
5 12 as recorded, you'd expected ---

6 A. I would have expected questioning about  
7 the blood pressure, about the oximeter.

8 Q. Okay, specific questioning about those  
9 items, not accepting something like "vital signs  
10 normal"?

11 A. If those numbers had been given and I  
12 was then told that the vital signs, however, are now  
13 normal, I think I would, yes, I would have wanted to  
14 know -- well, exactly what the heart rate was, what was  
15 the blood pressure, yeah.

16 Q. And if the physician, as we take his  
17 evidence, is told a present situation of diminished  
18 respirations, you'd expect him or it would be  
19 reasonable to expect him to ask further questions about  
20 heart rate and blood pressure?

21 A. Yes. And even more pro-active than  
22 that, I honestly would have expected, if there hadn't  
23 been a response, it wouldn't have surprised me in the  
24 situations I've been in that the nurse would have said  
25 to me what I'm saying is the heart rate is elevated. I

1 mean, I -- that dialogue is very important.

2 Q. There was obviously something missing in  
3 the dialogue between nurse and physician?

4 A. Mm-hmm.

5 Q. But specifically if we accept the  
6 physician's own evidence that he was told a present  
7 situation of diminished respirations, you would have  
8 expected further, more detailed questioning of the  
9 nurse?

10 A. Yeah, I would have expected if he'd  
11 understood at whatever level that was, I would have  
12 expected a different overall outcome. I would have  
13 expected an intervention that would have made a  
14 difference. This is one of the what-ifs, for sure.

15 Q. Okay. Thank you.

16 MS. POSNO: Mr. Coroner, I don't mean to  
17 interject (inaudible) but I think it's mis-  
18 stating the evidence of Dr. Schily the way it  
19 was put by Mr. Hawkins, and if you read the  
20 specific language in the letter of Dr. Schily  
21 on this one call which, in my submission, was  
22 consistent with his testimony, he said that  
23 he was told the nurse reported that Lisa's  
24 respiratory rate was just above 10 per  
25 minute. The nurse reported that all vital

1 signs are good, that Lisa is arousable, which  
2 the nurse confirmed, and when I asked if she  
3 needs me to come to 5A, that part's disputed.

4 But just with respect to the vital signs,  
5 the respiratory rate, the level of  
6 arousability, there may be a bit of a  
7 language issue here, as well.

8 MR. HAWKINS: The jury, with respect, Ms.  
9 Posno, we have Dr. Schily's transcript, the  
10 jury has an opportunity to review Dr.  
11 Schily's transcript and they can look  
12 specifically at that. As I read that letter  
13 and as I recall Dr. Schily's evidence, he  
14 testified to a present situation or that he  
15 was aware of a present situation of  
16 diminished respirations. I also recall  
17 distinctly ---

18 THE WITNESS: But there wasn't a present  
19 situation.

20 MR. HAWKINS: No, but, ma'am, there was no  
21 present situation.

22 THE WITNESS: Never mind.

23 MR. HAWKINS: But if Dr. Schily understood a  
24 present situation of diminished respirations,  
25 you would expect a greater response?

1 THE WITNESS: That's right.

2 MR. HAWKINS: Okay.

3 MS. POSNO: Dr. Cairns, my objection or  
4 interjection here isn't to tell the jury what  
5 Dr. Schily said. They're able to determine  
6 the evidence on their own. My only comment  
7 is that I think the way the question was put  
8 to Dr. Williams, I thought it was a little  
9 bit overstated, that's all I wanted to raise  
10 to them.

11 THE CORONER: So you wanted to bring the  
12 accuracy of the statement to what was  
13 actually in his written note?

14 MS. POSNO: In his written note. The jury  
15 can decide themselves what Dr. Schily said.  
16 They can read the transcript, they can  
17 interpret the letter and they've heard Dr.  
18 Schily. I just wanted to be fair to Dr.  
19 Williams that, in my view, it was an  
20 overstatement, but I'll leave it at that.

21 THE CORONER: Well, you've now read out the  
22 note, so I think the confusion, if there was  
23 any, has been clarified.

24 MR. HAWKINS: Thank you. Those are my  
25 questions, Dr. Cairns.

1 THE CORONER: Would you prefer to start your  
2 questioning now or after lunch?

3 MR. GOMBERG: I don't really care one way or  
4 the other; whatever is more convenient to  
5 you, Dr. Cairns, and to the jury is fine by  
6 me. I'm going to be a while. I'm not going  
7 to be forever, but I may be 45 minutes, I'm  
8 not sure.

9 THE CORONER: Well, I think if you're going  
10 to be 45 minutes and I've no objection to the  
11 length of time you take, but I think that  
12 probably we're going to get interfered by  
13 lunch somewhere and it's probably more  
14 appropriate to do your examination without  
15 the interference of lunch. So we can recess  
16 now, it's just 12:30, we can recess to 1:45  
17 and then you can start at that time?

18 MR. GOMBERG: That's fine.

19 THE CORONER: I should remind everyone that  
20 Dr. Williams is on the stand and she should  
21 not be approached by anyone, she should not  
22 be approached by the press, and she should  
23 not discuss her evidence at the break with  
24 anyone. We'll recess until 1:45.

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--- LUNCHEON RECESS

THE CORONER: Mr. Gomberg?

MR. GOMBERG: Thanks very much, Dr. Cairns.

CROSS-EXAMINATION BY MR. GOMBERG:

Q. Dr. Williams, I have a few questions to ask you. First of all, I take it that you'd agree with me that you've never had a meeting with me to discuss this case?

A. No. Yes, I would agree to that.

Q. All right. And you've never had a meeting with my clients to discuss this case?

A. That's right.

Q. And, for example, my clients aren't family or anything like that to you?

A. That's true.

Q. All right. And I take it that you haven't been hired by me or anything like that; quite the contrary, you were hired, if I can put it that way, by the Coroner's Office?

