

Chapter 9



1995 – THE AFTERMATH OF THE SHUTDOWN JANUARY TO MARCH 1995

FROM LINDSAY TO WILLIAMS AND ROY

The plan to have Dr. Bill Lindsay review the Pediatric Cardiac Surgery Program had to be abandoned on January 2, 1995. On that date, it was learned that Lindsay would not be taking up his position as the head of cardiovascular and thoracic surgery and cardiology for both the HSC and St. Boniface General Hospital until February 1995. Dr. Robert Blanchard assumed the responsibility of finding someone who could conduct a more immediate review. It was obvious that, with the decision to suspend the program pending a review, time was of the essence.

Because the decision to bring in outside reviewers had financial implications, it required and received the approval of HSC President Rod Thorfinnson. Interestingly, the decision to bring in external reviewers was not taken to the Medical Advisory Committee, which met in both January and February.

Dr. Bill Williams, head of cardiovascular surgery at the Toronto Hospital for Sick Children, and Dr. Larry Roy, a cardiac anaesthetist from the same hospital, were contracted to conduct the review. It was to be conducted with very tight timelines. On January 9, a notice was sent out to all the doctors involved in the program, asking for written submissions that could be sent to Williams and Roy by January 13. The doctors involved began preparing the information they wished the reviewers to see.

On the other hand, the nurses were not informed of the appointment of Williams and Roy, and they were not at that time asked to prepare any written submissions. This was an amazing oversight, given the degree to which the events within the program had affected them individually and collectively and the degree to which they had struggled to bring problems within the program to the attention of the authorities in the hospital. It was, however, sadly in keeping with the way that nurses had been treated throughout the process.

In his submission to Williams and Roy, Dr. Murray Kesselman said that the main issues for the pediatric intensive care unit with the pediatric cardiac surgery program had been confusion over supplies that the sur-

geon required for bedside care, controversy over sedation and pain relief (analgesia) and post-operative complications.

In her submission, Dr. Molly Seshia noted that the neonatal intensive care unit had not received any protocols from Odium. The NICU nurses early in 1994 had drafted a protocol, but it was still awaiting Odium's input. In a separate memorandum, she asked that Williams and Roy look into such matters as bypass times, mortality rates, complication rates and the quality of diagnostic, anaesthetic and post-operative care.

Giddins's submission was less concerned with addressing problems he saw with the program than with giving Williams and Roy information about what had occurred. Giddins identified three separate phases to the events of 1994. The first phase, from February to March 1994, was marked by what he termed 'understandable' issues, as the team members familiarized themselves with each other. He wrote:

While I had felt that pre-op discussions had been detailed, academic, and fruitful from an early stage, the intra-op 'network' is obviously more intricate – needing greater time to develop. As acting medical director, I must of course take major responsibility for case selections during this and later periods. (Exhibit 20, Document 284)

His admission that he had a 'major responsibility' for case selection was an appropriate and professionally responsible act, considering the fact that case selection had been such a major concern during 1994.

The second period, that of the crisis of confidence, took place in April and May. Of this period he wrote:

The anesthesia service in particular appeared uncomfortable with their role in the cardiac OR, and therefore a moratorium was placed on anything other than palliative (closed) procedures and simple open cases (ASD's). By August, the team (as it was now referred to) had proceeded to 'medium' risk procedures (non-infant VSD's), with good success. Vocalization of frustration that there weren't more of these 'medium-risk' cases around! By mid-September, it was felt appropriate by all to proceed to essentially 'all-comers' (understanding that complex situations – particularly neonatal – would be subject to transfer out). (Exhibit 20, Document 284)

The suggestion that "complex situations – particularly neonatal – would be subject to transfer out," however, has to be considered in the face of the fact that none of the "complex neonatal cases" that the team faced in the fall of 1994 were even considered for transfer.

The final crisis of confidence came, he said, in December. In summarizing the situation in Winnipeg, Giddins made the following observations:

There are, no doubt, weaknesses in the current makeup of the section of Cardiology. As a smaller pediatric centre and heart program, all staff (medical, nursing, technical) have had to be flexible. As the only cardiologist here for the 9 months before the arrival of Dr. Ward in July, it was impossible to provide any more than a consultation service to the hospital. Since his arrival, things have been little better, considering the inevitable medical 'backlog' that had developed. This has had direct effects on everything from our ability to get acquainted with transesophageal echo techniques to being more involved at the critical care bedside. While Dr. Ward is extremely accomplished, this is still his first staff appointment. Both of us would be considered junior in many centres. We have done our best to help short of direct bedside management, which with our current clinical demands would be impossible. (Exhibit 20, Document 284)

