

INQUEST INTO THE DEATH OF

L I S A   S H O R E

EVIDENCE OF DR. JAMES WRIGHT

TAKEN FEBRUARY 2, 2000

BEFORE DR. JAMES CAIRNS, DEPUTY CHIEF CORONER

CORONER'S COURT, TORONTO

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

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

REPORTING PLUS  
(905) 477-0126

1 DR. JAMES WRIGHT, SWORN

2 EXAMINATION IN-CHIEF BY MS. BROWNE:

3 MS. BROWNE: The next witness, Mr. Coroner,  
4 is Dr. Wright, Dr. James Wright. For the  
5 convenience of everybody, Counsel and jury  
6 members, I would just like to tell you what  
7 we're going to be referring to. For Counsel,  
8 it will be the Death Summary that is located  
9 in Volume Two of medical records and that  
10 will be at page 32, page 11 on the chart, if  
11 you could give Dr. Wright the charts, that's  
12 Exhibit 3. And, I believe that you have that  
13 also, that page, in the chart, do you not,  
14 jury members, right?

15 We also have another matter that I got  
16 from Ms. Posno today, and I believe she's had  
17 copies to be made an exhibit. All Counsel  
18 have it?

19 MS. POSNO: Yes.

20 MS. BROWNE: Yes, it's a handwritten note,  
21 and she's giving them out to the jury right  
22 now, and we will have one marked as an  
23 Exhibit for you, handwritten notes of Dr.  
24 Wright.

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--- EXHIBIT NO. 55:            Handwritten notes of Dr. Wright

MS. BROWNE:    Yes, thank you very much.

MS. POSNO:    There is another document as well that, the Death Summary of Dr. Lobo.

MS. BROWNE:    Sorry, yes, indeed, that's also within the chart. That's Death Summary of Dr. Lobo, and that appears ---

--- EXHIBIT NO. 56:            Death Summary of Dr. Lobo

MS. POSNO:    It's not in the charts. You'll hear from ---

MR. GOMBERG:    It's a draft of what's in the chart.

MS. POSNO:    It's a draft of what's in the chart. This was pulled off the system today.

MS. BROWNE:    All right. It's in addition to what you refer to in the chart as page 24? In the chart, the typed number?

MR. GOMBERG:    No, it's either 32 or 11.

MS. POSNO:    It's page 11. It is the Death Summary.

MS. BROWNE:    Sorry, then, I mistook -- we

1 had our draft of the Death Summary in the  
2 chart, but now we have the up-to-date one,  
3 which is now the Exhibit. Thank you very  
4 much, Ms. Posno.

5 MS. POSNO: No, let me just clarify that, I'm  
6 sorry, for the record. The jury will hear  
7 today about a draft of the Death Summary that  
8 is not in the chart. We just found out about  
9 it this morning, and printed it off the  
10 system this morning, or got it from the  
11 records department, and we've now produced  
12 it. You have a Death Summary in the chart  
13 which is the one that was prepared by Dr.  
14 Wright, and you will hear from Dr. Wright how  
15 the draft fits into the picture. So there's  
16 two.

17 MS. BROWNE: Okay, let's just go over that  
18 again. We have a Death Summary which has  
19 been provided to all Counsel in advance.  
20 It's in the chart. The jury members have it  
21 in advance in the chart, and it's already  
22 been made a part of Exhibit 3, which is the  
23 initial chart. We also today have got a new  
24 Death Summary which was printed off and which  
25 is now Exhibit -- whatever ...

1                   CONSTABLE CULLETON:    It's going to be 56.

2                   MS. BROWNE:     56, yes, 56 is the new Death  
3                   Summary.  And we had, which has just been  
4                   provided to you also, handwritten notes which  
5                   is Exhibit 55.  We also say page 9.

6                   Now, if I can just clarify all that, Dr.  
7                   Wright, because frankly, I'm kind of  
8                   mystified.  We just got this today and nobody  
9                   has really had time to read it, but we will  
10                  try to go ahead.

11                  THE CORONER:    I wonder could we just get a  
12                  short C.V.  ---

13                  MS. BROWNE:     Short break, would you ---

14                  THE CORONER:    No, a short C.V. of Dr.  
15                  Wright, first of all, who he is, what he ---

16                  MS. BROWNE:     Do you have a Curriculum Vitae  
17                  of Dr. Wright with you?

18                  THE CORONER:    Well, just verbal will be  
19                  sufficient.

20                  THE WITNESS:    Sure.  I'm an Associate  
21                  Professor of Surgery and Public Health  
22                  Sciences at the University of Toronto.  I'm a  
23                  staff orthopaedic surgeon at the Hospital for  
24                  Sick Children; I'm the R. B. Salter chair of  
25                  Pediatric Surgical Research at the Research

1 Institute, Hospital for Sick Children; I'm  
2 the acting Director of Population Health, the  
3 Research Institute at the Hospital for Sick  
4 Children, and I'm a scientist at the Medical  
5 Research Council of Canada.

6 THE CORONER: That's fine. Thank you.

7  
8 BY MS. BROWNE:

9 Q. Your specialty is?

10 A. Orthopaedic surgery.

11 Q. Orthopaedic surgery. You are the head  
12 of the Orthopaedics Department at Sick Kids, right?

13 A. No, no, that's incorrect.

14 Q. All right then.

15 A. I'm a staff orthopaedic surgeon, one of  
16 six attending orthopaedic surgeons.

17 Q. You're one of the attending ones, right?  
18 Can you tell me how you became involved in the care of  
19 Lisa?

20 A. I was in -- I was the orthopaedic  
21 surgeon on call, that ---

22 Q. On October the 21st?

23 A. Yes, that's correct. And I was in the  
24 operating room, attending to the care of another child,  
25 and Joel Lobo who was the resident on call, had been in

1 the Emergency Room seeing Lisa.

2 Q. And is Joel Lobo one of the orthopaedic  
3 staff?

4 A. No, he would be an orthopaedic resident.  
5 He would be in the training program at the University  
6 of Toronto.

7 Q. But it's in orthopaedics, that's ...

8 A. That's correct, yes, within  
9 orthopaedics, within ortho ---

10 Q. And how long had Dr. Lobo been at the  
11 hospital, do you know?

12 A. If it, if it was October, it would have  
13 been about three weeks, so it would have been a three  
14 month rotation for a, what we call, a junior resident,  
15 and he would have been at the hospital for about three  
16 weeks.

17 Q. Three weeks.

18 A. He would have been in the training  
19 program longer than that, but he would have been at the  
20 hospital for about three weeks.

21 Q. Back to your ...

22 A. Yes. It was around 11:00 or 11:30 at  
23 night. Joel came up to the operating room to let me  
24 know that he'd seen a patient in the Emergency  
25 Department. He advised me that I had never met Lisa or

1 her family before. He told me that Lisa had had a  
2 distant fracture of her tibia, and that she'd been --  
3 had come to the Emergency Department in extreme pain,  
4 and our discussion was that -- and he also advised me  
5 that she'd been seen by the Pain Service, I think about  
6 three weeks before that, and had been seen on a couple  
7 of occasions before that time.

8 Now, normally -- we discussed the fact  
9 that because it was a problem of pain, that she should  
10 be seen by the Pain Service, and I'd understood from  
11 him, in fact, that they'd already seen her and had  
12 begun to institute treatment in the Emergency  
13 Department. And it was their consensus that because of  
14 the amount of pain that she was in, that she should be  
15 admitted to hospital.

16 Normally, a child would come in under  
17 the most direct service, so for example, if she had had  
18 an acute fracture, a fracture that day, it would have  
19 been appropriate for her to come in under orthopaedics.

20 In this particular circumstance, her problem was one  
21 of pain management. The pain team, who are run by the  
22 Department of Anaesthesiology, do not have admitting  
23 privileges to the hospital, and we recognized that she  
24 needed to be admitted to hospital, so I agreed to serve  
25 as the responsible physician.

1 Q. And this all -- everything that you  
2 learned was from Dr. Lobo at that time?

3 A. That's correct.

4 Q. At 11:30, this conversation took place,  
5 outside the O.R., or ---

6 A. In the operating room.

7 Q. In the operating room.

8 A. Right.

9 Q. Go ahead.

10 A. And we discussed that the Pain Service  
11 would be in charge completely of her pain management,  
12 and that lines of communication should be directly  
13 between the nurses and the pain management, and that's  
14 the usual protocol for patients who are seen by the  
15 Pain Service. I believe they are one of two consulting  
16 services that have the ability to directly write orders  
17 without the approval of the consulting service, and  
18 that's in an attempt to assure there's continuity  
19 between the nursing staff and the Pain Service.

20 Q. Can I ask, if Dr. Lobo had -- I'm sorry  
21 to interrupt your phrase -- had this situation ever  
22 occurred before where somebody who was in Emergency  
23 being treated by Pain Service had to be admitted and  
24 had to go through Orthopaedics, or was this the first  
25 time?

1           A.    Not on my service, it had never happened  
2 before, but I'd understood it had happened previously.

3           Q.    Once? More than once?

4           A.    Oh, more than once.

5           Q.    Go ahead. Sorry.

6           A.    So that was my -- that was our  
7 arrangement. And he assured me that she was being seen  
8 by the pain team and they would -- they were happy to  
9 look after her care that evening and throughout the  
10 next day. I next heard about Lisa very early the next  
11 morning, sometime between 7:00 and 8:00 in the morning,  
12 when I was told that there'd been a cardiac arrest, and  
13 that's when I went to the ward.

14          Q.    Had you worked all night that night,  
15 or ---

16          A.    No, I'd worked through, I can't exactly  
17 remember, but after midnight, I'd worked, and by then,  
18 I'd understand she'd gone to the ward, and I went home  
19 and came back early next morning, as is my habit.

20          Q.    And were you present at the code?

21          A.    I was not, no.

22          Q.    You just learned of her death?

23          A.    That's correct.

24          Q.    And what further involvement did you  
25 have with regard to any meetings, debriefings, any ---

1 A. Sure.

2 Q. --- discussions? You should tell us one  
3 by one who you saw, where you saw, and so on. If you  
4 have to refer to any of the Exhibits ---

5 A. Sure.

6 Q. --- by all means.

7 A. Okay. That morning I spoke to Lisa's  
8 mother, and I believe, her grandparents, who were in an  
9 adjacent room, or in a room on the ward. I expressed  
10 my condolences to them, and I suggested if there was  
11 any way that I could help them in maintaining lines of  
12 communication between themselves and the hospital, that  
13 I would be happy to take on that role.

14 And I then, either before or after I  
15 notified the Coroner's office of her death, and I spoke  
16 to the person who answers the phone, who paged, I  
17 believe it was Dr. Reingold, who then -- he called me  
18 and I gave him what I knew about the -- Lisa's  
19 hospitalization. And he advised me that he would be in  
20 to the hospital some time that morning.

21 Q. Now, I know this might be difficult, I  
22 don't know whether you have any written notes, or  
23 whether if you look at the chart, it will refresh your  
24 memory, but what's your best recollection of when you  
25 were speaking to the Shores, and the grandparents? You

1 said it was near Lisa's room; do you know what time of  
2 the day it would be?

3 A. It was early in the morning. It was --  
4 I went up to the ward, and there was obviously a  
5 significant number of people around, there was quite a  
6 bit of confusion and concern about what had happened.  
7 I had very brief conversations with the nurses, and  
8 shortly thereafter, my concern was for the family. I  
9 believe shortly thereafter, I went and spoke to the  
10 mother.

11 Q. Can you narrow it down to a time at all?  
12 Approximately? I don't mean to the minute, but, you  
13 had said that you got to the hospital ---

14 A. Yes.

15 Q. --- around 7:00 or 8:00?

16 A. No, no. I'm usually in the hospital  
17 about 6:30 in the morning ---

18 Q. Oh, sorry.

19 A. And that's when I was. I, I, if I knew  
20 the time that the arrest was stopped, since I came up  
21 to the ward after the resuscitation had been stopped,  
22 and I would have thought within 15 minutes of that, I  
23 would have spoken to the family.

24 Q. Well ...

25 A. Well, I have an associate note here at

1 8:05 in the chart.

2 Q. That's your note?

3 A. No, no, this the paediatric associate  
4 note, who would have been responsible for running the  
5 resuscitation.

6 Q. Could you just tell us the number that  
7 you ---

8 A. Page 18.

9 Q. So that would be page 8 for us. It  
10 would be in the chart; 18 is on the chart, it's ---

11 A. On the top right-hand corner.

12 Q. Yes. Right. And that associate note is  
13 made by?

14 THE CORONER: Doctor, I can help you. The  
15 code was stopped at 7:52 a.m., according to  
16 the resuscitation record.

17 THE WITNESS: Right. So I would have been  
18 there around 8:00, and as best as I can  
19 remember, between 8:00 and 8:30, I would have  
20 spoken to Lisa's mother.

21

22 BY MS. BROWNE:

23 Q. And did you speak to Lisa's mother and  
24 the grandparents after you'd spoken with the nurses and  
25 found out what had happened?

1 A. Yes, that's correct.

2 Q. To whom did you speak to find out what  
3 happened?

4 A. I only remember speaking to Ruth  
5 directly. There were a number of nurses there. Bill  
6 Kreutzweiser was there at the time, as I recollect.

7 Q. Ms. Doerksen, that is, Ruth Doerksen?

8 A. Yes, that's correct.

9 Q. And Mr. Kreutzweiser is the care  
10 manager?

11 A. Correct.

12 Q. And you spoke to both of those, Ms.  
13 Doerksen and ---

14 A. There was a crowd of people, as I say,  
15 that were ---

16 Q. Were they outside the room where Lisa  
17 was?

18 A. Yes, in the nursing area.

19 Q. And do you recollect what you were told?

20 A. Yes, that she had been admitted to the  
21 hospital, had come to the ward, had not received any  
22 morphine from, I believe, after 2:00 a.m., and I'm just  
23 -- I believe that's correct, I believe that's what I  
24 was told, and that her vitals had -- she'd been woken  
25 at 5:00 and that her vitals had been taken at 6:00 but

1 she hadn't awoken, but her vital signs were, according  
2 to them, normal. And then, that she'd been found on  
3 rounds by the orthopaedic staff, and that she, and  
4 that's when the resuscitation, the arrest team had been  
5 called.

6 Q. Did you make any notes of what you were  
7 told on that day?

8 A. I did not, no.

9 Q. Was the Dr. Schily mentioned at all to  
10 you, as the pain fellow who'd been involved?

11 A. No. The pain, the pain team was  
12 involved. I didn't actually remember his name coming  
13 up.

14 Q. But it's possible they could have  
15 mentioned his name and you just don't remember it, in  
16 fact?

17 A. Yeah, that's possible.

18 Q. Was there any talk at all about any  
19 devices that were attached to her. Did you know about  
20 the PCA?

21 A. I knew the PCA had been ordered. I did  
22 ask them whether, as far as they knew, the PCA pump had  
23 been working. That was my first concern, that there'd  
24 been a malfunction, possibly, in an -- I'm not an  
25 expert in these machines, but I, it seemed that was the

1 first thing that I was concerned about, that there'd  
2 been some kind of malfunction in the pump, and I asked  
3 about that, and I was told that it had functioned  
4 appropriately.

5 Q. And was anything said about a Corometric  
6 monitor?

7 A. Not to my recollection, no.

8 Q. You were speaking with Ms. Doerksen and  
9 Mr. Kreutzweiser, right?

10 A. Those are the two people I remember that  
11 were there, that's correct.

12 Q. I presume from what we've heard that Ms.  
13 Doerksen was upset?

14 A. Very much so.

15 Q. And did she say anything about the apnea  
16 alarm being turned off?

17 A. I don't remember her saying anything  
18 about the monitoring, no.

19 Q. Did she say something about the monitor  
20 itself wasn't on, who turned it off?

21 A. I don't remember those comments being  
22 made.

23 Q. Do you have any specific memory of any  
24 specific comments? By a nurse who appeared distraught,  
25 can you remember anything specific?

1           A.    I -- what I remember was, that she  
2           seemed -- based on the information that she'd been  
3           awake -- wakened at 5:00 and seemed okay, and that the  
4           vitals had been, according what she reported to me, was  
5           that the vitals had been fine at 6:00.  How, up -- it  
6           was completely an unexpected situation, and how upset  
7           she was by what had happened.

8           Q.    Did you see the chart at that time?

9           A.    I did not, no.

10          Q.    Did you ask to?

11          A.    No.

12          Q.    How long do you think that you got their  
13          information from both people?

14          A.    Very quickly.

15          Q.    Is that a matter of minutes?

16          A.    Yes.

17          Q.    And then, after that, you went  
18          immediately to the Shores?

19          A.    Yes.  As I remember, yes.

20          Q.    And how long did you spend with them?

21          A.    I would say it was probably about five  
22          minutes.

23          Q.    That's the only time you spoke to them  
24          that day?

25          A.    That's the only time I've ever spoken to

1           them. I spoke to them that day, but I've never spoken  
2           to them subsequently.

3                   Q.    Now, the rest of that day, were your  
4           duties at all involved in the investigation of this  
5           death? Did you become involved in that?

6                   A.    I felt a certain moral obligation to try  
7           and make this as -- as I said, to suggest open lines of  
8           communication, so I then spoke to Lisa's paediatrician,  
9           Dr. Gallant. I felt it was important that I speak  
10          directly to her. As I remember, I didn't make any  
11          notes of that conversation, but as I remember, she  
12          actually knew by the time I called. But I hoped to be  
13          able to provide her any information that I could at  
14          that time.

15                   I believe I also said to her at that  
16          time that I'd suggested that if there was any way I  
17          could be helpful, if there was any -- if I could serve  
18          in any way, that they could call me; that I would try  
19          and facilitate any communication that I could.

20                   Q.    But you didn't hear from her?

21                   A.    I didn't hear from them, no. But my --  
22          I was offering. I didn't -- if they, if they didn't  
23          want to avail themselves of that opportunity, that was  
24          fine with me. It was ...

25                   Q.    You indicated also that you had called

1 the Coroner's office?

2 A. That's correct.

3 Q. Can you tell me when that was, as near  
4 as you can recollect?

5 A. Yes, well, in the associate's note at  
6 8:05, it says that Dr. Wright notified the Coroner, so  
7 it would have been around that time, 8:00.