A. That's right.

Q. All right, now, I'd like to contrast just quickly the care that Lisa received in the

1 emergency department with the care that she -- and I'm  
2 talking specifically now about the nurses, Nurse  
3 Matthews and the other nursing staff in the emergency  
4 department, with the care that she received on the  
5 ward. First of all, there was a lot of discussion  
6 about orders that Dr. Schily made and information. I  
7 think that you said that the notes, and I'm talking now  
8 about the two pages of handwritten notes made in the  
9 emergency department were a -- I can't remember the  
10 word you used, but the inference that I drew was that  
11 you thought that they were made with information  
12 acquired by Dr. Schily and information acquired by the  
13 nurses, if I can put it that way.

14 A. That's right. But, again, there was  
15 probably an inappropriate assumption on my part.

16 Q. Well, I don't know -- sorry ---

17 A. That's true, I thought it was ---

18 Q. We don't know, but what we do know and  
19 I'm not going to read through it, but we have a fairly  
20 extensive note made at 22:20, right, the blood pressure  
21 and all these other things?

22 A. Yes.

23 Q. And then there's a fairly extensive note  
24 made at 23:50 ---

25 A. Yes.

1 Q. --- recording heart rate and respiration  
2 and talking about all sorts of other stuff that's going  
3 on, and then there's a fairly extensive note made at 15  
4 minutes after midnight.

5 A. Yes.

6 Q. And another two notes, one made at 40  
7 minutes after midnight, and the other one made at 1:05  
8 in the morning.

9 A. Yes.

10 Q. All right. And those notes look like  
11 they were made by Nurse Matthews and I can't read one  
12 of the signatures, but certainly they were made in the  
13 emergency department, right?

14 A. Yes, that's what it looks like to me.

15 Q. And you'd agree with me that the care  
16 from what you can glean from reading the chart, was  
17 perfectly appropriate in the emergency department?

18 A. There was extensive both anecdotal  
19 recording and there was evidence of vital signs taken.

20 Q. All right. And that the good care, if I  
21 can put it that way, that she got in the emergency  
22 department, was good care that was provided to her by  
23 the nursing staff and by Dr. Schily?

24 A. I think so.

25 Q. All right. Now, just to follow through

1 on that theme, if I can put it that way, when she was  
2 in the emergency department, she was mostly awake.

3 A. Yes.

4 Q. All right.

5 A. From the notes, I think she drowsed off.

6 Q. All right, but certainly in the initial  
7 stages, she was ---

8 A. She was alert, grunting.

9 Q. Right.

10 A. Complaining about her pain.

11 Q. And her mother was with her?

12 A. That's right.

13 Q. So you have an awake mother?

14 A. Mm-hmm.

15 Q. And you have an awake child?

16 A. Mm-hmm.

17 Q. And then the question becomes, I  
18 suppose, in terms of monitoring, that's a type of  
19 monitor, it's not medical vital signs monitoring, but  
20 it's certainly a safety check that if something goes  
21 terribly wrong, all right, the mother is going to do  
22 something?

23 A. Absolutely.

24 Q. All right, because everybody's awake?

25 A. Mm-hmm.

1 Q. It's just common sense, right?

2 A. Mm-hmm.

3 Q. And notwithstanding that, as I

4 understand it, she was on an oxygen sedation -- an

5 oximeter, in the emergency?

6 A. I don't know that, and I may have missed

7 that.

8 Q. Well, it's not in the notes, but if I

9 tell you -- if that's the evidence that's been given in

10 this inquest ---

11 A. Yes, okay.

12 Q. --- then you'd accept the fact that

13 notwithstanding the fact that she was awake and her

14 mother was awake ---

15 A. Yes.

16 Q. --- and the two of them were there ---

17 A. Yes.

18 Q. --- notwithstanding that, they had her

19 on an oximetry device?

20 A. Yeah, which is a reasonable, very good

21 way to monitor, in my opinion, too, as an adjunct to

22 the mother, because I agree with you, I think mom

23 and/or dad at the bedside is also a good adjunct in

24 emergency department.

25 Q. That was point. Now, in terms of Dr.

1 Schily, I'd like to talk to you about Dr. Schily just  
2 for a minute. As I understand it, Dr. Schily was  
3 around the emergency department until, and I'm making  
4 this up, 'cause I can't remember it, but I think it was  
5 something like just before 1:00 when he went home, and  
6 I think that was the evidence, Dr. Cairns, but I really  
7 don't remember. Now, when Dr. Schily ---

8 MR. HAWKINS: My recollection is he said he  
9 was in and out on a couple of occasions and  
10 had gone somewhere else, like back to the  
11 operating room.

12  
13 BY MR. GOMBERG:

14 Q. Okay, I accept that, but he was around  
15 the hospital, all right, and was in the emergency  
16 department, as Mr. Hawkins said, until he went home for  
17 the night, all right? Now, while he was around, I take  
18 it that it's perfectly appropriate for Dr. Schily to  
19 make oral orders?

20 A. Yes.

21 Q. All right. Now, in terms of  
22 documentation, I guess it's better if you have written  
23 orders ---

24 A. Mm-hmm.

25 Q. --- but if you don't have the written

1 orders, certainly oral orders are better than no  
2 orders?

3 A. Mm-hmm.

4 Q. And if one accepts what Dr. Schily says  
5 about this, that's exactly what he did. Have you seen  
6 his statement given?

7 A. Yes, I have.

8 Q. All right.

9 A. The CMPA statement?

10 Q. Correct. And you'd agree with me that  
11 in the CMPA statement, and I'm talking about page two,  
12 two-thirds of the way down, I don't have it in front of  
13 me, but that's exactly what he said he did. Let me  
14 just read it to you:

15 "... Before I left I asked again  
16 Pauline, Emergency Room nurse, not to  
17 discharge Lisa from emergency until she  
18 had a pain score of 5 and to check her  
19 vital signs and to follow vitals up to a  
20 certain time before discharging her to  
21 the ward ..."