On January 12, 1995, Odium forwarded a letter to Williams, describing his perception of the issues at the hospital. A portion of that letter simply reprinted excerpts from his September 26 letter outlining the May 17 withdrawal of services. Odium then summarized the Wiseman Committee experience. He stated that

among the issues dealt with at that time were the mortality and morbidity rate, a lack of confidence in the surgeon, communication issues, the learning curve that the surgeon and cardiologist faced, proper decorum in the OR and the issues facing a pediatric cardiac surgery program in a small market. He concluded by saying:

Clearly, I have had some difficulty establishing myself as the captain of the ship. This is further unmasked by the lack of local leadership in cardiac surgery, cardiology, and anesthesia. (Exhibit 20, Document 286)

Ullyot prepared the anaesthetists' submission. It highlighted concerns about case selection, surgical results, and the program review and case review process. Her submission noted that the Wiseman Committee had not fully addressed the concerns that had led the anaesthetists to withdraw their services. It also emphasized the lack of an overall strategy for the program's development and called for a review of the number of anaesthetists required for the program. Finally, her report stated that the nurses must be involved in the review process.

Blanchard prepared a lengthy submission that is worth quoting in detail.

My own perspective is generic and necessarily non-technical. A serious error on my part when Jonah arrived was failure to anticipate the potential for difficulties in introducing a new surgeon without a senior mentor or team-builder. When Kim Duncan joined our program in July 1986, [Jary] Barwinsky had been carrying on a modest program of closed cardiac surgery at the Children's Hospital and served to introduce Kim into the system and assist him. More important, George Collins was the father-figure for the entire Variety Heart Program at the Children's Hospital and was a major influence in helping Kim Duncan over the rough spots, especially at the beginning of his activities here. After Kim Duncan left in August 1993, the program was discontinued pending the recruitment of a Paediatric Heart Surgeon. When Jonah arrived, there was no cardiac surgeon with any interest or recent activity at the Children's Hospital and George Collins was no longer with us. Unfortunately, we left Jonah to fend for himself in a new environment with different procedures than he had previously experienced. He did not know our team and the team did not know him. To make matters worse, Jonah has not, it appears, established strong links with easy communication among some of the key players, especially Anesthesia. From my perspective, the anesthetists behaved in an adversarial fashion without making allowances for the situation of a new junior surgeon who should have been the director of the team. It appeared to me that, when things appeared to go wrong, the anesthetists and some nursing staff were ready to believe that this was entirely the fault of inadequate surgical management.

Nonetheless, communications were not established from either side to try to sort these things out and I, at least, was not aware of the serious nature of the problem until the anesthetists unilaterally boycotted the program. We then set up a series of meetings chaired by Dr. Nathan Wiseman, Director of the Paediatric Surgical Services. His report is attached along with my response to it that may have been too optimistic. During this period I interviewed those who have worked with Jonah as assistants or colleagues and was told that he is technically capable, if somewhat slow. He has also been considered to be knowledgeable. The Anesthetists and staff at the General Hospital (Adult) have found his operative procedures to be on par with our average adult cardiac surgeons. I am not capable of judging his surgical skills nor surgical judgement directly. I tried to get Jonah to work more closely with another new recruit whose primary activity is adult cardiac surgery, Andrew Hamilton. Unfortunately, Jonah has not always availed himself of this individual's assistance and support and one is left wondering why he did not do this. My direct discussions with Jonah lead me to believe that he is open and willing to work things out. (Exhibit 29, Document 391)

He concluded the letter by stating:

From my perspective, the problems are as follows:

- A junior solo paediatric heart surgeon without a mentor.
- Jonah seems not to be sufficiently clear and direct in communications.
- When things go wrong in the operating room, it is reported Jonah appears to become flustered at times.
- There may be problems in judgement, both for case selection and in the conduct of some problems when things are not progressing as anticipated. I have no direct indication of this, but from interviewing Jonah I wonder whether he always scans the whole horizon of possibilities.
- Jonah maintains a dignified and calm exterior. Perhaps this is misinterpreted by some of the nursing staff as lack of caring. My own reading of Jonah is that he is a dedicated and caring individual who certainly is willing to work hard to develop a good program. It would appear, however, that he is somewhat reluctant to ask for help, advice, or moral support when it is needed.
- There are probably too many Anesthetists.
- There are two Critical Care Units dealing with a small volume of difficult post-operative patients.
- We failed to spend time at the beginning to work through the whole system, using simulations and trial runs. (Exhibit 29, Document 391)

On January 13, 1995, Blanchard sent a memorandum to sixteen doctors involved in the program, advising them that Williams and Roy would be present at the HSC on January 25 and urging them to make themselves available on that day.