8 Q. And do you recollect speaking to  
9 somebody, yourself?

10 A. Yeah, Dr. Reingold.

11 Q. What did you tell him?

12 A. I told him that Lisa had been admitted  
13 through the Emergency Department the night before; that  
14 she'd been admitted with a problem of severe pain; that  
15 this was an ongoing problem of hers, that in the  
16 distant past she'd had this tibial fracture, and that  
17 she had received some morphine; and that he -- and that  
18 she had died very unexpectedly that morning. I believe  
19 that he said to me, "Is the morphine machine still  
20 there?" And I said, "Yes, it's in the room. It hasn't  
21 been touched." And I think his recommendations were  
22 the usual recommendations, which is not to touch  
23 anything and not to clean up, which we'd already  
24 advised. That's the usual practice, and that's what  
25 we'd advised the nursing staff and the medical staff to

1 do. So once the arrest had been stopped, everything  
2 was just left in its place, as far as I know.

3 Q. Did you actually see into the room  
4 yourself?

5 A. I did, I just very briefly glanced in.

6 Q. But you knew the importance that  
7 everything had to be sort of frozen in time until ---

8 A. That's correct.

9 Q. --- the Coroner came to investigate?

10 A. That's correct.

11 Q. At that point, you didn't know there was  
12 any issue about a monitor?

13 A. That's correct.

14 Q. That's what you're saying?

15 A. That's correct. I believe I spoke to  
16 Bill Kreutzweiser, who I'm sure would have been aware,  
17 but I just reaffirmed with him that there was nothing  
18 to be touched, and nothing to be cleaned up, and it  
19 would be just left, and that I'd spoken to the Coroner,  
20 as is my responsibility, and that he would be coming  
21 shortly.

22 Q. Do you know when he did come?

23 A. I do not, no. I did not see him. He  
24 didn't call me, or ...

25 Q. You weren't remaining in that vicinity,

1            though, for the rest of the day? You went on to your  
2            other duties, is that right?

3                    A.    That's correct.

4                    Q.    So how long would you have been in the  
5            area where you might have seen the Coroner when he  
6            arrived?

7                    A.    He didn't give me any time of his  
8            arrival. I was, I think, probably there for about 15  
9            or 20 minutes, and then I had other obligations,  
10           actually, that I had to go to.

11                   Q.    And that was your connection that day?

12                   A.    That's my connection with the events.

13                   Q.    As we pointed out, we have in -- part of  
14           the chart, which is, I guess numbered 11 for you, and  
15           it's 32 for the Counsel and for the jury ---

16                   A.    Mm-hmm.

17                   Q.    --- a Death Summary?

18                   A.    Yes.

19                   Q.    And it's dictated by yourself ---

20                   A.    That's correct.

21                   Q.    --- as it indicates here?

22                   A.    Yes, that's true.

23                   Q.    And it's a two-page document?

24                   A.    Yes.

25                   Q.    And when did you do this? When did you

1 dictate it, and where, and under what circumstances?

2 A. Right. As is the routine, the resident  
3 staff are usually responsible for Discharge Summaries,  
4 and Joel Lobo dictated a Discharge Summary. And as I  
5 remember, someone from medical records, from Health  
6 Records, came to my office, saying there was a certain  
7 urgency that the chart be forwarded on to the Coroner's  
8 office, and that it was important that I sign the Death  
9 Summary. Now, the Death Summary is discharge --  
10 dictated in my name, so as is the usual practice,  
11 whether it be a discharge or a Death Summary, it's  
12 dictated "Joel Lobo, for James Wright, staff surgeon."

13 Q. You're referring to the second Death  
14 Summary we received today ---

15 A. That's correct.

16 Q. --- that's actually three pages if you  
17 count the cc's.

18 A. That's correct.

19 Q. Is that right?

20 A. That's correct.

21 Q. This one here ---

22 A. Yes.

23 Q. --- was that dictated by Dr. Lobo before  
24 you did anything?

25 A. That's correct.

1 Q. So this really predates in time the one  
2 that we have before you in the chart?

3 A. That's correct.

4 Q. And the one that the jury has.

5 A. Right.

6 Q. Okay, and was this given to you, or ---

7 A. I believe it came with the entire chart.

8 It was -- this is an unusual circumstance. Usually,  
9 charts would be collected and I would go to Medical  
10 Records to sign them, but as I remember in this  
11 particular circumstance, the chart and this letter were  
12 brought to me, as I understood it, that there was a  
13 certain urgency because we wanted to get this on to the  
14 Coroner's office, and to complete that process, I need  
15 to sign the discharge or the Death Summary.

16 Q. All right, but this first one, this was  
17 dictated by Dr. Joel Lobo for Dr. James Wright.

18 A. Correct.

19 Q. Can you tell me when that was done?

20 A. It says on it, "Dictated on 10/22/98."

21 Q. So that was the same day, right? That's  
22 when she died, October the 22nd, 1998?

23 A. That's correct. And that's what -- I'm  
24 not -- I can't tell you that's for sure, but that's  
25 what's written. That's what this indicates. And then

1 the "T," I presume, indicates transcribed, which would  
2 be 10/29/98.

3 Q. So it was written down, or taken out on  
4 that date?

5 A. Right.

6 Q. The one that we have that you say is  
7 signed by you ---

8 A. Yes.

9 Q. --- and dictated by you, that's done  
10 what date?

11 A. I think it's probably 11/06/98 because  
12 in my copy, this corrected copy, AB 11/06/98, I believe  
13 it was done at that time.

14 Q. What's the indication then above that  
15 where it says "JW," and it says "D 10/29/98."

16 A. Right.

17 Q. What's that?

18 A. Well, I'm not -- I can't actually tell  
19 you the dates. I don't remember.

20 MS. POSNO: Mr. Coroner, I don't mean to  
21 interrupt the flow of evidence, but I was  
22 present this morning when we found out about  
23 this, and we had some information from the  
24 Records Department as to the timing. The  
25 original dictation by Dr. Lobo was the date

1 on October 22nd, as indicated on the  
2 document, was transcribed on the 29th,  
3 brought up, apparently, to Dr. Wright on the  
4 29th, then dictated by Dr. Wright on the 29th  
5 as this says "D the 29th," and then typed  
6 because there -- which would be consistent  
7 with Dr. Wright's evidence that they wanted  
8 it done on the 29th, and then apparently, it  
9 was put into the Records Department, or  
10 accepted by Records on November the 6th date,  
11 and I actually -- and there may have been a  
12 slight revision or something, but we don't  
13 have anything to indicate what that would  
14 have been, if it was just the end revision or  
15 something as of November 6th.

16 MR. GOMBERG: Well, that's not quite right.  
17 That's not quite right, because at page 291  
18 of the material, we have yet another Death  
19 Summary that Dr. Wright did. And that was  
20 the one that he added on to, in preparation  
21 for the Death Summary that we saw for the  
22 first time today.

23 In other words, the sentence was added,  
24 for some reason:

25 "... I spoke with the family and

1                   communicated with the pediatrician who  
2                   has looked after her care, Dr. Lee Ann  
3                   Gallant. All subsequent information  
4                   will be forwarded through the Coroner's  
5                   office ..."

6                   That was a line that Dr. Wright saw fit  
7                   to add for reasons that I'll ask him about later. So  
8                   we have three Death Summaries.

9                   MR. HAWKINS: Just so I'm clear what we're  
10                  on, on page 291 of the brief, we have a copy  
11                  of the Death Summary that's date stamped as  
12                  received by the Regional Coroner on the 21st  
13                  of November, '98.

14                 MS. BROWNE: I don't think the jury has that  
15                  one. I'm just wondering, is that present in  
16                  an Exhibit of any kind? If you could just --  
17                  because if not, we'll have to reproduce this  
18                  for you. Is that -- do you have anything  
19                  listed for a Death Summary, that's been ...

20                 CONSTABLE CULLETON: I haven't even been  
21                  given a copy of the latest exhibit.

22                 MS. POSNO: I can give a copy to you. It  
23                  has highlighting on it.

24                 MS. BROWNE: Perhaps I can give this one,  
25                  and the officer can go and make -- could you

1 make it faster than the last one?

2 MR. GOMBERG: Dr. Cairns, it does highlight  
3 a point that I've been trying to make,  
4 though, and that is, it's very difficult to  
5 be dealing with this before 12:00 at night,  
6 which is what I've been doing every night  
7 when we're getting stuff at the end of the  
8 day, which is different from stuff that we've  
9 gotten before. And without ascribing any  
10 motives to that, it's got to stop.

11 THE CORONER: Well, it can stop if you want  
12 me to adjourn the inquest for two weeks while  
13 we get all the stuff together. That's the  
14 only way I can obviously make sure that you  
15 get this information, at this stage of the  
16 inquest, in a more timely fashion, so it  
17 would be very beneficial to the jury and for  
18 Counsel and for witness and for everyone if  
19 we all had the material in advance. That's,  
20 obviously throughout this inquest has not --  
21 has not been the way that it's been  
22 occurring.

23 But if possible, unless it's going to  
24 cause major problems, I would like us to  
25 persist, and I would request all Counsel,

1 obviously, as soon as they're aware of  
2 something that we're not aware of, to bring  
3 it to our attention. And I think it is the  
4 consensus of all Counsel and the jury to, if  
5 possible, continue with this inquest, and I  
6 apologize. This would be, I would much  
7 prefer this to be done so that everybody  
8 would have prepared the questions last night,  
9 and it's beyond my control, since I'm told  
10 this has just been found this morning.

11 MR. GOMBERG: I'm not being critical of you.

12 What I'm saying, though, is that to go  
13 leafing through and finding something on page  
14 291 which is different from, and markedly  
15 different, from something that we're seeing  
16 for the first time today, is unacceptable,  
17 from my client's perspective.

18 MS. POSNO: Actually, we had -- if I can  
19 just clarify something on the record, please?  
20 The Death Summaries that Mr. Gomberg was  
21 comparing, as a line being added, has been  
22 produced to all Counsel. I didn't appreciate  
23 the difference. But it has been produced to  
24 all Counsel from ages ago. Okay? The one  
25 that was produced today was the draft that

1 nobody had seen, that we just learned about  
2 today, that was -- continued to exist in the  
3 Records Department.

4 Now, if it's of any assistance, the one  
5 that is in our brief, that we've been  
6 discussing at page 291, that the jury and  
7 Counsel have, is date stamped November 21,  
8 1998. I don't know if that's the Coroner's  
9 date stamp, or whoever's date stamp it is.

10 However ---

11 THE CORONER: It's the Regional Coroner, Dr.  
12 Lucas's date stamp.

13 MS. POSNO: So that was received at -- on or  
14 around that date. The other one that is in  
15 the hospital chart was a corrected copy at a  
16 later date. Okay? So that, I'm throwing up  
17 as a possible explanation of the distinction  
18 between the two; one was earlier, one is the  
19 later one.

20 THE CORONER: But both ---

21 MS. POSNO: I don't why the Coroner would  
22 have received one that's unsigned, but ---

23 THE CORONER: But both of those were  
24 available to us all well in advance.

25 MS. POSNO: Those have been available since

1 November.

2 THE CORONER: So you're indicating the only  
3 one that's not -- that was not available in  
4 advance is the notes that you've got from  
5 this morning.

6 MS. POSNO: The Dr. Lobo, the one dictated  
7 by Dr. Lobo for Dr. Wright, which Dr. Wright  
8 now explained in detail.

9 MR. GOMBERG: And his notes.

10 MS. POSNO: And the handwritten notes ---

11 THE CORONER: And the handwritten notes.

12 MS. POSNO: --- regarding the meetings since  
13 January.

14 MR. HAWKINS: Perhaps you can clarify, Dr.  
15 Cairns, in terms of the copy that is sent to  
16 the Regional Coroner's office on November 21,  
17 1998. My understanding is that quite apart  
18 from your office requesting the chart by way  
19 of warrant as part of the death paperwork for  
20 the initial investigation, you request a copy  
21 of the Death Summary as opposed to the chart  
22 itself.

23 THE CORONER: That's correct.

24 MR. HAWKINS: So that would be how that copy  
25 got to your office on the 21st.

1 THE CORONER: The 21st of November.

2 MR. HAWKINS: Right.

3 THE CORONER: Usually because that is quite  
4 often available to us sooner than the whole  
5 chart may be, so that it gives us an initial,  
6 some initial information on the file.

7 MS. POSNO: If I may give to the witness a  
8 copy? I apologize that it's highlighted, but  
9 at least he can see the one that Mr. Gomberg  
10 has referred to.

11 THE CORONER: Please do.

12 MS. BROWNE: Well, I think the jury doesn't  
13 have this one. This has never been part of  
14 the chart, that -- and I think that they  
15 should have that, so that they, like the rest  
16 of us, have all three. And the -- we didn't  
17 -- did you give a copy of these new ones to  
18 Constable Culleton? Have you got any more?  
19 Okay, because they have to be marked as  
20 Exhibits. The two new ones have to become  
21 exhibits ---

22 THE CORONER: Oh, yes, but let's continue  
23 with the questioning while that's being done.

24 And we'll get -- it'll be back within five  
25 minutes. And the only reason I'm saying is,

1 that this Doctor, unfortunately, will not be  
2 available to give evidence tomorrow, and will  
3 not be available on Friday, so let's do a few  
4 things at the one time, pure and simply for  
5 the logic of getting on with it.

6  
7 BY MS. BROWNE:

8 Q. I think we're getting to the various  
9 summaries that we have. Perhaps you could just explain  
10 again -- I'm sorry, I didn't get these notes down --  
11 the original dictation of -- was by whom, and on what  
12 date?

13 A. Yes. It was done by Joel Lobo, Dr.  
14 Lobo, and it was done, according to this, on the 22nd  
15 of October, '98, and transcribed on the 29th of  
16 October, '98.

17 Q. That's the one that we have marked as an  
18 Exhibit that -- what we're going to have marked as an  
19 Exhibit, that is, soon should be, that's 55, no, 56.  
20 What was your connection in this? Did Dr. Lobo give  
21 it, draft it up and pass it on to you, or what?

22 A. No. He would have dictated it, and it  
23 would have been transcribed in the Health Records  
24 Department, and then normally, what would happen is I  
25 would go down on a periodic basis, usually weekly, to

1 sign dictated summaries, or letters, or Death  
2 Summaries, in this particular case.

3 In this circumstance, this was brought,  
4 as I remember, to my office, saying "Can you sign this  
5 immediately, because it needs to go to the Coroner's  
6 office?" I read the note by Dr. Lobo, and recognized  
7 there were several inaccuracies in the note.

8 Q. You're referring to this, this Death  
9 Summary?

10 A. That's correct.

11 Q. Well, what were the inaccuracies that  
12 you saw in this one?

13 A. Well, my understanding was, is that the  
14 doses of morphine that she'd received were inaccurate.

15 Q. Just point us to the specific line and  
16 paragraph?

17 A. Right. Oh, sorry, I'm ---

18 MR. GOMBERG: Third line from the bottom.

19 THE WITNESS: Yeah, third line from the  
20 bottom, "approximately 17 milligrams since  
21 admission." My understanding was that that  
22 was not the accurate dose. And secondly,  
23 there was a comment about the fracture having  
24 occurred five to six weeks prior to the  
25 current admission.

1

2

BY MS. BROWNE:

3

Q. Where is that comment?

4

A. That's in the second paragraph, fourth  
5 line down.

6

Q. Just read it, please?

7

A. "... She sustained a right tibial

8

fracture, approximately five to six

9

weeks prior to her current admission

10

..."

11

Q. Right. Anything else that's inaccurate?

12

A. I believe those are the two inaccuracies  
13 that I noted at the time.

14

Q. Did you talk to Dr. Lobo about these  
15 inaccuracies after you received this?

16

A. I spoke to him on a subsequent occasion.

17

Q. But not when you received this?

18

A. Not when I received this, that's  
19 correct.

20

Q. And you received this on when? October  
21 the 22nd?

22

A. On October the 29th.

23

Q. 29th, sorry -- 29th you received it from  
24 Dr. Lobo. Did you see him that day? Did he give it to  
25 you, or how did you get it?

1           A.    No, no.  The Medical Records people  
2 brought it to me.  They would just transcribe it,  
3 collate the chart and were bringing all the information  
4 together to forward on to the Coroner's office, and one  
5 of those requirements that the chart is complete, as it  
6 were, is that I sign the Death Summary or the Discharge  
7 Summary.

8           Q.    Did you sign this?

9           A.    Dr. Lobo's?

10          Q.    Yes.

11          A.    No, I did not.

12          Q.    So that that's not -- did he sign it?

13          A.    He would not normally sign it.  I would  
14 sign it, since I'm the responsible physician, so it was  
15 dictated on my behalf.

16          Q.    Right.

17          A.    And as is occasionally the case,  
18 sometimes people dictate letters or records, and  
19 they're inaccurate, and it's -- in this case, it was my  
20 responsibility to try and ensure as much accuracy as  
21 possible, and since I recognized there were  
22 inaccuracies, I felt it was appropriate that I dictate  
23 the letter.

24          Q.    So this letter was dictated by Dr. Lobo  
25 on December the 20 -- I'm sorry ---

1 A. October the 22nd.

2 Q. October the 22nd. You did not receive  
3 it till October the 29th?

4 A. That's correct.

5 Q. And at that point, you looked at it and  
6 realized that there were inaccuracies?

7 A. Yes.

8 Q. Do you know where Dr. Lobo got the  
9 information from that contributed to these  
10 inaccuracies?

11 A. I don't know where he obtained the  
12 information about the dose of morphine. I believe that  
13 the timing of the fracture, he may have gotten from the  
14 family, but I can't imagine that would be correct,  
15 'cause -- I don't know where he got this ---

16 Q. He didn't tell you where he got this  
17 stuff, did he? I'm assuming at some point you said to  
18 him, "Joel, there's a couple of mistakes in here."

19 A. Right.

20 Q. "What happened?"

21 A. Right.

22 Q. What did he tell you happened?

23 A. I don't believe we went over the  
24 specific inaccuracies. I emphasized to him the  
25 importance of accuracy, and said that there were a

1 couple of inaccuracies, and I needed to re-dictate the  
2 note.

3 Q. All right. Let's move to the other one  
4 that is marked in the medical record chart as page 11  
5 for the jury, page 32 for us, I guess. It's dictated  
6 by yourself?

7 A. That's correct.

8 Q. And that's dictated when?

9 A. I understand it was dictated on the  
10 29th. I can't actually remember, but I -- it would  
11 have been dictated the day that I -- Joel Lobo's copy  
12 came to me with the chart, 'cause I -- there was a  
13 certain urgency. It was said, "You have to dictate  
14 this right away, because we have to send it off right  
15 away." So I believe I immediately went back down to  
16 Medical Records, and they did what's called a "stat  
17 dictation," where as soon as I'd dictated it, it was  
18 supposed to come through and be transcribed.