22 All right?

23 A. Mm-hmm. And that's also collaborated in  
24 the 23:50 note, where after Lisa had been seen by the  
25 pain fellow under the nursing notation, she does note.

1 Q. All right. So my point is that to the  
2 extent that there's an issue about the monitoring that  
3 she got and orders for the monitoring in the emergency  
4 department, Dr. Schily, apparently, if you accept his  
5 statement, made appropriate orders and those  
6 appropriate orders were appropriately followed by the  
7 nurses in the emergency department?

8 A. Is that me? Excuse me. (cell phone  
9 rings)

10 Q. When that happens to a lawyer, they go  
11 to jail.

12 A. Oh, good. Sorry, so I missed the  
13 flavour of the ...

14 Q. I think the point was that the orders  
15 were appropriately made by Dr. Schily, albeit orally.

16 A. Right. In that statement that I read  
17 and I think they are confirmed in the notations made by  
18 the nurse on the chart, the record that we reviewed.

19 Q. All right. Now, I wanted to ask you  
20 something, but I'm fairly certain you're not going to  
21 be able to answer this but I want to ask it anyway, and  
22 that is: after having reviewed the chart, can you  
23 reach any conclusion about the time of death?

24 A. No.

25 Q. All right. And ---

1           A.    I know the time of -- I know, obviously,  
2           what the last notation of when she was alive ---

3           Q.    Right.

4           A.    --- and when she was dead and it was  
5           somewhere between 6:00 and 7:15.

6           Q.    All right, so she would have become  
7           vital signs absent, if I can put it that way, sometime  
8           between 6:00 and 7:15?

9           A.    Yes.

10          Q.    And then there were attempts to  
11          resuscitate her and we're not going to get into that,  
12          because there's no issue about that.

13          A.    Our committee had no issue with that.

14          Q.    All right, nor does the Deputy Chief  
15          Coroner, nor do the jurors, nor do any of the lawyers,  
16          all right?

17          A.    Mm-hmm.

18          Q.    Now, in terms of the ---

19          THE CORONER:    Just a minute, Mr. Gomberg, I  
20          have a quick note here just from the Court  
21          Reporter, if you could say "yes" or "no,"  
22          it's better for her transcription.

23          THE WITNESS:    I'm sorry, yes.

24  
25          BY MR GOMBERG:

1 Q. Now, when you had this meeting with Mr.  
2 Hawkins in December, were there any nurses present at  
3 that meeting?

4 A. No. And, I mean, I did take direction  
5 from the chair of the committee and it was to the  
6 report, the dialogue between us was to the report. You  
7 don't want me to say that?

8 Q. No, I'm not questioning the dialogue at  
9 all.

10 A. Okay.

11 Q. I'm not questioning the propriety of ---

12 A. There were no nurses there.

13 Q. The only point that I'm making is I  
14 wasn't at that meeting.

15 A. That's right.

16 Q. And I never had a meeting with you?

17 A. You could have, but no, you did not.

18 Q. I could have, that's right, but I  
19 didn't.

20 A. You did not, no.

21 Q. All right. And there was no directive  
22 not to bring nurses to the meeting if nursing input was  
23 something that was desirous; is that right?

24 A. To be honest, I would have called the  
25 Coroner's office to ask if I could be present with the

1 nurses. I mean, I don't know always all about ...

2 Q. All right. Now, I wanted to ask you a  
3 little bit about morphine and I appreciate that you're  
4 not a clinical pharmacologist or a toxicologist, but  
5 the point to doing all this monitoring is that morphine  
6 is dangerous, or potentially dangerous?

7 A. It has good and bad. It has bad side  
8 effects, yes, can have bad side effects.

9 Q. Particularly, and generally speaking,  
10 assuming that you're not comparing somebody who is oped  
11 tolerant to somebody who isn't, but generally speaking,  
12 the less you weigh and the more morphine you have, the  
13 more dangerous it can be. Is that a reasonable  
14 statement?

15 A. I think that's fair, yes.

16 Q. All right.

17 A. It is a weight-related dosing schedule.

18 Q. And without getting into the intricate  
19 details of it which are way beyond me, a dose of 14 and  
20 a half milligrams over an hour and 17 minutes, which I  
21 think the record will reflect is what happened here ---

22 A. Mm-hmm.

23 Q. --- is a fairly significant dose?

24 A. Mm-hmm.

25 Q. Do you agree with that?

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A. Yes.

Q. All right.

A. But it's within pain control management,  
yes.

Q. I'm not questioning that.

A. Okay.

Q. You see, I think that what we've heard  
at this inquest are things like what you just said,  
that it's therapeutic dosages and things like that and  
I think I understand what that means, but just for the  
benefit of me, if I don't understand it, and for the  
jurors, it can be within a therapeutic range, but it  
can still be a very hefty dose of the medication; isn't  
that right?

A. I mean, "hefty" isn't a medical term.

Q. No, I know that.

A. So, I mean, clearly we use medications  
like that for the benefit of pain control and there is  
a range within which it's therapeutic, reasonable, to  
give a dose in order to have on the one hand, the child  
comfortable while still being within a range that is  
considered to be ...

Q. Right, but just so I can understand  
this, if you were to give me or Dr. Cairns a shot of  
morphine, 14 and half milligrams in one shot, now, that

1 would be a fairly significant ---

2 A. Yes.

3 Q. --- administration of morphine, that's  
4 all? I'm not comparing that pharmacologically to what  
5 happened with Lisa, because she was given two boluses  
6 of two milligrams, plus one and a half milligrams seven  
7 times ---

8 A. Right.

9 Q. --- over a one hour and 17 minute  
10 period, but my question is: one shot of morphine, even  
11 to an adult, would have a fairly significant, pack a  
12 fairly significant punch, which is also not a medical  
13 term. But as a lay person, we could agree on that,  
14 couldn't we?