However, once again the nurses were left out of the loop. They had not been given advance notice to prepare submissions to the Williams and Roy Committee; nor were they given the same notice that doctors received of the impending visit. The director of pediatric patient services, Isobel Boyle, belatedly received notice of the Williams and Roy process. When she brought her concerns to the head of the Department of Pediatrics, Dr. Brian Postl, she said he indicated that the nurses had to be involved in the process. It fell to Irene Hinam and Carol Youngson to organize the nurses' response. Hinam approached both the NICU and PICU nurses and assisted them in preparing reports (Exhibit 20, Documents 278 M, 278 N, 278 O).

Their report stressed:

- Lack of preparation at the start of the program;
- Poor planning;
- Odim's poor understanding of hospital protocols;
- Poor communications with nurses and families;
- Lengthy operations;
- Increased need for heart pacing;
- Deaths of children who were not high-risk;
- Monitoring lines falling apart;
- Post-operative bleeding;

- Concern over longer than expected stays in ICU; and
- Poor morale.

On January 25, 1995, Williams and Roy met from 0730 hours to 1900 hours with individuals involved in the program. From their itinerary, while it would appear that they met with operating-room nurses, it does not appear that they spoke with any of the NICU or PICU nurses.

THE WILLIAMS AND ROY REPORT

On February 3, Williams and Roy sent their report to Blanchard. The report listed ten conclusions. Williams and Roy stated that there was evidence to question Odim's technical competence; that Odim might have been judged unfairly since he had attempted to adopt the HSC's methods rather than import his own preferences; and that the program had been poorly supported by the HSC from the outset. On this last point, Williams and Roy commented that it appeared that the program lacked protocols for effectively resolving disputes over patient care. It should be noted that Williams and Roy specifically stated that their report "neither exonerates nor condemns the present surgeon." (Exhibit 20, Document 364) They concluded that there was a crisis of confidence and identified the hostilities that have been described by this Inquest report. They also noted that their work was:

... hampered somewhat by the lack of relevant data. Information relating to morbidity and length of stay were unavailable. Those interviewed often referred to these issues but were unable to support their contentions with data. This program needs to establish an accessible database. (Exhibit 20, Document 364)

Other key issues that the report identified were the long periods of bypass, the large number of people involved in providing both anaesthetic and post-operative care and the lack of an identifiable budget for the program.

Their report contained two proposals for consideration. The first was that the program be consolidated with the program in Saskatoon.

An amalgamated single unit would be cost effective because of an economy of scale (which would need to be proven, although there is data to support such a conclusion) and would provide a critical mass of patients for focused expertise including two pediatric cardiac surgeons. If the program is moved to Saskatoon it solves all of the above problems in a single stroke. If the unit is located in Winnipeg, a major restructuring is required. (Exhibit 20, Document 364)

The report noted that in the United States, larger units were not only more cost effective, but had better morbidity and mortality rates than smaller units.

If the program was to remain in operation in Winnipeg, they suggested a complete restructuring. This would involve the creation of a cardiac program run by a triumvirate of a nurse administrator, a doctor and a hospital administrator.

All aspects of the cardiac service, namely surgery, cardiology, cath lab., operating room, ward, outpatient clinics, cardiac nursing, intensive care should be organized and run by the 3 program administrators. These three individuals should be directly responsible to the vice president or the CEO of the hospital and responsible for all aspects of the cardiac program including the budget. (Exhibit 20, Document 364)

They further stated that Lindsay needed to make this program his first priority. To do this, they recommended that the chief of surgery assist at all pump operations for the coming year. This was to allow an assessment of the surgeon, to provide consistency, and to resolve disputes. They also recommended that the chief of surgery be available to ensure that case selection was appropriate and that issues, such as the transfer of all patients to a single ICU, were resolved quickly. Williams and Roy believed that between two to three anaesthetists should be involved in the program, that all cases should be dealt with by a single ICU, that nurses had to be involved in program decision-making in a meaningful manner and that two more cardiologists should be hired.