19 Q. Now, you had with you all of Lisa  
20 Shore's medical records ---

21 A. I believe so.

22 Q. --- for the admission of October the  
23 21st?

24 A. And her past admissions as well.

25 Q. And her past admissions?

1 A. I believe so, yes.

2 Q. And what changes did you make? Can you  
3 just highlight the parts that you changed ---

4 A. Right.

5 Q. --- from what you got from Dr. Lobo,  
6 please? First of all, I notice that you moved her age  
7 from 11 to 10?

8 A. I also, sorry, in the second sentence, I  
9 commented that she had been treated over the past year  
10 following a tibial fracture.

11 Q. She'd been admitted on October the 9th.  
12 Was that another admission? Why did you -- in your  
13 first, if you look at what you've written here ---

14 A. Right.

15 Q. "... Lisa is a ten-year-old female ---"

16 A. Yes.

17 Q. "--- who presented through the Emergency  
18 Department at 21:51 on October the 9th,  
19 1998, with a painful right leg ..."

20 A. Right.

21 Q. Well, the date's obviously wrong.

22 A. That's correct.

23 Q. Okay, that's wrong. She is ten. That's  
24 right.

25 "... She has been treated for over

1 the past one year after a tibial  
2 fracture ---

3 A. Mm-hmm.

4 Q. "--- complicated by reflex sympathetic  
5 dystrophy ..."

6 A. Yes.

7 Q. And you go on with some of the history.

8 A. Mm-hmm.

9 Q. "... She was being treated at the time  
10 of admission with amitriptyline ..."  
11 That's an addition that Dr. Lobo didn't  
12 have.

13 A. Mm-hmm.

14 Q. You were being -- this is from the  
15 charts, I take it. You were looking at her charts.

16 A. That's correct.

17 Q. And she had amitriptyline, 75 to 100  
18 milligrams, carbam --

19 A. Carbamazepine

20 Q. I can't say it.

21 A. Carbamazepine.

22 Q. Carbamazepine, 100 milligrams and  
23 another anti-convulsant. Did you know the name of the  
24 other anti-convulsant?

25 A. I did not.

1 Q. How did you know there was another anti-  
2 convulsant?

3 A. I'd been told that she was on another  
4 anti-convulsant.

5 Q. Who told you?

6 A. I'm uncertain whether I'd been told by  
7 -- 'cause this was now about a week later, I may have  
8 spoken to someone from the Pain Service who may have  
9 told me. I can't remember who told me that there was  
10 another anti-convulsant.

11 Q. She was seen by -- she was admitted to  
12 the Emergency Department because of uncontrollable  
13 pain, seen by the Pain Service, given intravenous. I  
14 guess you corrected the 17 milligrams in your analysis  
15 of how much she got, right?

16 A. Right, but I understand -- I'm sorry to  
17 interrupt.

18 Q. Sorry, I interrupted you. I think the  
19 correction was that in the first one, she got 17  
20 milligrams.

21 A. That's correct.

22 Q. That's what Dr. Lobo said.

23 A. Right.

24 Q. And you're correcting it to how many?

25 A. Well, I'd corrected it, but I believe I

1 also made an error. She'd received two milligrams of  
2 bolus in the Emergency Department, for a total of four.

3 I'd been told that the PCA machine works by giving  
4 boluses of 1.5, and she'd received five of those, which  
5 would have made 7.5, plus 4, for a total of 11.5. But,  
6 in fact, my understanding is this isn't the actual  
7 amount, and I'm -- this came up in discussion with Dr.  
8 Reingold at a later meeting -- that in fact, she'd  
9 received 7.5 -- sorry ---

10 THE CORONER: 10.5.

11 THE WITNESS: 10.5, plus 4 is 14.5, and that  
12 was the correct dose. So I also made an  
13 inaccurate statement.

14  
15 BY MS. BROWNE:

16 Q. "... She was awoken at 5:00 a.m., vital  
17 signs were fine. She was found  
18 appropriately at 6:00 a.m. Her vital  
19 signs were taken, and found to be  
20 normal. She was found during rounds at  
21 7:15, she was V.S.A. She was pronounced  
22 dead shortly thereafter ..."

23 Can you tell me where you got the  
24 information about her being awoken at 5:00 a.m. with  
25 vital signs fine ---

1 A. Right.

2 Q. --- and so on?

3 A. That was a direct communication from the  
4 nurses on the morning of the event.

5 Q. And had you made a note at the time of  
6 the event which you then transferred to your letter?

7 A. I did not. That was based on my memory  
8 at the time. I remember having spoken to them that  
9 she'd been awoken at 5:00. And then at 6:00, her  
10 vitals were normal. I did not review the medical  
11 record or the flow sheet, so this is based on my  
12 recollection of what I was told at that time.

13 Q. But you had them with you, didn't you,  
14 when you ---

15 A. That's correct.

16 Q. You had the medical records and flow  
17 sheets and you didn't review them?

18 A. That's correct.

19 Q. The Coroner was notified, and there was  
20 no identifiable cause of death. PCA was working, pump  
21 had not been used. It had been taken away from her  
22 because of reasonable pain control and a concern of  
23 possible mild drop in respirations? Where did you --  
24 is that from the chart that you got that, or did  
25 somebody tell you that?

1           A.    I believe I was told that on the ward,  
2           along with the other information about her vital signs.

3           Q.    And everything you were told on the  
4           ward, you remembered from October the 22nd?

5           A.    That's correct.

6           Q.    All right.  The indication about the --  
7           the amount of fluid in the syringe:

8                   "... I spoke with the family,  
9                   communicated with the pediatrician and  
10                   all subsequent information will be  
11                   forwarded through the Coroner's  
12                   office ..."

13           Now, can you just explain what the  
14           corrected copy means there?  I don't understand what  
15           that is.

16           A.    I'm not sure what the corrected copy  
17           means, whether it refers to the fact that I corrected  
18           Dr. Lobo's copy, or whether -- I didn't make that  
19           notation, so I can't -- I can't say.

20           Q.    All right.  If we can go to the one that  
21           -- I think we have copies of these now.  This is the  
22           Death Summary from -- which I understand the jury  
23           didn't have, and ---

24           THE CORONER:  It's page 291 of the brief, is  
25           that correct?

1 MS. BROWNE: Right. And perhaps that could  
2 be entered as an Exhibit?

3 THE CORONER: Yes, and can we please shorten  
4 this to -- does any of the Counsel know what  
5 the difference between this copy are, or the  
6 one that's just been read?

7 MR. GOMBERG: I can help you. We read it  
8 word for word last night.

9 THE CORONER: Thank you.

10 MR. GOMBERG: The only difference is the  
11 addition -- the printing may be different,  
12 but we don't care about that. The only  
13 difference is the addition of having spoken  
14 to the family. Quote:

15 "... I spoke with the family and  
16 communicated with the pediatrician who  
17 has looked after her care, Dr. Lee Ann  
18 Gallant. All subsequent information  
19 will be forwarded through the Coroner's  
20 office ..."

21 That's the only distinction between drafts  
22 one and -- between drafts two and three, or one and two  
23 of his Death Summary.

24 THE WITNESS: I hate to interject. I'm not  
25 sure that, in fact, that this isn't a collage

1 of a single Death Summary, because as you'll  
2 see on page 291, I don't have the signature,  
3 my name and qualifications aren't written  
4 there, which would form -- page, what you  
5 have is page 292 where the copy should have  
6 gone.

7 MS. BROWNE: Mm-hmm.

8 THE WITNESS: So normally in a dictated  
9 note, there would have been the note, a page  
10 with my signature, and then some notation of  
11 the copies. And I wonder if this is not all  
12 the same thing, so what you're missing here  
13 is the second page, because as you see from  
14 page 291, my signature ---

15 THE CORONER: I think that's a simple  
16 explanation, that in preparing this brief,  
17 the second page with the signature has been  
18 inadvertently left out. But I, just to save  
19 us time, we will have the original of this in  
20 our file in the office, and I'll take it upon  
21 myself tonight to look at that. My  
22 assumption is that it is exactly the same  
23 cause I can find no other ---

24 MR. GOMBERG: Can I just help you with that  
25 for a minute? It may be exactly the same,

1 but the printing is different, because the  
2 way it runs on the page is different. For  
3 example, just so you don't have to ---

4 THE CORONER: No, I agree. It's not all on  
5 the same line, yes.

6 MR. GOMBERG: Pardon?

7 THE CORONER: The printing, it's not  
8 identical.

9 MR. GOMBERG: No, it's not identical.

10 THE CORONER: The wording is identical, but  
11 the printing is different.

12 MR. GOMBERG: Exactly.

13

14 BY MS. BROWNE:

15 Q. All right then, I'll leave all that.  
16 I'm going to try and hurry up, so other people can ask  
17 questions. The handwritten note that we have, and it's  
18 been marked as an Exhibit, okay, it's going to be  
19 Exhibit ---

20 CONSTABLE CULLETON: 55.

21

22 BY MS. BROWNE:

23 Q. 55, thank you. It said it was January  
24 the 26th, 9:00 to 10:00, can you tell me what this is?

25 A. Yes, these are a couple of notes that I

1 made for myself to document the meetings that I had  
2 with people, and if I -- anticipating that I might need  
3 to recall those at a later time, I wrote down the  
4 timing of those meetings, and who attended them.

5 Q. First of all, how many -- how many  
6 meetings have you recorded on this page?

7 A. This is basically three meetings, or at  
8 least, one meet -- on January 26th from 9:00 to 10:00,  
9 my first notation refers to a meeting that I had with  
10 Marion Stevens, Larry Roy and Cathy Sagan. This was in  
11 response to a letter that had come from Mr. Gomberg, I  
12 believe, and I'd spoken with the Coroner who said he  
13 spoke to me because I was the attending physician or  
14 surgeon, and he said that he thought it was best if a  
15 response came from the hospital.

16 He faxed that through to me, I believe  
17 on January the 6th is when I saw it, and I passed that  
18 on -- I scanned it, but suggested that Larry Roy of the  
19 Department of Anaesthesia would be in the best position  
20 to draft the response, since virtually all the issues  
21 are related to the -- her monitoring, and the  
22 management of her pain. We had a meeting on January  
23 26th with the people as listed there in which we talked  
24 about drafting a response to that letter. One of --  
25 and it details that I was going to speak with Dr.

1 Reingold and Dr. Laxer and Dr. Gallant, because I  
2 wanted to relate to them that we were drafting a  
3 response. I didn't want, as much as possible, to be a  
4 perception of a delay.

5 And then I have a notation to myself  
6 that I'd spoken to Dr. Gallant later on, to tell her  
7 that we were drafting a response, and offered her the  
8 opportunity to be involved in any meeting with the  
9 family. Ron Laxer, who ---

10 Q. Who is he?

11 A. He's the Associate Chief of Paediatrics  
12 at the hospital, and he, I believe, had seen her once  
13 in consultation, and he had, I understand, a good  
14 working relationship with the family, so in the spirit  
15 of trying to have as many people participate as  
16 possible, I suggested that he, I remember suggesting  
17 that he might be willing to participate in any meeting  
18 with the family, and I communicated with him on that.  
19 And then I spoke to Glenn Smith ---

20 MS. POSNO: Mr. Coroner, I'd just like to  
21 clarify. This next, point three, does relate  
22 to information provided to Dr. Wright from  
23 our offices. It would usually be privileged,  
24 but given the content of it, we don't have  
25 any concern with it being here. We're not

1 waiving privilege generally; we're just  
2 allowing this note to be presented in full,  
3 so that it -- so nothing is omitted.

4 THE CORONER: Thank you.

5 THE WITNESS: It had come up in the meeting  
6 in the morning with Marion Stevens and Larry  
7 Roy and Cathy Sagan, that the family might  
8 want a meeting with people at the hospital to  
9 discuss anything that was of concern to them,  
10 so I spoke to Glenn Smith specifically about  
11 that. Then, on -- between that meeting and  
12 the next notation, we'd also spoken -- I'd  
13 spoken with Dr. Reingold, and said that we  
14 were preparing a response, and I believe this  
15 meeting on March the 1st with him ---

16  
17 BY MS. BROWNE:

18 Q. Doctor, can you just clarify, who's  
19 Glenn Smith?

20 MR. GOMBERG: He is one of Ms. Posno's  
21 partners.

22 MS. BROWNE: Oh, I'm sorry. I'm sorry, Ms.  
23 Posno. I didn't realize that.

24 MS. POSNO: Okay.  
25

1

2

BY MS. BROWNE:

3

Q. And he recommended talking to somebody?

4

A. He recommended talking to parents

5

without lawyers being present on either side.

6

Q. Okay. The meeting included?

7

A. He suggested the meeting could include

8

any of the fellows that had been involved in the care,

9

Liz ---

10

Q. Sagan?

11

A. That would be Cathy Sagan.

12

Q. Cathy Sagan?

13

A. With or without the nurses who'd been

14

involved, myself, Dr. Laxer and paediatrician, I'm sure

15

referring to Dr. Gallant.

16

Q. And participants should draft a response

17

to the letter received?

18

A. Participants, this was his advice to me.

19

Participants should draft response to the letter --

20

this is Dr. Gomberg's letter, review with lawyers,

21

and ---

22

MR. GOMBERG: That's my father. Mr.

23

Gomberg.

24

MS. BROWNE: He's not a doctor.

25

THE WITNESS: Sorry.

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BY MS. BROWNE:

Q. Review with?

A. With the lawyers. And then, have a session beforehand, and Glenn Smith would speak with the Coroner.

Q. Now, all of these three items that you've got here reflect what, more or less, went on at that meeting on January 26th?

A. Yeah, it was what went on in the meeting, and then what I subsequently did, you know, later on in the day. For example, I spoke to Dr. Gallant at 12:30, and I spoke to Glenn Smith later on that day.

Q. Was the purpose of the meeting for you to sort of outline a game plan, or a plan of procedure with these people, or did they have input? I just want to know, is it you saying, "This is what we should do to answer the letter," or would the other people, Marion Stevens, Larry Roy, Cathy Sagan, would they have input also?

A. Yeah, it was an attempt to bring as many people together to provide a satisfactory response to Mr. Gomberg's ---

Q. Was there any discussion of the contents

1 of the questions, about the, you know, the Pain  
2 Service, and all the rest of it. Was there any  
3 discussion of what was being asked?

4 A. I think there was a very brief  
5 discussion. My involvement in her clinical care was  
6 minimal. I had had no input into the orders that had  
7 been received; I'd had no involvement in her care, and  
8 this was not an orthopaedic issue, per se, and  
9 virtually, or all the questions related to her nursing  
10 and anaesthesia care and therefore, I was involved  
11 because I was the attending orthopaedic surgeon, but I  
12 had relatively little to contribute in a content basis.

13 Q. All right. I see. The next meeting,  
14 March the 1st, what, you've got two meetings there,  
15 March the 1st?

16 A. Yes, we had a meeting before at about  
17 11:00 in which I believe we reviewed the response  
18 to ---

19 Q. You must mean '99, don't you? It  
20 says ...

21 A. Yes, yes.

22 Q. So this should be a correction of March  
23 1st, '99?

24 A. Yes. And that was to basically talk  
25 about the upcoming meeting with Dr. Reingold.

1 Q. So that this is -- you were having a  
2 meeting -- yeah, Dr. Reingold indicated that he had a  
3 meeting with you later. The first -- the one at 11:00,  
4 do you have any recollection of what happened there?

5 A. I recollect it was quite a brief  
6 meeting. I didn't keep any notes, so I don't think it  
7 was anything more than saying, "We've drafted a  
8 response. Dr. Reingold's coming." We talked about who  
9 would be there, and that's virtually all I remember  
10 about that meeting.

11 Q. And you have at 2:00 the meeting with  
12 Reingold, right?

13 A. Yes, Cathy Sagan, Larry Roy, Marion  
14 Stevens and Dr. Reingold.

15 Q. And can you explain what the next thing  
16 is?

17 A. These were my notations of what the  
18 discussion was with Dr. Reingold, and he took very  
19 extensive notes, so these were just brief notations to  
20 myself. In the top right-hand corner, there's a dot,  
21 and it says "dispute vital signs transmitted," and that  
22 was -- there was a conversation, not among myself, but  
23 with Dr. Reingold about there was some question about  
24 the vital signs being transmitted to the pain fellow.  
25 The second point ---

1 Q. Oh, you mean, this is discussing the  
2 communication between the care of Lisa on the ward that  
3 night, and the pain fellow ---

4 A. Correct.

5 Q. --- Dr. Schily, who ---

6 A. Yes.

7 Q. (inaudible). Okay, go ahead.

8 A. The second note was "no saturation  
9 monitor," and it just says "no sat," but that's my  
10 abbreviation, "/no sedation scale, i.e., orders not  
11 activated." And we discussed that with Dr. Reingold,  
12 that the orders had not been activated.

13 Q. And I take it you were getting this  
14 information from the people there? Or did you know all  
15 that by now?

16 A. I first became aware of that in response  
17 to the letter from Mr. Gomberg in January, and the --  
18 and I'm just -- this is what it was reported to me,  
19 that it became apparent to, I believe, Larry Roy at  
20 that point that the orders had not been activated. It  
21 became, in sifting through this letter, it became clear  
22 that orders were put on the chart, or on the -- in the  
23 Kidcom -- that were not performed. And so sometime  
24 between January the 6th and this meeting, it became --  
25 I heard from Dr. Roy that the orders had not been

1 activated.

2 Q. All right. Then the next thing, "apnea  
3 monitor not on or malfunctioning, malfunctioned" --  
4 right?

5 A. Right.

6 Q. What was the discussion about that? Can  
7 you recollect?

8 A. No, not specifically. I just -- I think  
9 there was a question from Dr. Reingold, is, if an apnea  
10 monitor had been on, why hadn't it gone off? And the  
11 -- I don't know that there was a satisfactory response,  
12 and it was commented that either it wasn't on, or it  
13 malfunctioned, as two possible explanations.

14 Q. Okay. I don't want to take too long.  
15 No blood pressure?

16 A. When heart rate equalled 130 beats per  
17 minute.

18 Q. Why was that not taken? That was a  
19 question raised by somebody at the meeting?

20 A. Yes.

21 Q. And what was the answer? Do you  
22 remember, was there an answer?

23 A. I just remember that as a statement of  
24 fact, that when the blood -- when the heart rate was  
25 130, that a blood pressure had not been taken. That

1 may have been in response to his, "Was a blood pressure  
2 taken?" And we said no.

3 Q. The next line, "apnea monitor turned  
4 off." It looks as if that -- you received some more  
5 information that you hadn't got two lines up?

6 A. Right. Yeah, I can't comment on that.  
7 As I remember, it was apnea monitor -- we didn't know  
8 when it happened, so as I suggested, it was apnea  
9 monitor either not on, or malfunctioned. But Dr.  
10 Reingold will have very extensive notes on that, and he  
11 might be able to give more details on that point.