15 A. I mean, my reservation is that I'm not  
16 an adult physician; I'm even worse in the adult field  
17 than -- I mean, in the pediatric field, that dose is  
18 whatever word you put on it, it is within the range  
19 that we would use in order to get pain control.

20 Q. All right.

21 A. So I hate to qualify it with ---

22 Q. All right.

23 A. --- was it a light dose, a heavy dose?

24 Q. Can you qualify it that way?

25 A. I think it was within the therapeutic

1 range is really what I should be saying.

2 Q. All right. Now, in terms of oximetry, I  
3 take you'd agree that oximetry was a significant  
4 adjunct to the monitoring in terms of figuring out what  
5 was going on with Lisa? First of all, it was ordered,  
6 right?

7 A. Yes, it was ordered.

8 Q. All right. And it was ordered for a  
9 good reason, right?

10 A. All of those things were ordered with,  
11 yeah.

12 Q. But in particular, oximetry is important  
13 because it gives you some indication of the oxygen  
14 saturation of the blood?

15 A. Yes.

16 Q. Isn't that right?

17 A. Yes. It's one more good way, it's  
18 another piece that had it been in place, hopefully the  
19 outcome would have been very different.

20 Q. All right. Now, in terms of the high  
21 heart rate, you talked about that I think earlier in  
22 your evidence, and I think you said that that can be  
23 caused by -- I'm talking about the readings on the flow  
24 chart ---

25 A. Yes.

1 Q. --- that say 134, for example, but that  
2 that high heart rate can be caused by pain, but it can  
3 be caused by something else, as well?

4 A. Yes.

5 Q. Is that right?

6 A. I mean, there is a differential  
7 diagnosis with a tachycardia, yes ---

8 Q. That's exactly ---

9 A. --- many things.

10 Q. That's what I was going to ask, and that  
11 is that when you're doing a differential diagnosis, as  
12 I understand it as a lay person, a differential  
13 diagnosis is you consider a number of different ---

14 A. Options, yes.

15 Q. --- diagnoses and then rule out ---

16 A. Or in.

17 Q. --- or rule in ---

18 A. Mm-hmm.

19 Q. --- and eventually by a process of  
20 either elimination or inclusion, you end up with the  
21 most likely ---

22 A. Where you need to be, yes.

23 Q. You end up with the most likely  
24 diagnosis?

25 A. Yes.

1 Q. All right, and that's what doctors do  
2 and that's what nurses should be assisting doctors to  
3 do, is that the idea? I mean, the nurses give the  
4 doctors the information and the doctors make the  
5 diagnosis?

6 A. There is nursing diagnosis, too, and you  
7 have to ask nurses about that, but, yes, in general.

8 Q. All right.

9 A. It's about all of us working together to  
10 try to figure out when parameters like heart rates are  
11 out of an accepted range.

12 Q. All right. So just to deal with that  
13 for a minute, if one is seriously considering pain as  
14 being the diagnosis of choice ---

15 A. Mm-hmm.

16 Q. --- then I take it that one of the ways  
17 to figure out whether that's correct as a diagnosis is  
18 to try to figure out how much pain the child is in?

19 A. Mm-hmm.

20 Q. Is that right?

21 A. Yes.

22 Q. In fact, it's the only way to deal with  
23 that issue, isn't it?

24 A. Well, I think the other way is to look  
25 back when we -- the last scale where we knew she did

1 have pain and to look at the heart rate there and, in  
2 fact, the heart rate was I think in the '70's ---

3 Q. Exactly.

4 A. --- when she had her highest pain  
5 scales.

6 Q. We dealt with that earlier in the  
7 inquest, but I wanted to make sure that I dealt with it  
8 with you. If the child is moaning in pain or whatever  
9 the words are in the emergency room ---

10 A. Mm-hmm.

11 Q. --- and her heart rate is 70 or 80 ---

12 A. Mm-hmm.

13 Q. --- and that's when she's in the worst  
14 pain, just as she's being administered morphine for the  
15 first time ---

16 A. Mm-hmm.

17 Q. --- one would have to take that into  
18 consideration and compare and contrast that to a heart  
19 rate of 134 when she's asleep; isn't that right?

20 A. That would make sense to me, yes.

21 Q. All right. And then logically, if the  
22 child is sleeping and it's likely that she's not in as  
23 much pain as she was when she was awake and moaning and  
24 groaning before she had morphine, then one would have  
25 to question very seriously another cause for an

1 elevated heart rate?

2 A. Yes.

3 Q. All right. And not to do that, not to  
4 question it, is not acceptable, isn't that right?

5 A. I would have questioned it.

6 Q. Okay. Now, certainly one would have at  
7 least done a pain scale, should have at least done a  
8 pain scale and done a blood pressure reading at that  
9 point ---

10 A. Yes, yes.

11 Q. --- to figure out what was going on?

12 A. Yes, yes.

13 Q. All right.

14 A. And partly because of the change and  
15 partly because of the level that it was at.

16 Q. Sure, there are two issues that ought to  
17 have led you to do those medical tests or checks; one  
18 of them is the heart rate, in and of itself is high?

19 A. Yes.

20 Q. And the second thing is by way of  
21 contrast to what was going on when she was moaning in  
22 pain, the contrast is fairly significant?

23 A. Yes.

24 Q. All right. So those are two prompts, if  
25 I can put it that way ---

1 A. Yes.

2 Q. --- that one should do further  
3 assessment?

4 A. Yes, I agree.

5 Q. All right. And one has to ignore those  
6 prompts or at least not pay attention to them if one  
7 fails to do those further tests, isn't that right?