RESPONDING TO THE REPORT

Blanchard received the report on February 7. Two days later, he met with Postl, Craig and Lindsay (who by now had arrived) to review the report. They decided that it would be necessary to place the PCS program on hold while the two options proposed by Williams and Roy were fully explored. They anticipated that this process might take six months. Craig informed Thorfinnson of the decision the following day. Craig and Thorfinnson arranged for the three department heads to meet with Thorfinnson, the HSC vice-presidents, and representatives of the Manitoba government on the morning of February 13. A meeting of all the HSC personnel involved with the program was set for noon on February 14. The Williams and Roy report was kept confidential: section heads were allowed to read it in the office of their department head, but they were not allowed to remove it from the office.

Present at the meeting on February 13 were Blanchard, Craig, Postl, Thorfinnson, the four HSC vice-presidents (Susan VanDeVelde-Coke, Helen Wright, Dr. J.D. Sutherland, and John Horne) and Jim Rodger, the assistant to the HSC president. Two representatives were present from the Manitoba Government: the Deputy Minister of Health, Dr. John Wade, and the Assistant Deputy Minister of Health, Tim Duprey.

At the meeting Blanchard summarized the Williams and Roy Report and its recommendations. All three department heads spoke in favour of restructuring the current program rather than switching it to Saskatoon. According to notes taken at the meeting by Rodger, the three also indicated that a new surgeon was needed and that it was not possible to rebuild around Odim. According to Rodger's notes, Wade said that he did not think that Manitoba had the population to provide a pediatric cardiac surgeon with the volume needed to maintain her or his skills.

Thorfinnson stressed the need to have a media strategy to deal with the issue. It was agreed that the program would be suspended for six months and that a news release would be issued the following day.

THE ROLE OF THE PRESIDENT AND VICE-PRESIDENTS

In their testimony, several of the vice-presidents indicated that they were surprised by the information that they had received at this meeting. Wright had been kept briefed by Postl of his concerns and knew in late November or early December that he had been thinking of closing the program. Wright testified that,

when she took on her new responsibilities on June 1, she was briefed by Dr. Agnes Bishop, the outgoing head of pediatrics. Bishop had told Wright that there had been problems with the Pediatric Cardiac Surgery Program, but a multidisciplinary committee was looking at the issue. Wright said that she may have briefed Thorfinnson about this matter at the end of June, but it would have been simply to say that a committee had been set up to deal with problems. Wright said that she had not seen the Wiseman Committee interim report when it was prepared in the summer of 1994, but had been briefed about its contents. The one report from her mentioning the program in 1994 that went to the Board of Directors of the HSC simply indicated that a new surgeon had been hired and that the program was providing full service.

VanDeVelde-Coke testified that before the meeting she had not known about either the withdrawal of the anaesthetists from the program or the existence of the Wiseman Committee.

Sutherland said that he felt the department heads should have informed him of the events of May 1994. He did add, however:

These three department heads, Dr. Bishop, Dr. Blanchard and Dr. Craig, were three of the people on whose judgment I relied on greatly. They were excellent department heads, and had good insight, good wisdom. And if they came to me and said, Ian, we have got a problem, and this is how I have dealt with it, and, in fact, looking at how they dealt with it in terms of setting up a committee of individuals who were involved in delivering the health care, and getting them to review it, and getting their buy in to re-establishing it, I don't think I could have done any better than that. (Evidence, page 38,437)

In his testimony, Thorfinnson said that before the summer of 1994, he had been made aware there were some problems in the program, but had been assured that they were being addressed. He was not certain how he had been given this information, but thought it might well have been from Wright. Thorfinnson testified that, with the benefit of hindsight, the details of the anaesthetists' action should have been brought both to his attention and to the attention of the Board of Directors. Again, he indicated, it would have been unlikely that either he or the board would have taken any action other than to allow the Wiseman Committee to do its work. Thorfinnson also said that he thought the matter ought to have been addressed by the MAC. He did not think it would have been appropriate to have been brought up at the Nursing Council. While nurses were involved in the program, it was in his opinion a medical and surgical issue, not a nursing issue.

Thorfinnson testified that Blanchard spoke to him about the program's problems twice in 1994, once in early December and once following the decision to stop performing surgery pending a review. At the first meeting with Blanchard, Thorfinnson said, Blanchard had said there were concerns with surgical outcomes and that he was monitoring the program. Thorfinnson testified that he asked if there were problems with Odim's competency, a question that Blanchard indicated that he could not answer. In terms of the manner in which the issues were reported to the Vice-Presidents and the President, Thorfinnson said:

It has become I think very clear to the vice-presidents and no doubt to the people who report to them that any activity of this magnitude should be reported up very quickly. And that's the major impact of that reporting mechanism. (Evidence, page 46,522)

Blanchard testified that he met with Odim on February 13 and informed him that the program was being shut down for at least six months. He also told him that if the program were to be revived, Odim would no longer be the surgeon. Blanchard advised Odim to seek another appointment and requested that he resign

immediately. Blanchard testified that Odim indicated that he would resign. However, Odim never submitted a resignation. He testified that he told Blanchard he needed time to consider whether or not to resign. He said that he spoke with Blanchard by telephone later that night and told him that he did not intend to resign. Blanchard did not pursue the matter, but Odim did not participate in any more pediatric cardiac surgery at the HSC after that date.