12 Q. "... No cause of death. A pediatric  
13 review ..."  
14 and what's that little -- does that mean  
15 an "and"?

16 A. Yes.

17 Q. Okay. And that was a discussion of what  
18 was going to happen down the road?

19 A. The -- Dr. Reingold said he wasn't sure  
20 what would happen. He, as I remember, suggested it  
21 might not come even to inquest, but that the -- that  
22 the plan would be for it to be reviewed next by the  
23 Paediatric Review Committee, and then reviewed by the  
24 Coroner's office, and then there might be a decision  
25 whether an inquest would be held.

1 Q. Yes, I think that we're going to hear  
2 from them, but could you just say briefly, what is the  
3 Paediatric Review Committee, so that the jury will know  
4 what to expect?

5 A. I actually can't.

6 Q. You can't ---

7 A. I can't talk to that. I don't  
8 understand the -- I don't know the composition of that  
9 committee.

10 Q. And there's a "should have segregated."

11 A. Calorimetric (sic) monitor.

12 Q. Thank you. And somebody said that?

13 A. Yes.

14 Q. Do you remember -- you don't know who it  
15 was.

16 A. I think Dr. Reingold brought up the  
17 aspect of the machine and says, "Was it segregated?"  
18 and the comment was made, it had not been.

19 Q. And the last part -- Heddup?

20 A. Heddon.

21 Q. Oh, sorry.

22 A. Dr. Heddon -- "leads not on."

23 Q. Do you remember any more about that?  
24 The leads not on, Dr. Heddon ---

25 A. I don't, really. I don't really

1 remember beyond the fact he came very late to the  
2 cardiac arrest, and as best I can recollect, when he  
3 went in, the leads were not on Lisa at that time. But  
4 he arrived, I understand, very late in the  
5 resuscitation.

6 Q. Those are my questions. I realize that  
7 there's a time problem here, so, thank you.

8 THE CORONER: Mr. Krkachovski?  
9

10 CROSS-EXAMINATION BY MR. KRKACHOVSKI:

11 Q. Yes, thank you. Dr. Wright, I gather  
12 from your evidence no one on the morning of the 22nd  
13 said anything about a Corometric monitor?

14 A. No, I don't remember anyone saying  
15 anything about the Corometric monitor.

16 Q. And I note that when you prepared your  
17 Death Summary, and I apologize, I'm not sure of the  
18 Exhibit, but the one that bears -- I take it that's  
19 your signature on page two? We have a signature,  
20 "James G. Wright"?

21 A. That's correct.

22 Q. All right. As of the preparation of  
23 this report, or the date of its preparation, you'll  
24 agree with me that there's no mention of a Corometric  
25 monitor?

1 A. That's correct.

2 Q. All right. And can I take -- and this  
3 report would have been prepared November the 6th?

4 A. At the latest, November the 6th. It may  
5 have been the 29th, but I'm afraid I can't give you the  
6 exact date. Either the 29th of October, or November  
7 the 6th.

8 Q. At the latest, would you have signed it  
9 November the 6th?

10 A. Correct.

11 Q. All right. And I presume you would have  
12 read it before you signed it?

13 A. That's correct.

14 Q. All right. And if you knew something  
15 about a Corometric monitor, you would have put it in  
16 the report?

17 A. That's correct.

18 Q. Right. Did you have an opportunity to  
19 look at Lisa's complete chart by this date, November  
20 the 6th?

21 A. As I remember, I had the complete chart  
22 available to me.

23 Q. Do you specifically recall looking at an  
24 added nursing note prepared by Ruth Doerksen that talks  
25 about a Corometric monitor?

1           A.    No, I don't.  I was under real time  
2 pressure to get this dictated, and I dictated relying a  
3 little bit on my memory, and I did not go through the  
4 chart in line-by-line detail.

5           Q.    When was it that you first learned of a  
6 Corometric monitor being in the room?

7           A.    I -- the first I ever heard of the  
8 monitor was some time between January 6 and the meeting  
9 with Dr. Reingold on March the 1st, and in fact, I  
10 think it was probably March the 1st where I even first  
11 heard the term "Calometric monitor."

12          Q.    Actually "Corometric."

13          A.    Corometric, I'm sorry.

14          Q.    Now, the evidence of both Nurse Soriano  
15 and Nurse Doerksen is that Lisa was attached to a  
16 monitor, but that Nurse Doerksen had turned the apnea  
17 alarm off.  I take it that piece of information should  
18 have been conveyed to you before you prepared the Death  
19 Summary?

20          A.    The usual purpose of a Death Summary, in  
21 my understanding, is to document the history and  
22 physical -- the course in hospital and any information  
23 about the cause of death.  I would normally not have  
24 put in issues of what was monitored and what wasn't  
25 monitored.  So I didn't -- that wouldn't have been

1 information that I normally would have put in this kind  
2 of note.

3 Q. Well, would the fact that seemingly Lisa  
4 was attached to a monitor, but no one heard alarm, an  
5 alarm sound that morning, have not been of significance  
6 that someone should have mentioned it to you?

7 A. I came on to the ward after the event,  
8 and I don't mean to minimize my responsibility, but as  
9 an orthopaedic surgeon, I had very little to do or  
10 relate to this patient. I came on to the ward; it was  
11 apparent there was nothing I could do in this  
12 situation. I wanted to make sure that the events were  
13 left untouched so that the Coroner would have access.  
14 My responsibility was to call the Coroner, which I did.

15 I felt a certain responsibility to speak to the family  
16 and to convey that information to the paediatrician,  
17 which is what I did.

18 Q. Did you see the notes prepared by Nurse  
19 Doerksen and Nurse Soriano, their own personal notes,  
20 at any time?

21 A. I did not, no.

22 Q. Were you aware that they had prepared  
23 such notes?

24 A. I was not, no.

25 Q. With respect to the very last notation

1 in your handwritten notes about Dr. Heddon saying the  
2 leads not on, I gather this is something he told you?

3 A. I suspect it was relayed to me at that  
4 time, at that meeting.

5 Q. Did you obtain information from any of  
6 the other doctors involved in the resuscitation, or any  
7 of the staff, for that matter, as to whether the leads  
8 were on or not on?

9 A. At this meeting, it became clear to me  
10 there was some dispute about what monitoring had been  
11 performed, whether leads were on or off, and I'd  
12 understood there was controversy, but I, it was -- I  
13 didn't go in and try to sort through this on my own, no  
14 I didn't.

15 Q. Did the hospital, that is to say, anyone  
16 from the hospital, try to sort that out?

17 A. Oh, I understand there was significant  
18 investigation going on, in terms of what went on in  
19 terms of the nursing care, went on in terms of the  
20 monitoring, the issues related to the anaesthesia team.  
21 We relayed to Dr. Reingold there'd been an extensive  
22 review of the protocols for patients on pain  
23 management. So you know, I understood people who were  
24 better skilled and appropriate to make these  
25 investigations were doing them.

1 Q. I'm just focusing on the Corometric  
2 monitor. What can you tell me in terms of what  
3 investigation the hospital conducted to try to  
4 determine if Lisa was, in fact, attached to one, and if  
5 she was, why, seemingly, it was turned off at some  
6 point?

7 A. I have no -- I was not part of that. It  
8 was not my responsibility to do so, at least as I  
9 perceived it, and I didn't have any discussions with,  
10 you know, trying to sort through what happened and what  
11 didn't happen. I didn't have those discussions with  
12 people.

13 Q. And I gather you haven't seen a report  
14 or other document stemming from any such investigation  
15 on behalf of the hospital?

16 A. That's correct.

17 Q. Thank you.

18 THE CORONER: Mr. Hawkins.

19  
20 CROSS-EXAMINATION BY MR. HAWKINS:

21 Q. Dr. Wright, I take it, well, as an  
22 orthopaedic surgeon, your patients frequently go to 5A?

23 A. Routinely, yes.

24 Q. And so, I take it you know the nurses on  
25 that floor?

1           A.    I would say in general, I have a good  
2 working relationship with the nurses on that floor,  
3 yes.

4           Q.    And you indicated that you remembered  
5 Ruth in a crowd of nurses, and that when you were asked  
6 if she was upset, you said very much so.  Would it be  
7 appropriate to describe Ruth as in shock that morning?

8           A.    As I remember, she was near to tears.  
9 She was extremely upset, yes.

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

11          THE CORONER:  Mr. Gomberg?

12          MR. GOMBERG:  Mr. Coroner, I'm going to be  
13 some time with this witness.  My expectation is that  
14 I'll be an hour, and I may be longer.  I have to use  
15 the facilities, so I'm in your hands as to what we're  
16 going to do -- so to speak.

17          THE CORONER:  Well, as long as it's not in  
18 my hands.  We'll recess for ten minutes.

19  
20         --- A BRIEF RECESS

21  
22          THE CORONER:  Mr. Gomberg?

23  
24         CROSS-EXAMINATION BY MR. GOMBERG:

25          Q.    Thank you, Dr. Cairns.  Dr. Wright, I

1 have a number of questions to ask you. The first  
2 relates back to something that you said earlier, and  
3 that is that there's a moral obligation to keep open  
4 lines of communication, right?

5 A. That's correct.

6 Q. And in addition, I suggest to you that  
7 in addition to keeping open lines of communication,  
8 it's important that whatever information is  
9 communicated, is accurate.

10 A. I agree with that.

11 Q. Right. And timely.

12 A. I agree.

13 Q. Right. Now, if there's a distinction to  
14 be drawn, or a contra distinction between accuracy and  
15 timeliness, obviously you would sacrifice timeliness  
16 for accuracy?

17 A. I believe that's true, yes.

18 Q. All right. In other words, in terms of  
19 getting information to the Coroner's office, and as you  
20 understood this to be a Coroner's investigation, it was  
21 important to get accurate information to the Coroner?

22 A. Correct.

23 Q. All right. And if that meant that it  
24 couldn't be as timely as you would otherwise like, then  
25 so be it.

1 A. In retrospect, yes.

2 Q. All right. Now, I want to see if I  
3 understand something about the interface between the  
4 Coroner's office and at least Wards 5A and 5B.

5 A. Mm-hmm?

6 Q. Because we've heard a lot about this.  
7 You, you -- I was going to say you've had the  
8 misfortune of not being here, but maybe you were lucky  
9 in hindsight. There's been a lot of evidence dealing  
10 with 5A, 5B, and the Coroner's office and what's  
11 supplied, and what isn't. Is Mr. Kreutzweiser the  
12 contact person between Wards 5A and B, and the  
13 Coroner's office?

14 A. I can't tell you what the absolute lines  
15 of communication. I'd spoken to Dr. Reingold on a  
16 couple of occasions, but I -- whenever I spoke to him,  
17 or he spoke to me, I tried as best as I could to,  
18 respond to his requests, but I don't know who --  
19 whether he had other requests, or who the actual lines  
20 of communication are supposed to be.

21 Q. All right. But in fairness, you'd agree  
22 with me that it would be preferable for there to be one  
23 point man, or point person to deal with the Coroner's  
24 office, so that some, that some practice or procedure  
25 be set up so that whoever is unfortunate enough to be

1           there, or to be around when a child dies, will know  
2           what to give the Coroner's office. That makes sense,  
3           doesn't it?

4                    A.    Well, I guess the difficulty would be  
5           that the information requests relate to a number of  
6           different disciplines, and a number of different  
7           specialties. But in general, I guess if that person  
8           can be assured to get all the information, it might  
9           make sense.

10                   Q.    Well, I guess what I'm driving at is  
11           that Mr. Kreutzweiser was apparently there that day,  
12           and there was some machinery that was there that day,  
13           for example, the PCA pump, the IVAC pump, and the  
14           Coroner's office did get that machinery, but they  
15           didn't get some machinery which someone suggested had  
16           some application to this, and you only found out about  
17           that on March the 1st, or around there?

18                   A.    Yes.

19                   Q.    All right. And that was pretty  
20           surprising to you, wasn't it, as the person in charge  
21           of this child, that on March the 1st you're getting  
22           information that a piece of machinery that may have  
23           something to do with the Coroner's investigation is  
24           lost in space?

25                   A.    My understanding, when it's a Coroner's

1 investigation, all the equipment is to be left in the  
2 room, and the Coroner then comes and makes  
3 recommendations about which equipment is to be saved;  
4 which is to be tested. As I say, my -- I understood my  
5 responsibility to relay to the nursing staff that the  
6 equipment was to be left alone till the Coroner came,  
7 and as far as I know, that's what occurred. Beyond --  
8 after that point, I can't say.

9 Q. All right, but what I'm suggesting to  
10 you, though, and we now have notes of the meeting, is  
11 you were at a meeting on March the 1st with a number of  
12 people?

13 A. Yes.

14 Q. Including the Coroner. And at that  
15 point, the issue of the Corometric monitor was raised,  
16 and I suggest to you that that was the first time that  
17 you found out that that could have some impact on an  
18 investigation into the death of your patient?

19 A. That's correct. That's the first time I  
20 found out.

21 Q. And that's somewhat surprising, isn't  
22 it? In November, December, January, February, four,  
23 four-and-a-half months later, you're finding out about  
24 an investigation that's hampered somewhat by late  
25 information?

1           A.    Right.  As I say, my understanding is  
2           that our first responsibility is to make sure nothing  
3           is touched, and then the Coroner comes.  I can't tell  
4           you what instructions the Coroner gives to people about  
5           equipment and what should happen to that equipment.  I  
6           can't comment.

7                         In retrospect, it would seem if that was  
8           an important piece of equipment, that maybe someone  
9           should have taken responsibility to make sure that  
10          piece of equipment was put aside.  But I don't know  
11          whose responsibility that was.

12           Q.    All right.  Well, I understand that you  
13          didn't know that on October 22nd, 1998.  Can you tell  
14          the jury who that is now?

15           A.    As I say, no, I can't.  My  
16          responsibility was, as -- my responsibility is to  
17          notify the Coroner.

18           Q.    Right.

19           A.    The Coroner tells me what to do, and I  
20          relayed that information.  And the information that I  
21          was told by Dr. Reingold, as best as I could recollect  
22          is that nothing should be touched.

23           Q.    Right.

24           A.    Unfortunately, I've been involved in  
25          several Coroners', potential Coroners' cases.

1 Q. Right.

2 A. And I hope I've got the language and the  
3 description correct, where I had, unfortunately, to  
4 call the Coroner.

5 Q. Right.

6 A. The instructions to me are that nothing  
7 should be touched.

8 Q. Right.

9 A. And that's what I relayed to the staff.

10 After that point, I can't tell you whose  
11 responsibility it is to preserve that equipment, or  
12 what's supposed to happen to that equipment.

13 Q. But you'd agree with me in principle,  
14 that whatever response -- that first of all, we should  
15 be able to figure out, in the context of this inquest,  
16 whose responsibility that is. I mean, that's something  
17 that, it's like certain things in medicine. I mean,  
18 you're dead or alive.

19 A. Mm-hmm?

20 Q. Somebody's got to be responsible for  
21 communicating with the Coroner's office. Like, it's  
22 not one of these black hole-type things, right?

23 A. I would agree with that, yeah.

24 Q. Now, just in terms of the -- what was  
25 going on on March 1st, 1999?

1 A. Mm-hmm.

2 Q. You have a handwritten note that says --  
3 I'm looking towards the bottom of the page ---

4 A. Yes.

5 Q. --- "apnea monitor turned off".

6 A. Mm-hmm.

7 Q. Now, didn't that cause you some concern  
8 when somebody mentioned that at that meeting of March  
9 the 1st? Like, weren't you shocked out of your mind?

10 A. As best I could recollect, and here I  
11 might regret not taking more detailed notes, but the  
12 note prior suggests that the apnea monitor was either  
13 not on, or malfunctioned. To the best of my  
14 recollection -- as I say, Dr. Reingold will have more  
15 detailed notes, because he took very extensive notes --  
16 that was the -- there was a discussion about the apnea  
17 monitor, and I believe that that was in response to one  
18 of your questions about whether the monitor would have  
19 been on. And the explanations were that it was either  
20 not on, or malfunctioned. And that's -- those are my  
21 very brief notes, as best I can recollect.

22 Q. All right. Let's just back up a little  
23 bit, because I think it raises an important principle  
24 that I'm sure the jurors are going to want to address,  
25 and that's this: First of all, would it surprise you

1 to know, and I don't want to spend a lot of time on  
2 this, that Dr. Reingold does not have detailed notes,  
3 that he hardly has notes at all? Would that surprise  
4 you?

5 A. That would surprise me, yes.

6 Q. All right. And you'd agree with me that  
7 sitting here, that really is a surprising proposition,  
8 that we have you thinking that he's got notes, and who  
9 knows what he thinks about you having notes, and we  
10 hardly have any notes? That's surprising, right?

11 A. It would seem surprising, yes.

12 Q. You know, my expectation is that would  
13 be surprising in any other endeavour. It's not any  
14 different in medicine, particularly when a young child  
15 dies, is it? You want as much information as you can  
16 assemble?

17 A. Mm-hmm.

18 Q. Yes?

19 A. Yes.

20 Q. All right. Now, on March the 1st, 1999,  
21 you were at a meeting, and for the first time you hear  
22 the following two propositions, in your notes: Number  
23 one, "apnea monitor turned off," and above that, "apnea  
24 monitor not on or malfunctioned." Didn't you almost  
25 have a heart attack when you heard that in terms of

1           trying to find out what happened?

2                   A.    I wouldn't say I had a heart attack.  I  
3           mean, this was an extremely upsetting event for many  
4           people involved, and for me as well.  So I think that  
5           at this meeting, there was a discussion of everything  
6           that had occurred around the time of this event.  There  
7           was a discussion of what was being done to, hopefully,  
8           anything we could think that might prevent such an  
9           event from occurring again.

10                   I remember discussing with Dr. Reingold  
11           that anything that he could provide us as information  
12           as soon as it was possibly available, that we would  
13           want to know that information, so that we could change  
14           our practice.  I just remember that being the sense of  
15           the people at this meeting, that anything that we could  
16           do to prevent such an event, if possible, from ever  
17           happening again, we would try to do.

18                   Q.    Right.  And my question to you is, was  
19           it necessary, in terms of doing the investigation --  
20           I'm going to talk to the -- speak to the issue of the  
21           Death Summary in a minute.  But as I understood your  
22           evidence, this meeting took place to formulate a  
23           response to questions that I'd posed of the hospital in  
24           a letter that I wrote in December.  Was that your  
25           understanding?

1           A.    Yes.  The timing is -- and I don't have  
2           your letter in front of me, but I believe you -- the  
3           date was in December.  I believe that I heard about it  
4           on the 5th or 6th of January, at which time I asked Dr.  
5           Reingold to fax it to me.