8 A. I'm sorry?

9 Q. Well, obviously you're ignoring the  
10 prompts or they don't make an impact on you ---

11 A. That's right.

12 Q. --- if they don't prompt you to do what  
13 you should be doing?

14 A. That's right, yeah.

15 Q. All right.

16 A. "Ignoring" would imply ---

17 Q. "Ignoring," I retreat from that, that's  
18 the wrong word. Okay, I agree with you. It implies an  
19 active ---

20 A. Yeah.

21 Q. --- kind of role.

22 A. Choosing to not versus not ---

23 Q. Exactly and I'm not suggesting that, all  
24 right?

25 A. Okay.

1 Q. Now, let's just talk about a Corometric  
2 monitor, just for a minute. I take it you'd agree with  
3 me that there shouldn't really be any confusion. We  
4 were talking about confusion before; confusion in terms  
5 of looking at the case and figuring or trying to figure  
6 out what went on. There shouldn't be confusion about  
7 whether or not a monitor was attached and working.

8 A. I agree.

9 Q. All right. And you talked earlier about  
10 Dr. Schily, his note and possibly it would have been  
11 better if his note, and I'm talking about the CMPA note  
12 for want of a better description.

13 A. Mm-hmm.

14 Q. It could have been in the hospital  
15 record.

16 A. Mm-hmm.

17 Q. All right? And therefore it would have  
18 been available to whoever called for the hospital  
19 record, but I take it you'd agree with me, do you know  
20 anything about the draft Death Summary that was done in  
21 this case?

22 A. A draft?

23 Q. Right, by a Dr. Lobo? You haven't seen  
24 that?

25 A. I would have to check which -- what

1 Death Summary I saw. I certainly saw a Death Summary.

2 Q. All right. Well, I don't really want to  
3 spend a lot of time on it. It was something,  
4 apparently, just to summarize it, a draft summary was  
5 done by a Dr. Lobo which was then reviewed by a Dr.  
6 Wright and he changed it and then put his Death Summary  
7 in the record, but I take it that you'd agree with me  
8 that that type of information also could go in the  
9 record, in the hospital record?

10 A. Sure.

11 Q. All right.

12 A. In my opinion, it could.

13 Q. Sure, because the more information you  
14 have, the better it is, right?

15 A. Mm-hmm.

16 Q. All right, and in addition, I don't know  
17 if you were here to hear this or whether it has been  
18 related to you, but Nurses Doerksen and Soriano made  
19 extensive notes about what happened that night. Were  
20 you aware of that?

21 A. Yes, and actually I was provided with  
22 those.

23 Q. And those notes went into sealed  
24 envelopes where they remained for months and were  
25 eventually given to their lawyer and furnished to the

1 Coroner and to Counsel in January of the year 2000.

2 A. Mm-hmm.

3 Q. I take it those notes could have gone on  
4 the record, too, and that would have been helpful?

5 A. I mean, I do feel there's a role for,  
6 you know, almost journal writing. I mean, clearly some  
7 of the content of those notes had to do with them  
8 dealing with the -- their emotional impact. However,  
9 there was also embellishment of the technical  
10 information that would have been useful in terms of  
11 understanding what had happened and, you know, although  
12 one could have expected the nurses involved to know  
13 this and to have included it in the chart, I think you  
14 have to also ask what the system didn't do about, you  
15 know, recruiting that kind of information to the chart,  
16 whether it was the Coroner or Sick Kids or -- so I  
17 agree that the -- and, in fact, one of the realms that  
18 the pediatric Coroner's Review Committee did was at  
19 Sick Kids in 1996 and that was one of the, sort of, top  
20 ten learning points that we did bring to rounds there  
21 was that very thing that, you know, recording and  
22 charting and even charting after things have gone amuck  
23 including, you know, a horrendous thing like this, is  
24 very useful in terms of, you know, sorting out,  
25 identifying what the issues are, trying to figure out

1           what can be done differently immediately and long-term  
2           and so the better the quality of information and the  
3           information is better when it's obtained right around  
4           the event, so ...

5                   Q.    All right.  Now, the other area that I  
6           wanted to ask you about very quickly is this  
7           communication thing between Dr. Schily and Nurse  
8           Soriano at roughly 4:00 or 4:05 in the morning.  You  
9           were asked questions about that earlier and I think you  
10          described it as a -- there's obviously a conflict which  
11          the jurors are going to have to resolve ---

12                   A.    Mm-hmm.

13                   Q.    --- as to who said what to whom, if I  
14          can put it that way.

15                   A.    Mm-hmm.

16                   Q.    And you called that a he said/she said  
17          type of thing.  And what I did want to ask you, though,  
18          is this:  regardless of what Dr. Schily said and what  
19          was said back to him and then what Ms. Soriano said, in  
20          other words, what they said to each other, all right,  
21          regardless of what they said to each other, the ball  
22          was dropped, wasn't it?

23                   A.    Somewhere.

24                   Q.    All right.  And in terms of the ball  
25          being dropped, whether it was dropped by Dr. Schily or

1 it was dropped by Nurse Soriano or it was partially  
2 dropped by the two of them, it's not something that  
3 should happen?

4 A. I agree.

5 Q. Now, you talked about Nurse Soriano not  
6 having made a progress note, and I think you indicated  
7 that that would have been valuable at roughly 2:50 in  
8 the morning, or sometime between 2:50 and 4:05?

9 A. I was reflecting on her testimony where  
10 she talked about doing progress notes only for  
11 incidents.

12 Q. Right.

13 A. And I think it was quite telling if that  
14 was her understanding of the progress notes, that her  
15 dealing with the respiratory rate and repeated calls  
16 from her point of view to the physician, it was telling  
17 to me that she didn't view that as an incident, so that  
18 was the point I was trying to make, that it wasn't of  
19 import enough to include in the progress note.

20 Q. All right, and you question that,  
21 though?

22 A. I do.

23 Q. All right. And in hindsight and  
24 certainly as part of what seems like common sense  
25 practice, when you have an incident that on her

1 evidence caused her to phone the doctor, page the  
2 doctor, that's Dr. Schily at 2:50, that's something  
3 that warrants at least a passing note by the nurse in  
4 the chart, doesn't it, particularly in light of what  
5 happened thereafter?