On February 14, 1995, the HSC issued a news release that read in full:

The Health Sciences Centre announced today that the Pediatric Cardiac Surgery Program will undergo an intensive six-month review to ensure that the best possible cardiac care service is available to young Manitobans and their families. This decision was made because patient outcomes have not achieved standards which the hospital hoped for when the program was re-introduced in February 1994.

An external review of the Pediatric Cardiac Surgery Program was commissioned by the Health Sciences Centre in January 1995. The report of the external reviewers highlighted a number of areas in which the program could be improved, including staffing patterns, resource allocation and the meeting of outcome objectives. Fundamentally, the review questioned whether, in a population of about one million people, there are sufficient numbers of children requiring heart surgery to maintain the clinical expertise required.

In the course of the next six months, the Health Sciences Centre will consider a variety of steps which might be taken to optimize the activities of the program. Such steps might include more formalized links with other centres where pediatric cardiac surgery is performed, reallocation of financial resources in support of the program and revisions to program staffing patterns.

Patients requiring pediatric cardiac surgery have been transferred to Saskatoon or Toronto since Christmas 1994 and will continue to be transferred until the Centre's review has been completed. This practice, which has been routinely followed in the past, will ensure that Manitoba's children continue to have prompt access to the full spectrum of pediatric cardiac services during the six month review period. (Exhibit 43)

Not surprisingly, this news release generated a considerable degree of coverage. That coverage was not without its negative impacts.

THE PARENTS

Unfortunately no thought had been given to the families of the 12 children who had died in 1994. With few exceptions, they heard about the shutdown through the media. The news shocked and distressed them. For a number of families, the news was also disturbing because they had yet to receive what were, by then, long-promised autopsy reports. It was, in fact, only at this point that the Terziskis were informed that no autopsy had been performed on their son.

Not surprisingly, the families began phoning the Heart Centre and the media. For its part, the HSC realized that a response was necessary. Lois Hawkins and Cathryn Martens, co-ordinator of the Patient Representative Office, began contacting families, although in many cases the families had already contacted them. The families were offered the opportunity to meet with HSC staff.

From the evidence, it appears that the families of Gary Caribou, Jessica Ulimaumi and Erin Petkau were never directly contacted. Hawkins testified that she spoke about the events with representatives of a family

services agency in Lynn Lake that was providing service to the Caribou family. Hawkins said that she was given to understand that the family was “all right.” (Evidence, page 12,226). In her testimony, Charlotte Caribou said that she only learned about the shutdown by reading about it. She also testified that her common-law husband had made an unsuccessful attempt to reach Odium by telephone. Hawkins testified that she communicated with northern medical officials, who told her that the Ulimi family did not wish any further involvement with the hospital. That information was confirmed by Christina Kopynsky, Q.C., Counsel for the Inquest, who travelled to Inuvik to meet with the family. Barbara Petkau testified that she was not contacted by the HSC.

Contact was also made with the Stills, who chose not to come to Winnipeg for a meeting. The Bichels, Pillers and Terziskis also chose not to attend a meeting.

Meetings were held with the families of Vinay Goyal, Aric Baumann, Marietess Tena Capili, Ashton Feakes and Jesse Maguire. The meetings were attended by family members (and, in some cases, friends), Odium, Hawkins, Martyn and—depending on who had been involved with the case—either Ward or Giddins. At the meetings, the doctors would review the medical issues and the family members would ask questions. From the evidence that was presented, these meetings varied considerably in tone and nature. Laurie Maguire, the Tena and Capili families and the Feakes were not satisfied with their meetings. The Tena and Capili families described the meetings as ‘a run-around’, while others were frustrated that no one at the meeting was able to explain why the program had been shut down. Indeed, several testified that Odium and Giddins essentially told the families that they had no explanation as to why the program was being shut down.

It is clear that the program’s history and the summer shutdown were not properly explained to the families; nor were they shown the Williams and Roy report, let alone advised of its existence. Finally, even when there were known facts that should have been brought to a family’s attention, such as the suture narrowing that had been identified in Marietess Tena Capili’s autopsy, this information was also not shared with the family.