6           Q.    And, just to be clear, the letter -- I'm  
7           not going to go through it now, but I intend to go  
8           through part of it soon -- has been marked as Exhibit  
9           39, a blowup.  That's a letter that I put together with  
10          a lot of help from people who knew what they were  
11          talking about, dated December 11, 1998.  Now, you  
12          understood that that letter existed some time in early  
13          January?

14          A.    It may have been January the 6th.  It  
15          may have been January the 5th.

16          Q.    Okay, I don't care whether it's the 5th  
17          or the 6th, but the point is that certainly by the  
18          middle of January, which was a month later, you knew  
19          about the existence of the letter?

20          A.    Correct.

21          Q.    All right.  And Dr. Reingold faxed the  
22          letter to you, or sent it over to you fairly promptly?

23          A.    I believe it was the same day, yes.

24          Q.    All right.  So the hospital had that  
25          letter from the middle of January until it responded

1           some two months later. That's a shocking proposition,  
2           isn't it?

3                     A.    One of the things that was discussed on  
4           January 26 was, there were many things that you  
5           requested, including some very detailed information.  
6           One of the concerns of the people at the meeting is  
7           that the timeliness of that response would be very  
8           important to the family, and that was one of the  
9           reasons why I spoke to Dr. Gallant later on that day,  
10          to say that it was my understanding that the hospital  
11          was drafting a response, so that it would be  
12          understood, and I felt that that was the best way I  
13          could communicate to the family that a response was  
14          being drafted, and I was not responsible for drafting  
15          that letter. It was outside my clinical expertise, but  
16          that's what I tried to communicate to the family  
17          through Dr. Gallant.

18                    Q.    Okay. I really don't want to be mean-  
19          spirited about it, but I want to make sure that we deal  
20          with the issue. The letter was written on December  
21          11th.

22                    A.    Yes.

23                    Q.    All right. The death took place October  
24          22nd, right?

25                    A.    Yes.

1 Q. All right? So the letter was written  
2 six weeks after the death. The letter goes out, and  
3 you get it within a month. That's January. And the  
4 family gets responses two months later.

5 A. Mm-hmm.

6 Q. Now, you'd agree with me that certainly  
7 the hospital was up on the details of the treatment  
8 that she'd received on October 29th, or certainly on  
9 November the 6th, when you wrote the Death Summary?

10 A. One of the issues that came out of your  
11 letter was a -- I believe -- an -- a discovery that the  
12 Kidcom orders had not been activated. So that was new  
13 information that came as a result of your letter, and  
14 trying to reconcile your letter with what was  
15 understood of the case. So that was kind of new  
16 information for the hospital at that time.

17 Q. But, you see, that's what I'm getting  
18 at, though. In terms of an investigation, that's a  
19 terrible way for the hospital to do an investigation  
20 into a death that took place in the hospital, isn't it?

21 To wait for somebody like me to write a letter and  
22 discover things, and then go and look to find them; and  
23 you find them, and then you find more stuff, and you  
24 find more stuff. Then you sit on the stuff for two  
25 months, and then write a letter? That's not

1 acceptable, is it?

2 A. I think that the -- there was a lot of  
3 stuff going on at that time, reviewing the pain  
4 protocols, the way patients were -- should have been  
5 managed. And again, I'm only relaying this to you  
6 because this is what I understand, because this related  
7 to Pain Service, anaesthesia care, and nursing care.  
8 My understanding is there was reviews of what had  
9 happened, the current protocols in place, so there was  
10 a lot of activity in the hospital, at least as I  
11 understood it, at that time. I don't -- it never  
12 occurred to me that orders were written and were not  
13 activated. It was nothing that had ever even entered  
14 my mind. So it was new information when we heard about  
15 it.

16 Q. Right. Well, you met with Nurse  
17 Doerksen on October 22nd?

18 A. Correct.

19 Q. That was the day of the incident?

20 A. Yes.

21 Q. Didn't she tell you about Kidcom orders?

22 A. There was no discussion about Kidcom  
23 orders, no.

24 Q. You didn't ask her?

25 A. No, I did not.

1 Q. And you were responsible, you were the  
2 responsible physician for this child.

3 A. The -- her disease and problem was  
4 outside of my clinical expertise.

5 Q. Okay, well, let me be charitable to you  
6 then for a minute, okay?

7 A. Sure.

8 Q. It's outside your area of clinical  
9 expertise. Then the person who was in charge of her  
10 should have been somebody who did have the clinical  
11 expertise to deal with her?

12 A. Right.

13 Q. Right? And they didn't have admitting  
14 privileges?

15 A. Correct.

16 Q. So that's the problem, right?

17 A. Well, in terms of why my name is on the  
18 medical record, that's the problem. In terms of what  
19 we put in place in terms of communication, this would  
20 seem to be primarily a problem of the Pain Service. We  
21 ensured that appropriate consultation occurred in the  
22 Emergency Department. We'd established the lines of  
23 communication directly between the nurses and the pain  
24 team, recognizing that I was not in the best position  
25 to be the true responsible physician.

1 Q. Right.

2 A. I admitted her to hospital, recognizing  
3 at midnight when I'm in the O.R., this is an  
4 unacceptable situation in the sense that she needs to  
5 be admitted to hospital. There is a child in the  
6 Emergency Department who is in pain who needs to come  
7 into hospital. I am not going to be able to resolve  
8 the unsatisfactory nature of the fact that she has to  
9 come into my service when it's not within my clinical  
10 responsibility.

11 Q. Right.

12 A. So I felt obligated -- well, not  
13 obligated -- I felt it was appropriate for her that she  
14 should be admitted to hospital, and if that meant me  
15 taking the responsibility, then I was willing to do  
16 that.

17 Q. All right. Well, I understand that  
18 problem. But I suppose in terms of doing the Death  
19 Summary, that you would agree with me that you were an  
20 inappropriate person, factually, or content-wise, to do  
21 that Death Summary. You were mandated to do it ---

22 A. Yes.

23 Q. --- by virtue of the fact that you were  
24 the treating doctor for the reasons we've talked about.

25 A. Yes.

1 Q. But you were an inappropriate person,  
2 and so was Dr. Lobo, to write that Death Summary.  
3 Isn't that true?

4 A. To say we were inappropriate, we  
5 probably were not in the best position, but the way the  
6 hospital -- and again, I understand this is the way --  
7 at the time the way the hospital by-laws or medical  
8 records, or policy is, is that the responsible  
9 physician has the responsibility. So we accepted that  
10 responsibility. As I've suggested to you, I think she  
11 should have been admitted under the team that was most  
12 appropriate. If that had occurred, then they would  
13 have been responsible for the Death Summary. Yes, they  
14 would have been in a better position to do so.

15 Q. Well, what I suggest to you, and we'll  
16 go through the Death Summary in a minute, but there are  
17 a lot of errors in the Death Summary, even in the  
18 corrected one, aren't there?

19 A. Correct.

20 Q. Right. And that's not acceptable, is  
21 it? In other words, if somebody comes to that Death  
22 Summary ---

23 A. Mm-hmm.

24 Q. --- like Dr. Cairns, or me, or the  
25 family, or the jurors, and read that Death Summary,

1 they might very well think that we're talking about  
2 somebody else?

3 A. I regret the inaccuracies, and I should  
4 have gone through the medical record in more detail  
5 than I did, not that this is in any way excuse -- an  
6 excuse. There was transmitted to me a certain time  
7 urgency, and I accept your point that accuracy  
8 overrides that. I had, you know, pressing clinical  
9 duties, and I should have taken that responsibility  
10 more seriously, and I should have ensured the accuracy  
11 as best I could.

12 Q. All right. Now, in terms of meeting  
13 with Nurse Doerksen, you realized, of course, that  
14 you'd have to, as the responsible doctor, write the  
15 Death Summary. We're talking now about October 22 and  
16 23.

17 A. Mm-hmm.

18 Q. Right?

19 A. Mm-hmm.

20 Q. And she showed you the chart, right?

21 A. Mm-hmm.

22 Q. Including --- she showed you Lisa's  
23 chart?

24 A. Who showed me Lisa's chart?

25 Q. Ruth Doerksen.

1 A. No, she did not.

2 Q. Well, who showed you Lisa's chart?

3 A. The only time that I saw Lisa's chart  
4 was when it was provided to me by the staff from Health  
5 Records, which I believe was on October the 29th.

6 Q. Right, and that was before you wrote the  
7 Death Summary?

8 A. I believe it was the day I wrote the  
9 Death Summary, that's correct.

10 Q. Well, no, not to get into a debate about  
11 it, it was before you wrote the Death Summary, because  
12 it had to be available to you so that you could read it  
13 and write the Death Summary, right?

14 A. Yes, it was the day of the 29th.

15 Q. No, but I'm saying you saw it before you  
16 wrote the Death Summary.

17 A. I think, I, I, as I remember, I had Dr.  
18 Lobo's note, and I may not even have had the chart at  
19 that time.

20 Q. Right.

21 A. It may have just been transmitted to me  
22 the actual letter and said, please sign this letter  
23 because the medical record has to go out. I may not  
24 even have had the medical record, but then I went down  
25 to Medical Records, and at that point, I had the chart,

1 and at that point I dictated the note.

2 Q. All right. So, now, we haven't asked  
3 you this, I don't think. What did Dr. Lobo have  
4 available to him when he wrote the Death Summary that  
5 you referred to, and which you then used to write your  
6 Death Summary?

7 A. The, to the best of my knowledge, at  
8 that time, I'd understood she'd received 11.5  
9 milligrams of morphine. So when I read in his note  
10 that she'd received 17, I recognized that as an  
11 inaccuracy. I'd found out subsequently that she'd --  
12 her fracture had been in February. So those were the  
13 two inaccuracies that I knew, without the medical  
14 record in front of me, I just had found out by talking  
15 to people subsequently.

16 Q. You see, we may be able to shorten this  
17 considerably. What I'm getting at is this: We have  
18 notes made in the Emergency Room ---

19 A. Mm-hmm.

20 Q. --- by Dr. Schily, Exhibit 5. You read  
21 that thoroughly before you wrote the Death Summary,  
22 didn't you?

23 A. I don't believe I did, no.

24 Q. You didn't read those Emergency orders  
25 before you wrote the Death Summary?

1 A. That's correct.

2 Q. So you didn't know that it said, smack  
3 in the middle, "See Kidcom orders"?

4 A. That's correct.

5 Q. Isn't that an amazing development that  
6 you wrote a Death Summary in a case that was being  
7 investigated by the Coroner, and you didn't know about  
8 any of that which was readily available to you?

9 A. I would normally not review line by line  
10 the orders, no.

11 Q. That's not the question I asked. I  
12 asked you whether it was a shocking proposition that  
13 you wouldn't know about that when you write a Death  
14 Summary under the Public Hospitals Act, which you are  
15 statutorily mandated to do, like in a Coroner's case.  
16 I asked you whether it's shocking that you wouldn't  
17 have seen that?

18 A. I didn't review those orders.

19 Q. Is it shocking that you didn't review  
20 them?

21 A. I didn't review the orders. That would  
22 not have been my usual habit, in a -- to review  
23 everything line by line from a medical record, no.

24 Q. Well, let's say my son comes into the  
25 hospital tonight and he dies on your watch, all right?

1           Are you going to read -- and goes through Emerg -- are  
2 you going to read that before you write the next Death  
3 Summary?

4           A.    Yes, I would be -- I would go through in  
5 more detail than I did when I reviewed Lisa's chart.

6           Q.    Well, if there was an issue of my son  
7 dying, and there was an issue of whether or not anybody  
8 had looked at the Kidcom orders, will you read the line  
9 right in the middle of the doctor's orders -- there  
10 aren't very many lines there ---

11          A.    Mm-hmm.

12          Q.    --- which say "See Kidcom orders". Will  
13 you read that before you wrote a Death Summary, now in  
14 January of the year 2000?

15          A.    I would go through the orders in more  
16 detail than I did when I read Lisa's chart, yes.

17          Q.    And you read the flow chart, of course.  
18 Before writing the Death Summary?

19          A.    I don't believe I did, no.

20          Q.    Well, this is -- this is a "yes" or a  
21 "no" question.

22          A.    As far as I remember, I did not.

23          Q.    Is that "no"?

24          A.    I can't honestly remember. I don't  
25 believe I did.

1 Q. I'm going to take you through every  
2 entry there, unless you tell me no.

3 THE CORONER: Well, I, I think to be fair,  
4 Mr. Gomberg, he said to the best of his  
5 recollection, he did not look at it.

6 MR. GOMBERG: Okay.

7 THE CORONER: I think he can't swear, but I  
8 think he's saying, as far as he can remember,  
9 he didn't read it. Is that fair, Doctor?

10 THE WITNESS: Yes, that's what I'm ...

11  
12 BY MR. GOMBERG:

13 Q. Did you see the Flow Sheet, chart or  
14 sheet that had been prepared in the Emergency  
15 Department?

16 A. I'm sorry. The Flow Sheet, you mean the  
17 Emergency Flow Sheet?

18 Q. Right.

19 A. No, I did not.

20 Q. Before doing the Death Summary?

21 A. No.

22 Q. And you were aware when you wrote the  
23 Death Summary that no sedation scales had been done?

24 A. No, I wasn't aware of that, no.

25 Q. You were aware of the fact when you

1 wrote the Death Summary that no pain scales had been  
2 done?

3 A. I wasn't aware. I didn't know that it  
4 had been ordered, so I wasn't aware that it hadn't been  
5 done.

6 Q. Did you sit down with Ruth, with Ruth  
7 Doerksen and ask her what had happened that night  
8 before you wrote the Death Summary?

9 A. No, I didn't.

10 Q. Did you sit down with Anagaile Soriano  
11 that night before you wrote the Death Summary, to find  
12 out what had happened?

13 A. No, I did not.

14 Q. Did you ask Ruth Doerksen why no blood  
15 pressures were taken that night, other than at 1:45  
16 a.m.?

17 A. I'd understood that was being looked  
18 into by the nursing administration, and I did not  
19 discuss it with her, no.

20 Q. The nursing administration don't write  
21 the Death Summary, though. You do, right?

22 A. That's correct.

23 Q. Did you ask Ruth Doerksen why, when her  
24 temperature was 35 degrees Celsius, and her heart rate  
25 was 126, no blood pressure was taken?

1 A. I did not, no.

2 Q. Did you speak to Dr. Schily before you  
3 wrote the Death Summary?

4 A. I did not.

5 Q. Did you speak to Mary Douglas before you  
6 wrote the Death Summary?

7 A. No.

8 Q. Did you speak to Bill Kreutzweiser  
9 before you wrote the Death Summary?

10 A. Other than on the morning of the -- of  
11 Lisa's death, I did not speak to Bill, no.

12 Q. And have we heard everything that he  
13 told you the morning of her death?

14 A. Yes, as best I can remember, yeah.

15 Q. Didn't you access the computer, that's  
16 the Kidcom, to print up the nurse's care plans before  
17 you wrote the Death Summary?

18 A. No, I didn't.

19 Q. Why not?

20 A. That would not be part of my, or perhaps  
21 anyone's, routine in a Death Summary.

22 Q. As I understand it, you have a statutory  
23 obligation to be accurate in the Death Summary.

24 A. Mm-hmm.

25 Q. And she has no statutory obligation to

1 participate in the writing of the Death Summary at all.

2  
3 A. The -- well, the -- my, as I understand  
4 my obligation is to relate the history and physical,  
5 and the course in hospital. In terms of what kind of  
6 monitoring was done, what kind of monitoring wasn't  
7 done, what kind of monitors were put on, what kind of  
8 monitors weren't put on, is, I don't believe, is  
9 normally part of a Death Discharge Summary.

10 Q. Why didn't Dr. Schily write the Death  
11 Summary, and then you could have reviewed it and signed  
12 it for him?

13 A. Because the way the hospital works, it's  
14 the responsible service to write the Death Summary.

15 Q. So if the responsible service knows  
16 less, a lot less, than the person who knows a lot about  
17 the patient, the procedure is that the person who knows  
18 less is going to write the Death Summary. Is that what  
19 you're saying?

20 A. Well, there are lines of responsibility.  
21 There is a responsible physician. In this particular  
22 case, I don't think that she should have -- given the  
23 lines of responsibility, the way the hospital works, it  
24 turned out to be unsatisfactory in this case because  
25 she was admitted to the orthopaedic service when I

1 think she would have been more appropriately admitted  
2 to the anaesthesia service.

3 Q. Okay, but I just want to see if I  
4 understand this. There was no impediment to you  
5 phoning up Dr. -- first of all, it's a highly unusual  
6 event to have a ten-year-old child with a non-life  
7 threatening condition, drop dead in the Emergency,  
8 sorry, on the Orthopedic ward, right? That's like,  
9 really surprising, right?

10 A. Mm-hmm. Totally astounding.

11 Q. All right, astounding. So was there any  
12 reason that you didn't pick up the phone the next day,  
13 or the next day, or the next day, or the next day, or  
14 the next week, and say "Hey Marcus, let's have a cup of  
15 coffee, and tell me what happened, so I can write an  
16 accurate Death Summary."

17 A. The -- I was attempting as best as  
18 possible, and I think that there are some inaccuracies  
19 which I regret. If I had spent more time reviewing  
20 those salient features, which I should have done, then  
21 I would have had a more accurate Death Summary. In  
22 terms of all the events surrounding Lisa's death, it's  
23 not my responsibility, necessarily, to go through in  
24 all those details and try and reconcile every event. I  
25 had alerted the Coroner, which was my responsibility.

1 He -- my duty was to report the events as accurately,  
2 and I have some inaccuracies as I said, which I've  
3 regretted, which I regret, but, I don't believe it was  
4 my responsibility.

5 I spoke with the anaesthesiologist. I  
6 spoke to the Pain Service, and I spoke to the nursing  
7 administrator, and I was reassured that steps were  
8 being taken to ensure that it was being investigated at  
9 hospital level. I'd spoken to the Coroner, which was  
10 my responsibility, and I understood the Coroner was  
11 investigating it. I, I -- it does not normally fall  
12 within my responsibility to bring all the people  
13 together to interview all those people, to bring all  
14 that information together. So that no, that's not my  
15 responsibility to do that.

16 Q. You see, I might agree with you if this  
17 was a child who came in to be treated on the  
18 Orthopaedic ward by the Pain Service ---

19 A. Mm-hmm.

20 Q. --- and the child then went home, as  
21 Lisa did in March, I might agree with you. But this  
22 was such an unusual event that I suggest to you that it  
23 was incumbent upon you to make sure that the Death  
24 Summary was accurate, and I also suggest -- first of  
25 all, do you agree with that?