6 A. Yes, and even perhaps moreso at 4:15 --  
7 4:05, after she had actually made contact with him, I  
8 think it would have been very useful, wouldn't it, to  
9 have in front of us a recording of that dialogue what  
10 had been said and what actions were to be taken and ...

11 Q. All right, and just to follow through,  
12 that note would be important in two contexts, I  
13 suppose. It would be important as a historical  
14 document in the sense that we can all look back at it  
15 and see what she recorded then as part of an expose  
16 facto\* investigation of what happened?

17 A. Mm-hmm.

18 Q. It's important from that perspective.  
19 It's also important, I suggest, in terms of anybody who  
20 may have looked at that chart between 4:05 and whenever  
21 Lisa died, whether it was 6:30 or 7:00 or 7:15; isn't  
22 that right?

23 A. It would be important for, like, the  
24 next nurse taking over having a better understanding of  
25 what was going on, what the thinking was, what the

1 directions were.

2 Q. That's exactly my point. In other  
3 words, when Nurse Doerksen took the patient back as her  
4 patient, she would have a written note in the progress  
5 part of the file from Nurse Soriano telling Nurse  
6 Doerksen precisely what Nurse Soriano noted and that's  
7 why she made the note; that's my point.

8 A. And, I mean, there is a note on the flow  
9 chart saying that the pain service is aware but, again,  
10 in retrospect, I think it would have been useful if  
11 there had been something more in the narrative.

12 Q. All right. Now, there was a discussion  
13 -- I can't remember whether Ms. Browne raised this or  
14 it was raised by one of the other lawyers, but you said  
15 that there was a lot of confusion about getting Dr.  
16 Schily's orders, those are the suspended orders, there  
17 was confusion about that.

18 A. Yes.

19 Q. And that was confusion on the, as  
20 related to you ---

21 A. Yeah.

22 Q. --- in terms of the study that was done  
23 by the Pediatric Review Committee?

24 A. Yes.

25 Q. Now without ascribing fault to anybody,

1 I take it you'd agree with me that it's a bad thing not  
2 to be able to get orders that should have been on the  
3 chart fairly promptly in terms of doing an analysis of  
4 what happened?

5 A. It's certainly an area of clarification  
6 where the problem was, whether it was on the Coroner's  
7 side, whether it's on the providing hospital side, but  
8 there does need to be an improvement in the quality of  
9 information and the transfer of that information  
10 between this hospital and other hospitals and the  
11 Coroner's office.

12 Q. All right.

13 A. There are so many sophisticated systems  
14 happening out there, it's very difficult for coroners,  
15 I think, to know what they need to ask for almost, and  
16 so we've got to work out a way to have better transfer.

17 Q. All right. Now, the other area of some  
18 confusion, I know that the jurors are considering this  
19 is that there's some confusion about when orders take  
20 effect in terms of hourly monitoring, if I can put it  
21 that way.

22 A. Mm-hmm.

23 Q. Are you aware of the fact that that's  
24 been an area of confusion ---

25 A. Mm-hmm.

1 Q. --- both to the nurses ---  
2 A. Yes.  
3 Q. --- and to others at this inquest?  
4 A. Yes.  
5 Q. All right. And I'm specifically  
6 talking, let's just talk about the order to take blood  
7 pressure every hour, let's just make it simple.  
8 A. Yes.  
9 Q. The order to take blood pressure every  
10 hour is made by Dr. Schily. Now, it's true nobody --  
11 every hour for the first four hours.  
12 A. Mm-hmm.  
13 Q. So let's just talk about that one for  
14 the minute. Should there be confusion about that or is  
15 that an area, really, that everybody should be talking  
16 a universal language?  
17 A. If there is confusion, that's something  
18 that needs to be identified and sorted out. It  
19 appeared clear in the minds of the pediatric Coroner's  
20 Review that the Kidcom orders hourly for the first four  
21 hours related to when she was admitted, so it would  
22 have been from 1:45 plus four hours.  
23 Q. All right.  
24 A. If there is confusion between when we  
25 call admission with respect to that monitoring scale,

1 that's something that needs to be flagged on, the  
2 Kidcom flagged on the protocol.

3 Q. Clearly as a doctor, though, it's  
4 somewhat shocking to be in the middle of an inquest and  
5 to find out that there is confusion amongst the nursing  
6 staff about what that means, and I'm talking, let's  
7 just talk about the blood pressure for a minute. I'm  
8 not going to go through them one by one, but it is  
9 somewhat shocking, isn't it?

10 A. "Shocking," I mean, that's your word.  
11 It's disappointing, it's concerning, it's ...

12 Q. I accept that. Now, in terms of the --  
13 I take it you'd apply the same terminology,  
14 "disappointing," is one word that comes to mind, to the  
15 fact that no pain scales were done.

16 A. Yes.

17 Q. And you'd apply the same word to the  
18 fact that no sedation scales were done, formal sedation  
19 scale?

20 A. Yeah. I mean, I don't think in my mind  
21 and the committee's mind, on the one hand, as much  
22 respect as I have for Sick Kids as an institution. You  
23 know, when I was a practising physician, they did  
24 incredible things clinically for many of my patients on  
25 cutting edge on the one hand; their academic and their

1 research track records are incredible.

2 On the other hand, this is a very  
3 disappointing -- something failed badly here with  
4 respect to Lisa and Lisa's family, obviously, and I  
5 don't think anyone from Sick Kids in the room would  
6 feel otherwise. I mean, this is a horrendous outcome,  
7 so if "shocking" is the label that we all need to put  
8 on it, then we should, and from it we've got to learn  
9 steps forward and figure out what we can do to resolve,  
10 improve and, I mean, I would love to have known that  
11 anything we identified had already been identified and  
12 resolved at Sick Kids and maybe it has been and we just  
13 haven't heard the clear messaging around it, but it was  
14 not reassuring with some of the testimony that I heard  
15 on Monday to feel that -- I mean, clearly there are  
16 some systemic things that have changed. There are a  
17 number of examples that we were provided with and I  
18 accolade Sick Kids for acting and doing those things.