There were also expressions of support for the program. Dr. J. Bergman, the pediatric chief resident, wrote Odium a letter of support on behalf of all the pediatric residents at Children’s Hospital. Dr. Denis Hosking, the section head of Urology, also wrote Odium a letter of support.

Giddins received a letter of support from the Manitoba Pediatric Society on February 23. On March 7, 1995, Odium distributed an open letter to his colleagues. Along with it was an eight-page statistical summary of the program. In his letter, Odium wrote:

This information is in the public domain. It has been presented at our open year-end mortality and morbidity rounds. In addition, both the executive branch as well as concerned department heads have had copies of this information over the last two months.

As a matter of professional courtesy, you deserve to have an account of the program’s activity during this period. The on-going media attention is affecting all of us at HSC. I am sharing the facts with you to clarify the rumours and distortion of the press. (Exhibit 20, Document 311)

In his testimony Thorfinnson testified that he was surprised by Odium’s behaviour but took no action in response to his release of this documentation.

Letters of support were also sent to Odim from families whose children he had operated upon. In addition families whose children would now have to leave the province also raised their concerns.

THE QUALITY ASSURANCE COMMITTEE

The events in the Pediatric Cardiac Surgery program in 1994 were never discussed or reviewed by the HSC's Quality Assurance Committee, which is a committee of the HSC's Board of Directors. Thorfinnson testified that this was because the matter was not brought to the Committee's attention. He indicated that he believed that it should have been brought to the Committee. However, he also stated that he believed the Committee would have allowed the Department Heads to deal with the issue.

DELAYS IN THE AUTOPSY REPORTS

Autopsies were conducted on nine of the 12 children who died in 1994. In the cases of Gary Caribou and Vinay Goyal, the families requested that there be no autopsy. In the case of Daniel Terziski, a miscommunication led to a situation where an autopsy that should have been performed was not performed.

In the nine cases where autopsies were carried out, the autopsy itself was performed within a short period of time (generally within 48 hours), but there were extremely long delays between the autopsy and the completion of the autopsy report. The Baumann family had to wait over five months, while several other families had to wait over four months for the reports to be completed. In the Still and Piller cases the reports were completed quickly. However, it is also apparent that other autopsy reports were completed only because of the pressure that mounted following the closure of the program in February 1995.

It appears from the evidence that five autopsy reports were completed in February 1995, within a ten-day period following the closing of the program. If the program closure had not generated intense demand from the parents for these reports, then it would appear to be reasonable to assume there might have been further delays in completing those reports.

Dr. Susan Phillips, the Chief Pediatric Pathologist at the HSC, testified that during 1994 she believed pediatric pathology to have been understaffed. She pointed to efforts that she had made to have a third pathologist appointed to assist her and Dr. Joseph de Nanassy. However that position was not filled.

In 1994 Phillips and de Nanassy did 197 autopsies. They also examined 2,271 pediatric surgical specimens. These are specimens removed from living children, usually during operations. In general, the specimens must be examined and reported on within 24–48 hours.

The *Fatality Inquiries Act* states that, where an autopsy has been ordered by the Chief Medical Examiner, an autopsy report must be submitted to the Chief Medical Examiner's Office within 30 days of the autopsy. There is no deadline if an autopsy is not ordered by the CME. Phillips testified that she understood that requirement to mean within 30 days of the completion of all tests, not 30 days after conducting the initial autopsy. She pointed out that many tests results do not come back until well after the 30-day period. She stated that it was her goal to have the autopsy reports to the CME within three months of conducting the initial autopsy. Using that as a standard, the HSC met this deadline in six of nine cases.

However, the Act itself is clear: a report is to be submitted within 30 days of the autopsy. It is also clear that this report must be comprehensive enough to allow the CME to make the crucial decision as to whether to proceed with further investigation or even to order an inquest.

One of the factors that seems to have contributed to the ongoing disputes that existed within the program was the lack of specific information about, or disagreements over, what had occurred. The pathologist's report is one tool that can be used to help resolve such disputes and questions. Unfortunately, the delay in the autopsy reports meant that decision-makers lacked access to valuable information. The narrowing of the cannula sites in the Tena Capili case should have been made known by October before the operations on Erica Bichel, Ashton Feakes, Jesse Maguire, and Erin Petkau were undertaken.

In his testimony to the Inquest, Markesteyn indicated that his office was not able to enforce speedier completion of autopsy reports.