1           A.    I think I had a responsibility to ensure  
2           that it was accurate, whether that required me to go  
3           and speak to all of the people involved ---

4           Q.    How about taking the chart home and  
5           reading it for an hour?  Forget about speaking to the  
6           people involved -- looking at the Flow Sheet, looking  
7           at the Flow Sheet in the Emergency Department; looking  
8           at the Emergency thing that we talked about before.  
9           You see, I think you knew it had to be accurate because  
10          you recognized that Dr. Lobo's Death Summary was also  
11          inaccurate.

12          A.    Mm-hmm.

13          Q.    All right?  And I suggest to you that  
14          for two reasons, number one, this was a death, and  
15          number two, you knew that Dr. Lobo made some  
16          significant errors.

17          A.    Mm-hmm.

18          Q.    And based on those two elements, I  
19          suggest to you that you had an even higher duty ---

20          A.    Mm-hmm.

21          Q.    --- to sit down for an hour with the  
22          chart.  Forget about talking to people, and make sure  
23          that your Death Summary was accurate.  And you didn't  
24          do that.

25          A.    Yes, I should have gone through in more

1 detail.

2 Q. Why didn't you?

3 A. You know, I'm -- this is not in any way  
4 to suggest it's an excuse. It was -- there was a  
5 significant rush on the events. I don't mean to  
6 minimize the importance of a Death Summary, but it was  
7 meant to be a very succinct summary, it wouldn't -- all  
8 the -- I knew there was an extensive investigation. I  
9 knew there was additional information within the chart.

10 Yes, I should have gone through line by line, to see  
11 that any statement that I made was accurate, but I was  
12 given some information which I had no reason to suspect  
13 was inaccurate. I relayed that information by writing  
14 it in the Death Summary.

15 Q. All right. Well, I'm not going to go  
16 through all the details, but let's just talk about a  
17 couple of things that are absolutely critical to the  
18 jury.

19 A. Yes.

20 Q. Right? I suggest, number one. You say  
21 in the Death Summary, and I quote: "Her vital signs  
22 were monitored throughout the night." Right? Have you  
23 now looked at the chart? That's the Flow Sheet?

24 A. Mm-hmm.

25 Q. Can we agree that that's not true?

1           A.    She did have some vital signs taken  
2 throughout the night, but they are sporadic vital  
3 signs, and I don't know what the Pain Service, whether  
4 those were in compliance with the Pain Service orders.

5           She did have some vital signs throughout the night,  
6 but they were not complete. I would agree with that.

7           Q.    Look, we can shorten this up, or we'll  
8 go through them one by one. She was under your care.

9           A.    Mm-hmm.

10          Q.    Right? And you wrote an inaccurate  
11 Death Summary.

12          A.    Mm-hmm.

13          Q.    All right, now. Her vital signs, in  
14 terms of blood pressure, let's just talk about that for  
15 a minute. Her blood pressure was taken at 1:45, and  
16 that was never taken again.

17          A.    Mm-hmm.

18          Q.    Right? That's not vital signs taken  
19 throughout the night, at least ---

20          A.    I agree, that they are incomplete.

21          Q.    All right. And pain scales were never  
22 done.

23          A.    I understand that they were never done,  
24 that's ---

25          Q.    And that's not vital signs, but that's

1 no good, either. Right?

2 A. I believe it's part of the Pain Service  
3 protocol that pain measurement should be done, or at  
4 least ordered, in her case.

5 Q. You're aware of the Patient Controlled  
6 Analgesia nursing resource manual?

7 A. I am aware that it exists, yes.

8 Q. Well, are you aware of the monitoring  
9 required --- first of all, 5A, that's a ward where you,  
10 where you work?

11 A. Correct.

12 Q. All right. And many of the patients on  
13 5A are admitted on PCA morphine pumps?

14 A. Correct.

15 Q. All right. So 5A is a ward that has  
16 extensive experience with PCA morphine?

17 A. Correct.

18 Q. Right. Now, I'm not going to take you  
19 -- cross-examine you on the details of the manual, but  
20 you are aware of the fact that there is a manual, and  
21 that it has obligations for monitoring, right?

22 A. Mm-hmm.

23 Q. And that some of those requirements are  
24 things like pain scale, sedation scale, and things like  
25 that?

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A. Yes.

Q. All right. And certainly, you'd agree with me that those things, in a general way, weren't done?

A. Those were incomplete vitals.

THE CORONER: Mr. Gomberg, I would like to ask the witness a question of this on that point. I know that these are frequently used on 5A and PCA pumps are used on 5A. Can you help me? If a PCA pump is used post-operatively, and that may well be on a patient that you've operated on, would you be responsible for writing the PCA orders, or is that something that's done by the Anaesthetic Department?

THE WITNESS: Right. Most often it's done by the Anaesthetic Department in consultation. Occasionally, it's done by Orthopaedics.

THE CORONER: Have you had the responsibility, then, for writing PCA orders?

THE WITNESS: I would not, but the resident would have written those orders.

THE CORONER: Thank you.

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BY MR. GOMBERG:

Q. Right. Just to continue, she was awoken -- I'm not sure that's a word, but anyway -- awakened, at 5:00 a.m. and her vital signs were fine, and she responded appropriately. Where did that come from?

A. That's what was relayed to me the morning of her arrest.

Q. Well, that's just factually wrong, isn't it?

A. Yes, it is.

Q. It's so factually wrong, that you're embarrassed that that's in the note, aren't you?

A. I should have commented. As I said to you that I should have gone through the Flow Sheet and commented on the increased heart rate, both at 0500 and 0600.

Q. You see, what concerns me about this is this: If we weren't sitting in a courtroom with a Coroner and five jurors, and somebody just came and read what you wrote there ---

A. Mm-hmm.

Q. --- they would be whacked out, I suggest to you, in terms of trying to reach a conclusion about what was going on.

1 A. Mm-hmm.

2 Q. Isn't that right?

3 A. It's inconsistent with the more accurate  
4 documentation in the Flow Sheet, yes.

5 Q. Right, and I take it, it shouldn't be,  
6 should it?

7 A. No, I regret not going through the Flow  
8 Sheet and being more accurate in my statements in the  
9 Death Summary.

10 Q. Now, just in terms of the PCA protocols,  
11 I take it that you were aware of the fact that, for  
12 example, oxygen saturation is an important element of  
13 monitoring somebody who's on PCA morphine?

14 A. Yes, I understand that many children,  
15 and again, I'm -- I understand for many children who  
16 are on morphine, oxygen saturation is an important  
17 aspect of monitoring.

18 Q. And was your understanding on March the  
19 1st when you had this meeting that we've heard about,  
20 that oxygen saturation had been applied to Lisa?

21 A. I don't remember the details of whether  
22 it had been applied. My understanding at that point  
23 was that the Kidcom orders had suggested that it should  
24 be applied. I don't know whether it was applied or  
25 not.

1 Q. Well, when you wrote the Death Summary,  
2 because the Coroner's office wanted the document you  
3 say, I take it that that was something that you  
4 considered, namely the oxygen saturation issue?

5 A. I didn't consider it, no. I didn't  
6 comment on it.

7 Q. Now, just while we're dealing with the  
8 Death Summary, you also mentioned what happened at 6:00  
9 in the morning, and I take we can agree that your  
10 reference there is wrong, too.

11 A. That's correct. My reference is wrong.

12 Q. Your reference is wrong, okay. Now, did  
13 Ruth Doerksen ever come to you and say, "Here, I have  
14 in my hand orders, inactivated, suspended orders. I  
15 just printed these up. I think you should see them."

16 A. No.

17 Q. And I take it, certainly in terms of  
18 writing an accurate Death Summary, you would have liked  
19 to have known about the suspended orders.

20 A. I think that it's -- the Death Summary,  
21 again, would not normally have included issues of what  
22 monitor was on, what monitor was not on. Obviously, in  
23 looking back over the care she received, it was an  
24 important bit of information, yes.

25 Q. Well, we'll get to the letter that I

1 wrote and to your response in a minute, but surely, if  
2 you had found out in the week between when she died,  
3 and when you wrote the Death Summary, that a Corometric  
4 should have been on, and it wasn't; or an oximetry  
5 should have been on, and it wasn't; or sedation scales  
6 should have been taken, and they weren't; pain scale  
7 readings should have been taken, and they weren't; and  
8 most of the blood pressure -- or, there was no blood  
9 pressure after 1:45, and her temperature was 35, which  
10 is very low at 6:00, at 5:00 in the morning. Those are  
11 things, if you'd known about them, they all sort of  
12 create a kind of atmosphere, don't they?

13 A. Well, the general expectation is that  
14 physicians write orders, and nurses follow them.  
15 That's correct.

16 Q. All right. No, but the atmosphere,  
17 seeing as though you're the captain of the ship, if I  
18 can put it that way, the atmosphere is that whatever  
19 orders the captain was giving, or a captain was giving,  
20 whether it was you, or a co-captain ---

21 A. Mm-hmm.

22 Q. --- weren't being followed at all, and  
23 surely, that's something that should be in the Death  
24 Summary, so that somebody can read it, and figure out  
25 what's going on. And by "somebody," I don't mean a

1 Coroner, or somebody, or the jurors in the context of a  
2 courtroom, but I mean, somebody like me who might write  
3 to get the records, and read the thing, and say, "Hey,  
4 I understand what happened here."

5 A. I did not become aware of the problem  
6 with the orders till some time after January the 6th.

7 Q. All right. Well, have the hospital  
8 records been fixed since January the 6th, or since  
9 whenever you became aware of the Kidcom?

10 A. I can't comment what's been done to the  
11 medical record.

12 Q. Right. Now, is there any reason that  
13 either you or Dr. Schily, or both of you, or all of the  
14 medical staff, or somebody didn't call Nurses Doerksen  
15 and Soriano in, and anybody else who was around there,  
16 to do a debriefing, and figure out what had gone on?  
17 Before you wrote the Death Summary?

18 A. I'd understood that there was ongoing  
19 review of policy, that the nurses were being  
20 interviewed; that the anaesthesia protocols were  
21 reviewed, and that as best as could be done, the events  
22 of the night were being reviewed, and that's what I  
23 understood was ongoing.

24 Q. All right. Now, just go back to the  
25 Death Summary for a minute, the PCA had been taken away

1 from her because of reasonable pain control, and a  
2 concern of possible mild drop in respiration.

3 A. Mm-hmm.

4 Q. That's wrong too, right?

5 A. That's what was relayed to me, and I  
6 think that is the -- that corresponds with her  
7 respiratory rate of 8, is my understanding.

8 Q. Well, a respiratory rate of 8 is pretty  
9 low, isn't it?

10 A. I would normally -- it's -- it's  
11 abnormal.

12 Q. That's my point. I think we can move  
13 on. Dr. Schily wanted to know, to be told if his  
14 orders, as he notes, said, "Let me know if the rate  
15 falls to 11." So 8 is less than 11?

16 A. Mm-hmm.

17 Q. And if he wanted to know at 11, then  
18 certainly you would have wanted to know at 11, or 10 or  
19 9, but certainly before it hit 8.

20 A. I didn't write the order, but, yes, if  
21 that's what he wrote, he should have been informed.

22 Q. Right. Now, in terms of the -- I  
23 understand that the nurses, they don't work for you,  
24 they work for the hospital, is that right?

25 A. That's correct.

1 Q. All right. But you were aware that  
2 these two nurses were working, were in charge of Lisa,  
3 one or the other, throughout that night. You were  
4 aware of that when you wrote the Death Summary?

5 A. Yes.

6 Q. Talking about Nurses Soriano and  
7 Doerksen, right?

8 A. Mm-hmm.

9 Q. Well, as part of whatever thought  
10 process went into doing the Death Summary, did you say  
11 to yourself, you know, I'd better talk to these nurses,  
12 and figure out what happened before they go back and  
13 treat some more patients.

14 A. I did -- that's not my responsibility  
15 because I don't employ them; I'm not responsible for  
16 their practice. I communicated to Cathy Sagan that  
17 that should be looked into, and I understand it was  
18 being looked into.

19 Q. Well, what did you tell her?

20 A. I said that this was a tragic event, and  
21 that we should be reviewing all aspects of her care,  
22 and redressing anything that we could find that could  
23 in any way minimize the risk of such an event happening  
24 again.

25 Q. All right. The only other major issue

1 that I want to raise with you, and I'll do this as  
2 quickly as I can, I'm mindful of the hour, is the  
3 questions that were sent by me, and the answers that,  
4 as I understand it, were put together by a number of  
5 people, and you were one of them.

6 A. Actually, I had nothing to do with the  
7 response to those questions in terms of drafting a  
8 response. It was done, I believe the lead was Dr. --  
9 from the Departments of Anaesthesia and the Pain  
10 Service.

11 Q. Well, all right. We have blowups of the  
12 answers.

13 A. Mm-hmm.

14 Q. The cover sheet is a letter from Marion  
15 Stevens to Dr. Reingold.

16 A. Mm-hmm.

17 Q. Who in turn, fairly promptly after he  
18 got it, sent it along. Indeed, it says:

19 "... I enclose a copy of the response to  
20 the questions in the letter to the  
21 Coroner's office. These answers were  
22 assembled following our meeting with you  
23 March the 1st. These written responses  
24 were reviewed, and edited by myself,  
25 Cathy Sagan, Director of Surgical

1 Services; Lawrence Roy, Anaesthetist-in-  
2 Chief; and James Wright, attending  
3 Orthopaedic Surgeon ..."

4 A. Mm-hmm.

5 Q. As you know, and then I don't think I  
6 have to read that -- but the point is that the  
7 implication that I get from reading that, is, these  
8 written responses were reviewed and edited, and that  
9 you were one of the four or five people who reviewed  
10 and edited the answers. And, if you did that, then I'm  
11 going to ask you questions about the answers. If you  
12 did not participate in the answers, then I would like  
13 an acknowledgment that this is wrong, and I won't ask  
14 you questions about the answers.

15 A. I -- I did review the letter. I didn't  
16 edit the letter.

17 Q. Do you stand by the letter, and the  
18 information in the letter?

19 A. I reviewed the written responses.  
20 That's what I -- that's what I did.

21 Q. You wouldn't permit the hospital, you  
22 wouldn't permit the hospital to send a letter to Dr.  
23 Reingold that had inaccuracies in it, would you?

24 A. Not if I knew it to be true.

25 Q. Well, certainly, if Doc -- let's just go

1 at it this way ---

2 A. Mm-hmm.

3 Q. If the summary, the Death Summary,  
4 constituted answers to my questions, and you realized  
5 that there were mistakes ---

6 A. Mm-hmm.

7 Q. --- you wouldn't have permitted the  
8 Death Summary to go out either.

9 A. That's correct.

10 Q. All right. Let's just talk about some  
11 of the answers, keeping in mind, of course, that at the  
12 time this letter went out, there was no assurance that  
13 there was going to be an inquest and that we would get  
14 answers to any of these questions under oath. You're  
15 aware of that?

16 A. Yes.

17 Q. All right. Now, it's hard for me to ask  
18 the questions and play with the Exhibit. Maybe  
19 Detective Culleton can help me a little bit. First of  
20 all, questions number one and two, and the jurors will  
21 have the questions, I'm not going to read the  
22 questions. I think the answers are fairly self-  
23 explanatory.

24 "... A Corometric monitor displays heart  
25 rate and respiratory rate continuously.

1                   Leads from the monitor are attached to  
2                   the patient's chest. The heart rate and  
3                   respiratory rate are displayed  
4                   numerically on the front panel. The  
5                   nurse set the alarms at 50 to 60 for the  
6                   low heart rate, and 160 to 180 beats per  
7                   minute for the high heart rate, as  
8                   appropriate to Lisa's age ..."

9                   You don't adopt the 160 to 180, do you,  
10                  Dr. Wright, as being appropriate to a child of Lisa's  
11                  age? I mean, that's just not right, is it?

12                  A.    It's not -- a heart rate would, of 160  
13                  to 180 would not be normal for her age.

14                  Q.    Well, you'd want to know, I suggest to  
15                  you, Doctor, as a reasonable doctor, whether you're an  
16                  orthopaedic surgeon, or you're practising as a  
17                  physician ---

18                  A.    Right.

19                  Q.    --- you'd want to know long before the  
20                  heart rate got anywhere near 160 to 180, that it was  
21                  going up and that there was a problem, right?

22                  A.    Yes.

23                  Q.    And that certainly sending an answer  
24                  like that, to whoever, to Dr. Reingold, all right, or  
25                  to me, or to Dr. Cairns or trying to stand by that

1 answer in front of these five jurors, is just not  
2 right, is it?

3 A. I mean, that's what was done. I don't  
4 know whether, I mean -- if your point is, is it  
5 appropriate for her age, I would guess that that heart  
6 rate is not appropriate for her age.

7 Q. Right. And that anybody who wrote that  
8 in a solemn answer to a solemn series of questions in a  
9 situation where a young girl died and people were  
10 looking for answers, wouldn't be completely forthcoming  
11 when they suggest that that's appropriate for her age,  
12 that's all I'm asking?

13 A. Yeah.

14 Q. Right?

15 A. That heart rate is not appropriate for  
16 her age, that's correct.

17 Q. Right, okay.

18 MS. POSNO: Mr. Coroner, I'm sorry to  
19 interrupt. I apologize. I waited to the end  
20 of this line of questioning. I think that's  
21 an unfair interpretation of that line. This  
22 witness, first of all, is not a nurse, and  
23 does not set the high heart rate and the low  
24 heart rate on the monitor. What this line  
25 says is what the alarm rates were set at. It

1 does not suggest that the normal heart rate  
2 for someone of Lisa Shore's age would have  
3 been 160 to 180. What it says is that's what  
4 was normal to set the alarm high heart rate  
5 at. And this individual, Dr. Wright, is not  
6 a nurse, and it wasn't established, in any  
7 event, that Dr. Wright would set the alarm or  
8 know what's acceptable or a normal setting  
9 for this Corometric monitor.

10 MR. GOMBERG: I agree. I'm not asking that  
11 question. What I'm asking is very simple.  
12 Dr. Wright participated as a committee member  
13 in writing a letter to a series of solemn  
14 questions that were posed to try and find out  
15 what happened. One of the issues was the  
16 setting on the Corometric monitor. I don't  
17 care what a reasonable heart rate is, I'm  
18 asking ---

19 MS. POSNO: That was the question.

20 MR. GOMBERG: No, that was not the question.  
21 The question is ---

22 THE WITNESS: Oh, I'm sorry, that's how I  
23 responded to the question.

24 THE CORONER: In due respect, Mr. Gomberg, I  
25 took the question in that regard too.

1 MR. GOMBERG: Fine ---

2 THE CORONER: You'll have to re-phrase it,  
3 but I took the question ---

4 MR. GOMBERG: --- then I'll ask the  
5 question ---

6 THE CORONER: --- that 180 was not a  
7 reasonable heart rate, and my understanding  
8 of the witness's reply was that the witness  
9 did not agree that that was a reasonable  
10 heart rate, so maybe we should define whether  
11 we mean what's a reasonable heart rate, or  
12 what the heart rate -- what I think this says  
13 is "these are the settings that the alarm  
14 would send" ---

15

16 BY MR. GOMBERG:

17 Q. That's all I'm dealing with. You see,  
18 when we wrote the letter, we didn't specifically  
19 segregate nursing questions and send those to nurses,  
20 and medical questions, and segregate those to doctors,  
21 you understand that?