19 There clearly are some other issues,  
20 though, even as the inquest is unfolding, that have  
21 been, I think, highlighted that clearly need attention  
22 to ensure that, you know, this was in my mind one of  
23 these situations where there were a number of what-ifs,  
24 what-ifs, there must be a list of 20 what-ifs that  
25 might have changed the course of this, you know, to

1 bring us to a different outcome and none of them, none  
2 of them did.

3 Q. All right. And I'm almost finished,  
4 but, for example, you'd agree that when Dr. Schily says  
5 that he told the nurse at 4:05 and I quote, "Keep a  
6 close eye on her," that wasn't done?

7 A. And maybe it wasn't enough, maybe it  
8 needed to be blood pressure, heart rate, I mean, it's a  
9 whole system that somehow failed so, no, "a close eye,"  
10 however that's translated, obviously wasn't done.

11 Q. All right. Now, the only other question  
12 that I had for you relates to this issue of activating  
13 the Kidcom orders, if I can put it that way. And I  
14 don't know if you heard any of the evidence with regard  
15 to that, but I take it that in terms of a doctor  
16 prompting, if I can use that word, somebody on the  
17 floor that's a nurse to activate the Kidcom, that in  
18 terms of that message getting up there, there are two  
19 things; there's the form of the message and then  
20 there's the content, right? The form being how you  
21 communicate the information up to the floor, phone or  
22 in writing.

23 A. Okay.

24 Q. All right, that's the form.

25 A. Yes.

1 Q. And then there's the content ---  
2 A. Yes.  
3 Q. --- being "see the Kidcom."  
4 A. Mm-hmm. Yes.  
5 Q. Right. It really shouldn't matter which  
6 form the prompt takes, should it?  
7 A. I believe that's true.  
8 Q. All right. In other words, it's the  
9 message is the medium on this one, you get the message,  
10 you activate the Kidcom.  
11 A. Yeah. Maybe that's not quite true,  
12 because, in fact, especially if it's something more  
13 complicated, you would do a verbal on top of, you know,  
14 but I could certainly understand having carefully laid  
15 out a series of orders in the Kidcom system to write  
16 "See Kidcom" and expect that it would be seen.  
17 Q. Well, okay, I just want to finish on  
18 that, but you understand, I think, that Dr. Schily, and  
19 I'm showing you Exhibit 5, which is the blow-up, said  
20 -- I think it's Exhibit 5 -- "See Kidcom orders."  
21 A. Mm-hmm, yes.  
22 Q. And you're aware of the fact that that  
23 wasn't done, so the message was sent.  
24 A. That's right.  
25 Q. It just wasn't received.

1           A.    That's right.

2           Q.    Now, just to finish on that point, are  
3 you aware of the fact two phone calls did go up from  
4 the emergency room, one at roughly 12:00 midnight and  
5 one at 1:30?

6           A.    Yes, I am, from the testimony as -- I'm  
7 not sure they're recorded here, but there's probably  
8 one recorded and I think I'm aware of a second one,  
9 "spoke to both nurses."

10          Q.    Right.  And you'd agree with me that  
11 those are two more prompts that ought to have put up  
12 some red flags with regard to activating the Kidcom or  
13 at least thinking about it?

14          A.    I wouldn't have tied it directly to  
15 that, that might not have been articulated as a piece  
16 of -- but clearly it was written.

17          Q.    All right.  And you'd agree with me that  
18 the patient coming up in a gurney with her mother is  
19 yet another prompt to look for orders?

20          A.    Yes.

21          Q.    Those are my questions.  Thank you very  
22 much.

23          THE CORONER:  Does the jury have questions  
24 of Dr. Williams?

25

1 CROSS-EXAMINATION BY THE JURY

2 BY JUROR #1:

3 Q. Can I ask a question about gabapentin?

4 A. Yes.

5 Q. Would you know if there's an antagonist  
6 for that drug?

7 A. No, I would not know. I don't believe  
8 there is, but I don't know that.

9 Q. Thank you.

10 THE CORONER: I will get that information  
11 for you. To the best of my knowledge also,  
12 there is not, but I'll get that information  
13 for you.

14 JUROR #1: Thank you.

15 THE CORONER: Any other questions of Dr.  
16 Williams or any questions from other Counsel  
17 that arise out of the questioning? Thank  
18 you, Dr. Williams.

19 THE WITNESS: Thank you.

20 MS. BROWNE: I have a question that I should  
21 put on the record now. This has to do with  
22 timing. We've all been discussing relative  
23 timing and when it would go on and when the  
24 evidence would finish, and I appreciate the  
25 next witness we anticipated to be from the

1 hospital, but I've been looking over some of  
2 the will says that I got from Mr. Hawkins in  
3 January. A lot of them, we've decided, all  
4 of us as Counsel, we don't need to have any  
5 of these people called, but having reviewed  
6 them again, I'm going to be asking that a  
7 Miss Sian, S-I-A-N, Phillibert, P-H-I-L-L-I-  
8 B-E-R-T, be called as a witness before any of  
9 the other Counsel get the chance to call  
10 their witnesses, and I'm going to ask that  
11 that maybe be arranged for Monday, if it can.

12 It appears, and I haven't appreciated this  
13 until I read it a lot, that this lady was the  
14 day nurse on charge in 5A and she overlapped  
15 in her attendance with Ms. Doerksen and Ms.  
16 Soriano, and I think that that certainly  
17 would be relevant as to care and to the  
18 instructions and so on. May I ask her to be  
19 called?