THE COLLEGE OF PHYSICIANS AND SURGEONS

As noted in Chapter Four, the College of Physicians and Surgeons of Manitoba (CPSM) created standards committees at all Manitoba Hospitals. In 1994 the Children's Hospital Standards Committee reported to both the HSC Centre-Wide Committee and the CPSM's Paediatric Death Review Committee. A panel of three surgeons reviewed surgical deaths in Children's Hospital and sent a report to the Children's Hospital Standards Committee. That panel did not make its report until the final autopsy on the child had been completed (in those cases where there was an autopsy). Once that report was prepared, Dr. Nathan Wiseman, a member of both the Standards Committee and the panel of three pediatric surgeons who reviewed cases, presented the report to the Standards Committee. The two other members of that panel were Odim and Dr. Postuma. Wiseman was asked if there was not a conflict of interest in Odim reviewing his own cases. He said in response.

It's difficult. This is the problem, there is no peer who is in a position of being able to be an expert in this area. We dealt with this for X number of years with Kim Duncan, where we sat down and reviewed cases with him; and it's dealt with basically by sort of challenging and asking questions and attempting to get objective answers, and trying to be satisfied that those answers are reasonable and appropriate.

There is definitely, I mean, if it gets down to the nitty-gritty, there is a phenomenon of mea culpa. People are very willing, maybe not always, but very willing to say, look, I screwed up. You have to recognize your own failings and put them on the table, and it happens.

...

THE COURT: You don't have a policy then of excluding from the committee a member whose cases are actually being under the review?

THE WITNESS: At the level of our sort of standards fact gathering to present to the hospital committee, no. At the level of the hospital committee, then there is no participation from the individual. The second level of review is—

THE COURT: That's Dr. Tenenbein's committee?

THE WITNESS: Yes. (Evidence, pages 40,748–40,749)

The fact that Odim was a member of the panel of surgeons that reviewed each surgical death for the Children's Hospital Standards Committee had the potential for a serious conflict of interest when the death involved one of Odim's patients. His involvement was called for because he was the only pediatric cardiac surgeon in Manitoba. A specialist in the field could have been brought in to assess the cases, thereby eliminating any potential conflict. That was not done in 1994, and the results of that process remain tainted by that fact.

The Children's Hospital Standards Committee would discuss the case and a report would be forwarded to the the CPSM's Paediatric Death Review Committee. There the case would once more be summarized and reviewed by the committee. Dr. Milton Tenenbein, the chair of the Children's Hospital Standards Committee, was also a member of the Paediatric Death Review Committee, as were Wiseman and Phillips.

All 12 deaths under consideration by this Inquest were reviewed in this manner. Those reviews did not take place in a timely manner. That was a matter of some concern to members of the section of pediatric anaesthesia. In October 1994 the pediatric anaesthetists wrote to both the panel of three surgeons and the Children's Hospital Standards Committee, urging them to expedite their review of the cases. Their concern persisted. On February 20, 1995, Dr. Carol Bachman, an anaesthetist, wrote a letter to Tenenbein on behalf of the pediatric anaesthetists, stating:

It is our hope that all children who had cardiac surgery and who died in the perioperative period be reviewed by the Standards Committee as soon as possible.

I realize that it is not uncommon for several months to elapse between a death and its review by the Standards Committee. Also, a separate review process had been instituted in the summer of 1994 for these specific cases, which may have delayed final review and recommendations, by the Standards Committee. (Exhibit 20, Document 295)

While it is not possible to determine from the evidence when the Children's Hospital Standards Committee reviewed each of the 12 deaths, it is clear that most of the reviews did not take place until after the program had been closed down in 1995. In his testimony, Wiseman testified that by January 1995 the surgical panel would have reviewed only those deaths that occurred before July 1994. According to a letter sent from the College of Physicians and Surgeons of Manitoba's counsel to this Inquest, by the date of the program closure the College had not assembled any data that would enable it to evaluate the program and/or form opinions about any trends (Exhibit 20, Document 360).

This suggests that, if the Children's Hospital Standards Committee had reviewed any of the 12 cases by February 14, 1995, it had not forwarded them to the Paediatric Death Review Committee. In his testimony, Tenenbein said that the committee attempted to deal with cases within six months during 1994. However he acknowledged that the process of review of the Paediatric Death Review Committee could be slow. In fact, he said (in response to a question about the length of time that the committee took to prepare its report), getting it out within two years of the year under review was considered a significant accomplishment.