22 A. I understand, if -- I'd understood your  
23 question to mean was that an appropriate heart rate for  
24 her?

25 Q. Right.

1           A.    And my response was, no, that's not an  
2 appropriate heart rate.

3           Q.    Okay, then that was the question I  
4 intended to ask.  The question that was asked in our  
5 question that was sent to the hospital related to the  
6 setting of the setting of the rate of the machine.

7           A.    Right.

8           Q.    What I'm asking you is, it appears from  
9 this answer that you or the committee members who  
10 drafted this letter, endorsed the setting of 50 to 60  
11 on the low side ---

12          A.    Mm-hmm.

13          Q.    --- and 160 to 180 on the high side.

14          A.    Mm-hmm.

15          Q.    Right?  And my question, now, to be  
16 clear ---

17          A.    Yes.

18          Q.    --- is, I suggest to you that a setting  
19 of 160 to 180 on the high side is not appropriate.

20          A.    I will answer, as an orthopaedic  
21 surgeon, I'm not responsible for nursing care or  
22 anaesthesia protocols or setting guidelines for  
23 monitors.  It does seem high to me, but I'm -- this is  
24 not within my ---

25          Q.    You see, I understand that, but my

1 concern is that when this letter was drafted, and the  
2 covering letter came to me, the indication, the only  
3 indication that I had about the people who participated  
4 in the drafting of the letter, and I assume these are  
5 the only people who did, were the people listed on the  
6 covering letter. So I had nobody else to ask those  
7 questions of, in terms of the drafting of the letter.

8 A. Right. I mean, I don't -- obviously  
9 I'll take your questions individually, line by line.  
10 My only general comment is I didn't feel as if I had  
11 much to contribute as an orthopaedic surgeon to the  
12 decisions about what the nurses setting the alarms,  
13 high or low. I would not be in a position to challenge  
14 the nursing staff or the anaesthesia staff whether  
15 that's too high or too low. If you ask me if the heart  
16 rate's too high for her age, yes, it is, but whether  
17 that's an appropriate setting or not ---

18 Q. You see, I think that I'm asking you  
19 another question. What I'm asking you is this: You  
20 participated as a member of a committee that answered  
21 some very specific questions, right?

22 A. Yes, sir.

23 Q. All right. And I asked you earlier,  
24 because I was hoping to avoid going through this line  
25 by line, whether you stood by the answers of the

1 committee, right? And I thought you said there may be  
2 some errors in there, but by and large, you stand by  
3 the answers. And I'm trying to show that some of the  
4 answers are misleading at best, right? And duplicitous  
5 at worst.

6 A. Again, I may have misinterpreted your  
7 question. My response was, in response to your letter,  
8 I feel ill-equipped to respond to these questions. I  
9 felt ill-equipped, and I remain ill-equipped, because  
10 it's not within my clinical specialty.

11 Q. All right.

12 A. These are not where I have expertise, so  
13 I relied on the people who I thought had the expertise,  
14 but -- so I'm not in a position to provide an expert  
15 opinion on whether this is right or not.

16 Q. All right.

17 THE CORONER: I think, Mr. Gomberg, there  
18 obviously were a number of people. We've  
19 heard the witness say he relied on other  
20 people. If there is -- are any other  
21 responses here, that would be, in my opinion,  
22 in his expertise, then I think he should  
23 answer to those directly. I think otherwise,  
24 it appears he's going to say he accepted the  
25 opinion of the other people on the committee,

1 because it's not his expertise.

2 MR. GOMBERG: You see, Dr. Cairns, there's a  
3 problem with that, though. And the problem  
4 is, for example, right, just by way of  
5 example, there's a statement here in response  
6 to a specific question, and the answer is  
7 "Blood pressures were not taken so as not to  
8 awaken her." All right? That's a statement  
9 that, as a committee member, with the  
10 greatest of respect, he either has to agree  
11 with or disagree with, because he  
12 participated in the authorship of the answer  
13 to my letter.

14 Now, if he wants to say that he had no  
15 participation and they should have taken his  
16 name off the letter because he had no input  
17 into it, I'll stop asking the questions.

18 THE CORONER: Well, that's fine. If the  
19 witness can indicate to us how much  
20 involvement you had in this letter, how much  
21 you will stand by the answers, or how much  
22 you feel that you signed off to answers that  
23 you really didn't look at in any depth, that  
24 may be of some help, will it, Mr. Gomberg?

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BY MR. GOMBERG:

Q. Absolutely. I thought that I crossed that bridge about a half an hour ago.

A. I did not participate in the drafting of the response to this, because I felt it was outside my expertise. I did review a draft, but I made no substantive comments because I felt they were outside of my expertise. I did not actually sign this letter, or that letter, but I did, by virtue of the fact, having read over it, I did review it. But I did not edit it, I did not contribute to its substance, because I felt at the time and continue to feel that it's outside of my expertise to comment on these issues. Does that answer your question?

Q. Well, it does up to a point. Is it fair to say, Dr. Wright, is it fair to say that there are many, many, many inaccuracies, distortions in the letter? And I'll give you an opportunity to read it, and that we don't have to go through them one by one. And the jurors, based on the evidence that they've heard, can figure out what really happened. Is that fair?

A. I have not gone through that letter, and I'm not -- I don't have access to all the information.

1 I haven't been at this hearing, so I wouldn't be able  
2 to be in the position to reconcile all the statements  
3 that were made there, and their veracity. If you, I  
4 mean, if we go through it line by line, it may be that  
5 I agree with you at some points that there are some  
6 inaccuracies, but I can't name them. I would be in a  
7 poor position to go, to make that, to agree to that  
8 question.

9 MS. POSNO: Dr. Cairns, I have some concerns  
10 with that line of questioning. In meetings  
11 with Dr. Wright to prepare him for today, we  
12 certainly did not address the evidence at the  
13 inquest. The issues that have come up that  
14 the jury has heard, to equip Dr. Wright with  
15 the necessary information to address these  
16 concerns of Mr. Gomberg, we just didn't  
17 appreciate that would be an issue before you.

18 MR. HAWKINS: And I have a second concern  
19 with Mr. Gomberg's suggestion. He has to  
20 this point had all of the witnesses who were  
21 involved in the care of Lisa as witnesses at  
22 the inquest. And with the exception of one  
23 or two points with a couple of witnesses, the  
24 factual information in this letter was not  
25 put to any of those witnesses. And with the

1 exception of one or two points on other  
2 issues, it was not put to any of those  
3 witnesses, and for Mr. Gomberg to now suggest  
4 when all of the factual witnesses are over,  
5 that there are many, many distortions,  
6 without putting it to those witnesses, is  
7 inappropriate, in my view. And particularly  
8 with this witness, who has indicated his  
9 involvement in the process.

10 THE CORONER: But with regard to this  
11 letter, with regard to who composed this  
12 letter, I think this witness can indicate to  
13 us whether, in fact, he read over the letter,  
14 accepted at face value that the other members  
15 that were composing this letter were the  
16 experts, and he signed it without due  
17 consideration to whether he agreed with it or  
18 whether he was in a position to agree with  
19 it, and that in retrospect, perhaps he  
20 wouldn't sign such a letter in the future,  
21 unless he's going to say he does feel that he  
22 has some expertise in the various questions  
23 and answers, and will therefore be held  
24 accountable, or want to challenge Mr. Gomberg  
25 on the accuracy of those questions.

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THE WITNESS: Oh, sorry to interrupt, sir,  
but I didn't sign it.

THE CORONER: No, I agree.

THE WITNESS: I never signed the letter.  
All I did was review it. I actually had  
never seen this letter to Dr. Reingold as  
well, so it wasn't cc'd to me. I had no  
knowledge that I was named as one of the  
participants in this. As the -- I just  
happened to have been provided a draft.

THE CORONER: You see, that's my point, Mr.  
Gomberg. I don't think this witness really  
is the author of the answers that were --  
that you -- the questions that you sent, and  
that he has been included because he was, on  
paper, the staff person in charge. And  
that's valid. But that it's my understanding  
that the issues that you raised, the very  
valid issues you raised, were issues that  
really required to be answered by Nursing and  
by Anaesthesia, if my memory serves me right,  
from your answers, and that he was there, but  
really, it doesn't appear that he took any  
active role in those answers.

MR. GOMBERG: Well, that's fine, then. I,

1 I'm content to stop as long as we have Dr.  
2 Roy and Marion Stevens here to answer my  
3 questions, since they apparently authored the  
4 letter.

5 THE CORONER: I certainly have no problem  
6 with calling -- with Dr. Roy. Dr. Roy was on  
7 the list of witnesses that we had agreed to  
8 at one stage; it's gone on and off again.  
9 With regard to Marion Stevens, we may have to  
10 have some discussion with Council in chambers  
11 with regard to that.

12 In principle, I have no problem with any  
13 of the people who composed that reply being  
14 called to give evidence. And it's not to, in  
15 any way, abbreviate your examination of this  
16 witness, but I genuinely don't think we're  
17 going to get any further valuable evidence  
18 from this witness. From what he's told me, I  
19 don't really think he played a major role in  
20 the content. I think he has said most of the  
21 content, if not all, is outside his direct  
22 area of expertise.

23 Is it fair to say, Doctor, when it's  
24 outside it, you accepted the opinion of the  
25 people whose expertise you thought it was

1 within their expertise to give that opinion?

2 THE WITNESS: Absolutely. And the letter  
3 was not written to me directly. I wasn't put  
4 in the position of responding, and I did not  
5 sign it, so, yes, I -- since I didn't have  
6 the responsibility of ensuring its veracity,  
7 but if you ask me today, yes, I would have  
8 deferred to those people and their expertise.

9  
10 BY MR. GOMBERG:

11 Q. Right, so I guess in hindsight, it would  
12 have been better if your name wasn't referred to as one  
13 of the committee members by the hospital when they sent  
14 that letter to the Coroner's office?

15 A. Given your line of questioning, yes,  
16 that's probably true. I wouldn't have -- I didn't  
17 write that letter to suggest that I was part of that  
18 process. It was ---

19 Q. I'm not suggesting that you suggested  
20 you were, but what I am suggesting is that it was  
21 suggested to the Coroner, that's to Dr. Reingold, and  
22 to me, and to Dr. Cairns, and to the jury, it was  
23 suggested in that letter that you were part of that  
24 committee. That's what I'm suggesting.

25 A. Yes.

1 Q. Thank you.

2 THE CORONER: Ms. Posno?

3

4 CROSS-EXAMINATION BY MS. POSNO:

5 Q. I will try not to go on at any length,  
6 but I think there are a few points of clarification  
7 that need to be made. Dr. Wright, you explained to us  
8 a little bit, right at the beginning of your testimony,  
9 in terms of your expertise and your background, and  
10 we've heard the reference to your expertise a few  
11 times. Can you express in lay persons' terms, please,  
12 to the jury, what you do, what your profession is?

13 A. Sure. I'm an orthopaedic surgeon, and  
14 my responsibility is to deal with children with broken  
15 bones, acutely broken bones, and generally, to put  
16 those back together. So injured children would be my  
17 responsibility as it relates to bones and ligaments and  
18 tendons. As well, there's a number of conditions which  
19 are deformities of joints, be they congenital, that is  
20 present at birth, or subsequent to birth, which I would  
21 operate on and correct. So that's where my expertise  
22 lies.

23 Q. And as an orthopaedic surgeon, you  
24 indicated that your residents, on occasion, may input  
25 PCA orders. I think your evidence was that you didn't

1 input PCA orders.

2 A. I've never input PCA orders, never once.

3 Q. Who normally manages that element of the  
4 care of an orthopaedics child, from your standpoint?

5 A. It's usually the residents and most of  
6 the time, it involves consultation with Anaesthesia and  
7 the Pain Service.

8 Q. The Pain Service. Do you have any role  
9 at the hospital as an investigator into death, or into  
10 issues that occur in the care of the patient?

11 A. No, I don't.

12 Q. Is there someone who does have that  
13 position?

14 A. Marion Stevens in Risk Management is  
15 responsible for investigating such events. I think, as  
16 close as I understand your question, she would be the  
17 most appropriate person. But I don't know that there's  
18 any investigator, per se.

19 Q. So the hospital does have a department  
20 or a person who deals with that element of  
21 communication.

22 A. Yes, Marion Stevens.

23 Q. And as the most responsible physician,  
24 can you explain to the jury what that means, they've  
25 heard that you were the most responsible physician.

1           What does that mean?

2                   A.    Right.  In general, when a child is  
3                   admitted to hospital, someone assumes authority for  
4                   their care, and that is listed as the "responsible  
5                   physician."  It's usually one of the staff surgeons, or  
6                   paediatricians at the Hospital For Sick Children, or  
7                   the psychiatrist, or the ophthalmologist, whoever.  It  
8                   would be one of staff physicians are delignated (sic)  
9                   the responsible physician on the chart.  And in  
10                  general, that's the person who the child should be most  
11                  appropriately admitted to.  For example, if it was a  
12                  child with a broken bone, I would be the responsible  
13                  physician, because I would treat that child directly,  
14                  and I would be responsible for all aspects of their  
15                  care.

16                  Q.    And in this case, we've heard that the  
17                  Department of Anaesthesia at that time did not have the  
18                  privilege to admit patients directly.  Can you give us  
19                  any guidance on why Dr. Schily was not the admitting  
20                  physician in this case, or one of the anaesthetists?

21                  A.    That is -- the anaesthetists, usually in  
22                  their job is generally to provide anaesthetics and pain  
23                  relief in patients who are admitted for other reasons,  
24                  be it surgery, or for some other reason, some other  
25                  painful condition.  A small part of their practice is

1 dealing primarily with children where the pain is the  
2 primary issue. 'Cause in this case, the child had a  
3 fracture, Lisa had a fracture, I believe in February,  
4 so a full nine months prior, and my understanding was  
5 that, because I was not involved in her care, it was a  
6 very minor fracture, at least from an orthopaedic  
7 standpoint.

8 The subsequent complication of this  
9 chronic pain syndrome, reflex sympathetic dystrophy,  
10 and again, I was not part of her care, so I can't make  
11 any comments on what that actual diagnosis is, that  
12 would be a complication of treatment which we would  
13 frequently, almost always, then look to another service  
14 to provide care, because that's a complication of  
15 treatment; it exceeds my clinical -- my job was --  
16 well, in this case, my job might have been, there were  
17 other orthopaedic surgeons involved in her care, to  
18 make sure the bone healed correctly.

19 Once that's been established, and in her  
20 case, there was this unfortunate complication, it then  
21 becomes another team's responsibility for any  
22 complication of care. In this particular case, it was  
23 a pain problem, and therefore the most appropriate  
24 service was the Pain Service. And they had seen her as  
25 an outpatient, I understand, and were managing her in

1 concert with a Pain Service from another hospital in  
2 another country.

3 And generally, and I think this is the  
4 -- my understanding is is this is the way works now, if  
5 she were to come back tonight with this problem, she  
6 would be admitted to the Pain Service, not to  
7 Orthopaedics, because she did not have, per se, an  
8 orthopaedic problem. Not that that wasn't the original  
9 event, but it had been so distant from her care that  
10 this was not kind of an orthopaedic problem at this  
11 point. Does that help?

12 Q. So as of today, who would be the most  
13 responsible physician for a child who comes in with  
14 chronic pain?

15 A. I believe it could be the anaesthetist  
16 on call, or the pain -- certain of the anaesthetists  
17 have sub-specialty expertise in pain, in the care of  
18 children with pain. And it might have been, for  
19 example, there might be someone on call for the Pain  
20 Service who might have admitted her. But whoever was  
21 on call, or it may be the anaesthetist on call.

22 Q. So although you were the most  
23 responsible physician, by the time of the morning, had  
24 you seen Lisa at all?

25 A. I had not seen her overnight, as I

1 usually would not see a child admitted at midnight who  
2 had gone to the ward, and was sleeping. It would have  
3 been -- well, I don't know whether she was sleeping,  
4 but it would have been the middle of the night, so I  
5 normally would have done rounds, usually in the  
6 morning, say around 8:00 or 9:00 would be my -- now,  
7 the residents would see them routinely every morning  
8 between 6:00 and 7:00, and, in fact, that's what  
9 happened. She was discovered on their rounds, where  
10 they visit each patient as a group. So I would not  
11 normally have seen her, no.

12 Q. We have heard about a Death Summary, and  
13 that's the document that we now have two or three  
14 copies of; it's at page 11 of the hospital chart. Can  
15 you describe for the jury, what is the purpose of the  
16 Death Summary, and if you can also tell them again what  
17 it is that it's supposed to contain, what information?

18 A. The Discharge or Death Summary is  
19 supposed to provide a very brief summary of the  
20 patient's course in hospital. The medical record  
21 serves as the complete body of information. The  
22 Discharge Summary is meant to be a very brief summary,  
23 so that in someone going through the chart, they would  
24 not have to go, generally, to all aspects of the chart.  
25 So it's not meant to be an exhaustive document, in

1           general.

2                   Q.    And, again, if you could just summarize  
3           for the jury the nature of information you would  
4           include within the Death Summary?

5                   A.    Sure.  Normally, it would include the  
6           presenting complaint, the history of the child's  
7           complaint, the physical examination, the salient points  
8           of treatment, the outcome of treatment and in the case  
9           of a Discharge Summary, it would include what the  
10          necessary follow-ups, so it would be a very brief  
11          summary of those.

12                  Q.    And in the normal course, as the most  
13          responsible physician, do you regularly have personal  
14          involvement at all those levels of the patient's care?

15                  A.    Oh, no, I would have -- there's a whole  
16          team looking after this child, and at minimum, at least  
17          to a surgical ward, it would include, you know, the  
18          nurse, and the residents, and the fellows, anaesthesia,  
19          possibly consulting anaesthesia, discharge planning;  
20          those would be the minimum, and in each individual  
21          case, of course, it could be substantially more people  
22          involved in the care.

23                  Q.    So is there anything uncommon about you  
24          reporting about the medical care provided by other  
25          members of the team within the Death Summary?

1           A.    No, that's not unusual.

2           Q.    And is there anything uncommon about you  
3 speaking to other members of the team to get  
4 information about the care of the patient to include  
5 within your Death Summary?