20 THE CORONER: Can you explain to me what you  
21 mean by "overlap"?

22 MS. BROWNE: Well, she's supposed to be on  
23 day -- the charge nurse in charge of the day  
24 shift and we've heard about what orders were  
25 left and so on. I find out when I read it

1 specifically that she got there before her  
2 shift was supposed to start and she was  
3 actually dealing with patients and so on from  
4 6:30 a.m.

5 Now, we don't know when Lisa died, we  
6 know when the resuscitation was called and  
7 when that happened, but I think that the  
8 critical period in there, I think we should  
9 know what she knew about and what steps she  
10 took with regard to the care of Lisa at that  
11 time.

12 THE CORONER: Certainly from the information  
13 you've given me, I think that there is a lot  
14 of confusion around that time and if any  
15 witness can be of assistance, I would like  
16 this jury to hear them, so I will issue a  
17 warrant for that witness. Now, in terms of  
18 Mr. Hawkins, it was the intention that we  
19 would finish all witnesses subpoenaed by the  
20 Coroner before any witnesses that you wished  
21 to bring give their testimony and with the  
22 exception of this witness, it was intended  
23 that you would be calling one of your  
24 witnesses, so I have no objection if you want  
25 to postpone your witness until after this

1 witness has been subpoenaed by our office.

2 MR. HAWKINS: I would ask for a brief recess  
3 in the sense that Miss Phillibert has not  
4 been subpoenaed to this point. I do not know  
5 her availability. I can probably check that  
6 if we take a brief recess. She's certainly  
7 not available today, I'm assuming.

8 THE CORONER: No, I'm not -- but what I am  
9 saying is I am going to issue a subpoena for  
10 her attendance and unless she is actually out  
11 of the country, I do not anticipate her to be  
12 here today.

13 MR. HAWKINS: My assistant writes me a note  
14 that may make that an issue, unfortunately,  
15 that Miss Phillibert is on vacation at the  
16 moment. I don't know, so I've got to check  
17 that issue.

18 THE CORONER: That's fair. So ---

19 MR. HAWKINS: Because she had not been  
20 subpoenaed to this point.

21 THE CORONER: I couldn't agree with you  
22 more.

23 MR. HAWKINS: So I do not know her  
24 availability and nobody had suggested she had  
25 to be available because nobody has subpoenaed

1 her, so I've got to check that, so if I can  
2 have a brief recess, perhaps we can check  
3 that and see where we're at.

4 THE CORONER: Yes. Well, why don't we -- we  
5 need an afternoon recess anyway, we can  
6 recess for 20 minutes and then consider it  
7 after. Thank you, Mr. Hawkins.

8  
9 --- A BRIEF RECESS

10  
11 THE CORONER: Mr. Hawkins?

12 MR. HAWKINS: Yes, we're trying to sort out  
13 here availability; hopefully it will be for  
14 Monday. My suggestion is that we adjourn  
15 until 9:00 tomorrow ---

16 MR. GOMBERG: Monday.

17 THE CORONER: I prefer Monday.

18 MR. HAWKINS: I won't be here then, either.

19 I would suggest if we adjourn until 9:00  
20 Monday and if there are any scheduling  
21 difficulties, I will contact you over the  
22 weekend.

23 THE CORONER: That will be fine. So we will  
24 adjourn until 9:00 a.m. Monday in  
25 anticipation that the witness will be

1 available at that time, so I don't suppose  
2 you'd be too disappointed that -- I'm trying  
3 to make up for keeping you until 7:30 the  
4 other night, so if we add up the hours I'll  
5 probably still owe you a few, but at least  
6 you can have a little bit earlier of a  
7 weekend. Have a good weekend.

8 MR. HAWKINS: There is one point, Dr.  
9 Cairns, before I forget and it's on something  
10 completely different. You had received a  
11 letter which you provided to Counsel from ---

12 MR. GOMBERG: It should be filed.

13 MR. HAWKINS: --- the makers of Eclipsys  
14 that should probably be filed and I had a  
15 note to myself to do it and I forgot,  
16 yesterday, so I thought I better do it today.

17 THE CORONER: Thank you. It should be, yes.

18 As was indicated, the witness from Sick Kids  
19 had said that the tape, once it was recycled,  
20 it was not available by any other means and I  
21 did take it that we would confirm  
22 independently, I did speak and I think I told  
23 you that, I did speak to a representative and  
24 we now have a faxed reply which we'll put in  
25 as the next exhibit, which basically is

1 confirming what I gave to you orally, I think  
2 it was yesterday.

3 MR. HAWKINS: Yes. Do you want me to simply  
4 read it?

5 THE CORONER: Yes, why don't you?

6 MR. HAWKINS: It's a letter from Joanne Cook  
7 who is with Eclypsis to Dr. Cairns and it  
8 says:

9 "... As per my conversation this morning  
10 with Jeff Mainland, this is to confirm  
11 that the print queue log available with  
12 the Eclypsis 7000 product known as  
13 'Kidcom' at the Hospital for Sick  
14 Children can be preserved on tape, the  
15 length of storage is site specific. If  
16 the tape is reused and the information  
17 deleted from the system, this  
18 information would be permanently removed  
19 from all sources. In discussing this  
20 within Eclipsys technical resource, he  
21 confirmed that a typical site would keep  
22 this information for approximately one  
23 week. These are operational decisions  
24 at each and every site. Regards, Joanne  
25 Cook ..."

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THE CORONER: Thank you; that will be the next exhibit.

MR. HAWKINS: I would certainly mark my copy if someone would give me another copy.

MR. GOMBERG: I will.

CONSTABLE CULLETON: Exhibit 63.

EXHIBIT NO. 63: Letter from Eclypsis

THE CORONER: Thank you for your co-operation, Mr. Gomberg. I'm glad to see that you and Mr. Hawkins are co-operating so nicely.

MR. HAWKINS: We always try.

THE CORONER: We'll adjourn, then, until 9:00 a.m. on Monday.

--- ADJOURNED

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.

1  
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3  
4  
5

Barbara A. Pollard  
Certified Court Reporter