In light of the public debate that followed the February 14, 1995, announcement, the Children's Hospital Standards Committee introduced new timelines. On March 14, 1995, Tenenbein wrote to Dr F.W. Orr, the head of Pathology for the HSC. The letter stated that the Standards Committee wanted provisional autopsy reports in 72 hours (unless it was a complex case when the deadline would be two weeks) and final reports in three months. If there were outstanding toxicology reports, the autopsy should be released with

the caveat that the toxicology reports could change the final report. Orr agreed to the proposal. (Exhibit 322)

The Paediatric Death Review Committee issued an annual report for 1994 in January 1997. The report commented on all 12 deaths under review by this Inquest. The report concluded,

Of the 12 cases, the committee classified four as being possibly preventable with improved medical management. (Exhibit 156)

While they were not named in the report, the cases were summarized. It is apparent from the summaries that the committee was referring to the cases of Jessica Ulimaumi, Vinay Goyal, Marietess Tena Capili and Jesse Maguire. The report concluded that:

There is a lengthy delay in information reaching the College through the normal Standards route. There is a need for a timely, accountable, concurrent audit process at the hospital level whenever complex multidisciplinary programs of this nature are undertaken in children. Educational action at this point has consisted of letters to the physicians involved. (Exhibit 156)

THE OFFICE OF THE CHIEF MEDICAL EXAMINER

As noted earlier, the death of any child must be reported to the Office of the Chief Medical Examiner. That was done promptly in each of the cases under examination. In each of the cases, a Medical Examiner Investigator made a timely visit to the HSC to look at the chart and to meet with Odium. The investigators differed from case to case, so that the same investigator was not involved in every case. That fact may have contributed to a slowness in the response of the CME's Office to the issues that were apparent from the cases. Apparently no trend in the deaths was noted, and information relating to the program itself and the changes that had occurred within it (including the arrival of a new surgeon) was not obtained. The fact that the anesthesiologists had withdrawn their services in May due to concerns over poor results, that there was dissension within the program, and that there had been a slowdown in the types of procedures the program was doing, had not been communicated to the CME's Office.

It is the policy of the CME's Office to authorize an autopsy when a child dies during or immediately after surgery. Parents are normally told of this policy. In the cases under discussion, the surgeon also requested the parent's permission to hold an autopsy. In the case of two children, Gary Caribou and Vinay Goyal, the families requested that there be no autopsy. Based on the Medical Examiner Investigator's report that there were no apparent issues with those cases, the Chief Medical Examiner chose to honour the family's request.

In the case of Daniel Terziski, no autopsy was held, despite the fact that the parents were amenable to an autopsy and the fact that both Odium and the Chief Medical Examiner's office believed that one should have been conducted. As discussed earlier, it appears that an autopsy was not held because of a failure of communication.

In eight of the twelve cases, the Medical Examiner Investigator concluded that there was no need for further investigation. In four cases, however, further investigation was authorized: those of Jessica Ulimaumi, Erica Bichel, Jesse Maguire and Erin Petkau. In the case of Jessica Ulimaumi, it was concluded that her death

was the result of ‘therapeutic misadventure’ and the matter was referred to the Children’s Inquest Review Committee, a multidisciplinary committee convened by the Chief Medical Examiner. The committee reviewed the matter and, aside from referring the file to the Paediatric Death Review Committee, took no other action. It should be noted that CME investigations usually take place following the completion of an autopsy. Aside from the Bichel case, the only other CME-ordered autopsy completed before the program was closed was that of Jessica Ulimaumi.

Upon reviewing the autopsy in the Bichel case, the Chief Medical Examiner did not refer the case to the Children’s Inquest Review Committee. Markesteyn concluded that the circumstances of the death in that case did not warrant the holding of an inquest.

Throughout 1994 the Chief Medical Examiner was not aware of the events taking place in the Pediatric Cardiac Surgery Program. In addition, the Chief Medical Examiner’s office was not made aware of the shutdown in December 1994. The Chief Medical Examiner was not informed of the review conducted by Drs. Williams and Roy, nor of its results. The Chief Medical Examiner’s office was not consulted about the findings of the review; nor was the Chief Medical Examiner involved in the decision to suspend the program for a further period of six months.

Markesteyn testified that he became aware of the events in the program only when he read about them in the newspaper in February 1995. He then undertook further investigations and wrote to the HSC, asking for all documentation on the cases. The CME’s office contacted the parents to inform them of the investigation. He contracted Dr. Walter Duncan to undertake a review of the deaths on his behalf. After receiving Duncan’s report, Markesteyn consulted with members of the Children’s Inquest Review Committee and decided that it would be appropriate to establish an inquest into the 12 deaths.