6           A.    I think I'm speaking for virtually every  
7 physician and surgeon at the hospital, and again, I'm  
8 just -- having been a physician since 1981, the -- you  
9 provide a brief summary of the information within the  
10 chart, so it doesn't involve conversations with other  
11 people. You rely on the written documentations,  
12 sometimes on information that occasionally, you might  
13 not even know, that might not even be in the chart,  
14 because, I mean, sometimes you know some things that  
15 might not be there that you would include, for example.

16          Q.    And how would you learn about those  
17 other things?

18          A.    Well, for example, you would go to the,  
19 perhaps the old charts or something like that and pull  
20 out the salient features, so it may not be in the  
21 admission, for example, but you might pull out some  
22 pieces of information.

23          Q.    That might be helpful to clarify for the  
24 jury, as well. When you dictated your Death Summary,  
25 and you said you had the chart, did you have just this

1 admission, the 20 or 30 or so pages that we have, or  
2 did you have the whole chart?

3 A. I can't recollect. There was -- this is  
4 not an excuse, but there was a certain sense of urgency  
5 that we wanted to get this on to -- to the Coroner's  
6 office, and I was very rushed because this was  
7 presented to me in -- in -- as I've already suggested,  
8 so -- sorry, can you ask the question again?

9 Q. When you went down to the Records  
10 Department, you ---

11 A. Yes.

12 Q. --- indicated you had the chart  
13 available.

14 A. Yes.

15 Q. I just wondered, to assist the jury,  
16 with what records you had available there, was it just  
17 the records from this admission, or was it her entire  
18 hospital chart?

19 A. Yeah, I honestly can't remember. It  
20 would often be the whole chart, but in this particular  
21 case, it may have just been this hospital admission.

22 Q. At the time you dictated your Death  
23 Summary, in terms of the issues that we're addressing  
24 through the inquest, and that you've learned about in  
25 your subsequent meetings in January and in March of

1 1999, turning back to October 29 when you dictated  
2 this, can you outline for the jury what issues you knew  
3 of, as of that time? What issues of concern there were  
4 with respect to the care provided to Lisa Shore?

5 A. Well, this was an unexplained death. It  
6 was an unexpected death, so the general response to the  
7 hospital to these kinds of events would be we need to  
8 revisit all aspects of care. We need to look at the  
9 nursing care, we need to look at the physician care.  
10 We need to -- that everyone has responsibilities that  
11 need to look at that, and I'd understood that was in  
12 place following her death. So aspects of nursing care  
13 were reviewed, the protocols were reviewed, the pain  
14 management protocols were reviewed. This is what I'd  
15 understood was ongoing, and was planned.

16 Q. So you didn't know particulars in  
17 connection with a Corometric monitor, whether it was  
18 attached, apnea turned on or off?

19 A. I wasn't aware of any of those issues.

20 Q. You didn't know the saturation --  
21 whether an O2 saturation monitor had been attached or  
22 not?

23 A. I did not, no.

24 Q. Whether the Kidcom orders had been  
25 looked at or followed, or not?

1           A.    It didn't even enter my mind.

2           Q.    When you mention that, when you say  
3 that, what do you mean, it didn't enter your mind in  
4 connection with the orders?

5           A.    I had understood some orders had been --  
6 I knew that some, you know, vital signs had been taken.  
7 I had no reason to presume the orders weren't given,  
8 and that they weren't followed. It never occurred to  
9 me to question that.

10          Q.    At the time you were providing, or  
11 dictating your Death Summary, did you have any reason  
12 to doubt the information given to you by the nurses, or  
13 to question the accuracy of the information given to  
14 you by the nurses?

15          A.    No.

16          Q.    When you prepare a Death Summary, and I  
17 presume you've done many of them -- sorry, not a Death  
18 Summary, but a Discharge Statement or a Discharge  
19 Summary or something along those lines that would  
20 normally go at the end of the admission of a patient?

21          A.    Yes, every child who's discharged from  
22 the hospital has either what's called a short form  
23 which is a written notation summarizing the discharge,  
24 or would have a written or a dictated Discharge  
25 Summary.

1 Q. Sorry about that, I mis-spoke. And is  
2 the Death Summary similar to a Discharge Statement that  
3 would be prepared by the most responsible physician?

4 A. Yes.

5 Q. And when you're preparing a Discharge  
6 Summary, is it your practice, or an expected practice  
7 of others that you will review the physician's orders  
8 for the patient, and whether they were followed for  
9 that patient?

10 A. No.

11 Q. Those are my questions. Thank you, Mr.  
12 Coroner.

13 THE CORONER: Jury requests?  
14

15 CROSS-EXAMINATION BY THE JURY:

16 BY JUROR #3:

17 Q. Dr. Wright, the Death Summary, you have  
18 dictation by change (sic) right in here? You did this  
19 without the Flow Chart?

20 A. I believe I probably had the Flow Chart,  
21 and I regret not consulting it in more detail. I  
22 relied on the information that had been relayed to me  
23 by the nurses at the time of the resuscitation or at  
24 the arrest.

25 Q. Have you seen the Flow Chart by now, the

1 full Flow Chart that was then the Flow Chart that we  
2 are talking about on ---

3 A. I believe this is it right here.

4 Q. The detailed one?

5 A. Yeah, I believe this is it right here.

6 CONSTABLE CULLETON: Exhibit 8:

7 THE WITNESS: Yeah.

8  
9 BY JUROR #3:

10 Q. You have seen that?

11 A. Yes, I've seen it.

12 Q. In your Death Summary, you have stated  
13 in here:

14 "... She was awoken at 5:00 in the  
15 morning and her vital signs were fine,  
16 and she responded appropriately. At  
17 6:00 a.m. her vital signs were taken,  
18 and also found to be normal. Then at  
19 7:15, her vital signs were absent at  
20 that point ..."

21 A. Yes.

22 Q. Isn't that unusual?

23 A. In which -- which part of it, that  
24 they'd been normal ---

25 Q. Yes.

1           A. --- at several points? Well, I think  
2           that one of the points is that I relied on the  
3           information that was given me, and I think if I had  
4           reviewed the Flow Sheet, I think the heart rate is  
5           elevated at both 5:00 and 6:00 a.m. On the specific  
6           issue, is it normal? There are some causes of cardiac  
7           arrest where the child could have either a normal heart  
8           rate or a slightly elevated heart rate, and then  
9           suddenly die.

10                        There are things like cardiac heart  
11           arrhythmias, where suddenly the heart is working well,  
12           and suddenly it goes into an abnormal rhythm. There  
13           are kinds of -- one of the most serious is the heart  
14           just stops beating. And there are various causes of  
15           death. There are situations where we call pulmonary  
16           embolism where a blood clot could be in the leg and be  
17           asymptomatic, so therefore the child is -- has a  
18           perfectly normal heart rate, and then suddenly, within  
19           seconds, that blood clot could go from the leg and into  
20           the right side of the heart and into the lung, and  
21           basically block the whole right side of the heart and  
22           the child could die almost instantly because of that.

23                        And that was certainly one of the  
24           diagnoses that was considered for this girl, that she  
25           -- we would not have expected this girl to suddenly

1 die, and that one of the explanations was is because  
2 she had this problem of the chronic pain, maybe she  
3 wasn't moving this limb as well, and that the blood had  
4 congealed or clotted, and that would be an explanation  
5 for this sudden change in, you know, from mildly  
6 elevated heart rate.

7 As it turns out, that wasn't the case.  
8 But that was certainly considered at the time. So to  
9 answer your question, it could be; it certainly could  
10 have been.

11 THE CORONER: Any other questions? Yes?

12  
13 BY JUROR #4:

14 Q. You had stated that the nurses were  
15 being interviewed.

16 A. I understood they were being  
17 interviewed, yes.

18 Q. Do you know by whom?

19 A. I spoke directly with Cathy Sagan, who,  
20 and I can't give you her exact title, but it was her  
21 responsibility to -- for the nursing care. So I  
22 understood that she was responsible for that.

23 Q. I'm going to ask a silly question. The  
24 information that you have now about the charts, the  
25 protocol, what was done, what wasn't done; do you feel

1 that there was negligence on anybody's part?

2 THE CORONER: I'm sorry, but a Coroner's  
3 inquest is not allowed to make a conclusion  
4 in law, and cannot comment on whether there's  
5 negligence or not. So since your verdict  
6 cannot include that, I cannot allow a  
7 witness, even if they have an opinion on  
8 that, I cannot allow them to answer that  
9 question, and I'm not in any way scolding  
10 you. I know it's the process, but that is  
11 one of the things that you must remember, you  
12 cannot reach any conclusion of law or find  
13 fault in answering your questions.

14  
15 BY JUROR #5:

16 Q. Did you call the Coroner's?

17 A. Yes, I did.

18 Q. What reason?

19 A. Oh, it's -- mentioning it's the law, any  
20 child who's admitted to hospital with an unexplained  
21 death. And even if it hadn't, I mean, I believe it is  
22 the law, but in this particular case, we would err on  
23 the side of calling the Coroner, because I've been  
24 involved in cases where we've called the Coroner, and  
25 the Coroner has decided that this is not a Coroner's

1 case, per se, but in my practice, the general policy is  
2 to call the Coroner to make absolutely sure that the  
3 Coroner has an opportunity to review the facts of the  
4 case. But I believe in this particular case, that was  
5 mandated.

6 Q. Why not the police?

7 THE CORONER: Well, let me help you. The  
8 Act and, in fact, if you look at page 28 of  
9 your, I think it's your copy of the hospital  
10 chart, there are guidelines to the --  
11 everyone in the Hospital for Sick Children,  
12 where the physician in charge must either  
13 personally or through the resident call the  
14 Coroner's office under certain circumstances.

15 And it's clearly documented there, "in a  
16 patient whose death occurs suddenly and  
17 unexpectedly." And Lisa was admitted with a  
18 non-life-threatening condition. There was no  
19 one would have ever anticipated that Lisa  
20 would have been dead next morning, so she  
21 died suddenly next morning; she died  
22 unexpectedly next morning. It is the law for  
23 the physician to call the Coroner's office.  
24 If, in fact, he called the police, it would  
25 be the police's responsibility to call the

1 Coroner's office. So the calling of the  
2 police, would, all that would do would refer  
3 the call on directly to the Coroner's office.

4 But always you must call the Coroner's  
5 office. Any other questions?

6  
7 BY JUROR #5:

8 Q. Did you see any monitors when you went  
9 in the room?

10 A. I looked in extremely briefly, and it  
11 was after the resuscitation had stopped, and I wasn't  
12 looking for that, I have no memory of that, so I didn't  
13 see anything.

14 Q. Did you see a PCA pump?

15 A. No, I asked about the PCA pump, but I  
16 didn't see it.

17  
18 BY JUROR NO. 3:

19 Q. Have you done your personal  
20 recommendation relating to the procedure because of  
21 what had happened, like, to enhance the regulations and  
22 procedures that should be done?

23 A. We have a process by which we review all  
24 unanticipated outcomes of surgery, or in this case, a  
25 unexplained death, and it was reviewed, what are called

1 "morbidity and mortality rounds." These are held  
2 monthly within all the surgical divisions. In this  
3 particular case, we reviewed this case, and this was  
4 seen not to be an area in which we had any expertise.  
5 It was not an orthopaedic condition. There was no  
6 orthopaedic care, per se, delivered. There was nothing  
7 that I could do that would affect that. As I told you,  
8 I'd been assured that there were other responsible  
9 services and the nursing group that were looking into  
10 us, and that's where our responsibility lied, and we  
11 felt that we satisfied that responsibility.

12 THE CORONER: Is it fair, in summary,  
13 Doctor, that this patient came in under your  
14 name, where not as person would have come in  
15 under Pain Service, you had no expertise at  
16 all for the treating of this patient?

17 THE WITNESS: That's correct.

18 THE CORONER: And that the situation now is  
19 that somebody who would have expertise in the  
20 condition and the treatment for which this  
21 patient was admitted, would be in the  
22 position of writing a Death Summary?

23 THE WITNESS: That's correct. The Death  
24 Summary would have been written by that  
25 person. I, I don't ---

1 THE CORONER: Would you anticipate that the  
2 Death Summary under those circumstances,  
3 given their knowledge, would more accurately  
4 reflect the situation than yours, and I'm not  
5 meaning to be in any way disrespectful ---

6 THE WITNESS: Yes.

7 THE CORONER: --- for yours.

8 THE WITNESS: No, no. I think I had a  
9 certain responsibility, too. I relied  
10 somewhat on what had been told me, and I  
11 accepted that at face value. I had no reason  
12 to not suspect the veracity of that  
13 information. I've already suggested to Dr.  
14 -- excuse me, Mr. Gomberg -- that I should  
15 have gone through the Flow Sheet in more  
16 detail. It's not an excuse, there was a  
17 certain amount of time pressure, and other  
18 clinical responsibilities, but I should have  
19 done that in more detail. I think that those  
20 are the issues which are where I've made  
21 errors. I think if another responsible --  
22 yes, I think she should have been under the  
23 other service, and they would have dictated  
24 the Death Summary. I don't know that the  
25 particular content or expertise was relevant

1 here. It was a reporting of events. That's  
2 the responsibility is, is just to report the  
3 events, not to provide cause, not to talk  
4 about what should or should not have been  
5 done, it was to report the events. And in  
6 this particular case, I felt that, as I --  
7 and I'm sorry to run on here a bit, but I --  
8 there was a certain obligation to this child  
9 to have her admitted to hospital. This  
10 seemed to be the only way that we could do  
11 it, but we established lines of communication  
12 to make sure that person with the appropriate  
13 expertise was in the position that they could  
14 be responsible for her care. And we wrote in  
15 the record, and we've communicated with those  
16 people that we would -- the communication  
17 will go directly from the nurses to the Pain  
18 Service, since that's who should have been  
19 providing the care, and that's who was  
20 providing the care. So I was really written  
21 down in the chart because of the problem with  
22 the responsible physician.

23 THE CORONER: Thank you.

24  
25 RE-EXAMINATION BY MR. KRKACHOVSKI:

1 Q. Do these monthly morbidity rounds give  
2 rise to a report or a document of some kind?

3 A. They do now, which is for the past, not  
4 so much in related to this event, but I don't believe  
5 there's any notation on this case, other than the case  
6 was reviewed, and it was not an orthopaedic case. That  
7 would be the documentation.

8 Q. Who was involved?

9 A. Oh, it would come through all the staff  
10 orthopaedic surgeons, all the residents, all the  
11 fellows would have been there.

12 Q. How was the case presented to the -- can  
13 I call it a "committee"?

14 A. No, no. We meet twice a week for a  
15 review of clinical material. That's what we -- it's  
16 part of our educational process, it's part of our  
17 quality in management. This case would have been very  
18 briefly presented; it would have been one of, you know,  
19 maybe a half dozen cases on a monthly basis where we  
20 review all aspects of care, and it would have been  
21 mentioned that this was admitted under us because I was  
22 the responsible physician, but it was a Pain Service  
23 problem, and that it was an unanticipated death. But  
24 it had nothing to do with Orthopaedics.

25 Q. Would you have had the -- when I say

1 "you," the group, would you have had Lisa's chart in  
2 front of you?

3 A. No, not usually.

4 Q. Does the Pain Service go through a  
5 similar process?

6 A. I don't know.

7 Q. Thank you.

8 MR. GOMBERG: Mr. Coroner, can you find that  
9 out, just before we forget? Because I was  
10 going to ask that very question.

11 THE CORONER: I think that's a valid  
12 question, and I will find out whether, in  
13 fact, there were any morbidity or mortality  
14 rounds done by the Pain Service, who would  
15 really be the appropriate service to review  
16 this. And if you can let me know in the  
17 morning, Mr. Hawkins, and if there is,  
18 provide me with the documentation so that we  
19 can properly assess how relevant it is, and  
20 who we may or may not need to call.

21 MR. HAWKINS: Okay, we can address that  
22 tomorrow.

23 THE CORONER: Thank you. The witness is  
24 excused. I apologize to the jury for the  
25 lateness of the hour, and to everyone else.

1 The only reason was that this physician is  
2 not available until Tuesday, and I did not  
3 want to stop and I wanted to get it over  
4 with, so I apologize to you. I'll make sure  
5 the government pay you overtime.

6 We will actually adjourn until 10:00  
7 a.m. tomorrow morning, because I would like  
8 to meet with Counsel at 9:15 in the morning  
9 so that we can perhaps have some discussion  
10 about witnesses and about some of these items  
11 so that as far as possible, we don't waste  
12 the jury's time, coming in and out, doing  
13 photostatting, et cetera.

14 MR. HAWKINS: If I might suggest, before the  
15 jury is sent home, if Counsel meet very  
16 briefly, because I understood there were  
17 scheduling issues with respect to tomorrow,  
18 so we might need to address that issue,  
19 but ...

20 THE CORONER: There may be what?

21 MR. GOMBERG: Scheduling issues with respect  
22 to tomorrow, depending on witnesses and  
23 various other things. So we might need to  
24 address that briefly before the jury is  
25 excused for the evening.

1 THE CORONER: It was my understanding that  
2 Ms. Douglas was going to be a witness for  
3 tomorrow.

4 MR. HAWKINS: Yes, Ms. Douglas is available  
5 tomorrow. I don't know that we have any  
6 other witnesses set up or available for  
7 tomorrow.

8 THE CORONER: Anybody else have any views,  
9 then, if there's only one witness for  
10 tomorrow as to whether we should sit  
11 tomorrow?

12 MR. HAWKINS: I'm, I'm -- Ms. Douglas is  
13 available, and I am certainly prepared for  
14 Ms. Douglas to testify tomorrow, but I don't  
15 understand that we have anybody else  
16 available for tomorrow, and I had understood  
17 Ms. Douglas was simply to answer some  
18 questions for the jury. I don't know how  
19 long that's going to be. I don't know if  
20 it's therefore worth the jury's time, your  
21 time, et cetera, to reconvene.

22 JUROR #4: How about Cathy Sagan?

23 MR. GOMBERG: I thought Dr. Reeder was  
24 testifying, too.

25 THE CORONER: Dr. Reeder's available.

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MR. HAWKINS: My understanding is that she was testifying after Dr. Williams was to testify.

MR. GOMBERG: Oh, all right.

THE CORONER: Dr. Reeder has been called on behalf of the hospital, so ...

MR. GOMBERG: Oh, that's right, that's right. I forgot.

THE CORONER: Why don't we have the jury here for 10:00 a.m., and we can see, I'm sure, if we only have one witness and the jury get the most of the day off, it will not be to their displeasure.

MR. HAWKINS: No, that's satisfactory. I just wanted that addressed.

THE CORONER: We'll adjourn until 10:00 a.m. in the morning.

--- 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 Barbara A. Pollard  
2 Certified Court Reporter