TRANSCRIPTION
Audio time: 0:06:49
Marthas legacy lives on.mp4

[00:00:07] In September of 2002, our daughter, Martha, died. She went to bed and in the morning, when her father went to wake her up, she was dead.

[00:00:18] Martha was our eldest child. She was quite an achiever. She was highly intelligent and probably the most passionate and compassionate person I've ever known. She used to spend so much time with her youngest sister. The two of them were nine years apart, so it was like the fun mum. She had had illnesses through her teens and had decided that she wanted to help people who were ill. So she was studying nursing so that she could follow that dream.

[00:00:52] And we waited for the autopsy reports, the toxicology reports; we waited to find out what had happened to our daughter. People don't just go to bed and not wake up the next day. The autopsy came back with no visible sign of death. The toxicology came back. No alcohol, no illegal drugs. So they classified her death as natural and closed the file. For our family, that wasn't enough. We said, “We really have to know more. We want to know what's gone on.”

[00:01:24] So at that point, we set out. We got political involvement. We got media coverage. We put a lot of pressure on to have an inquest to find out what had gone wrong, so that we could prevent it from happening again.

[00:01:42] Well, Martha had a couple of medical conditions. Martha did everything she could to get better, and she was within the health care system trying to get well. And a series of mistakes kept happening that ultimately cost her her life. She had a bit of a potassium deficiency, and she also had been diagnosed with bipolar disorder, so she had mood swings. And in the summer of 2002, she was put on lithium. Martha had some issues with low potassium, so there was a recommendation in her file that she shouldn't be prescribed lithium. The report that said that Martha shouldn't be given lithium was written by a psychiatrist because they're the ones that treat bipolar disorder. But the next psychiatrist that took over when this psychiatrist left the practice decided that he didn't think the risk was that great, and he didn't discuss the risk with Martha; he just told her that she should try lithium and that it often had a positive effect on people. So there's no obligation on one doctor's part to follow the recommendations of another doctor.

[00:02:56] She also had a lot of rapid heartbeat incidents that she'd had checked out and some EKGs done and things, and she was told that it was just anxiety. I went to her billing records, and I located all the EKGs I could find and I sent them to the coroner's office. In the end, they

looked at 17 of her EKGs, all with the same abnormality, and they concluded that she had a congenital heart defect. The CPS manual on lithium advises that anyone with a cardiac abnormality should not be given lithium, that it's a contraindicated drug, that it can cause arrhythmias and it can cause fatal arrhythmias. One of the recommendations by the Pediatric Death Review Committee was that every pediatric patient should be given a cardio checkup before they're ever put on any psychotropic drugs.

[00:04:00] We found that she had been to a cardiologist. He had ordered further tests just the year prior to her death. The abnormal results had come in, but he'd never notified her. He'd never let her know that there was anything wrong with her heart. Their practice was to order tests, to wait until the patient came back, and then to read the results when the patient was there. So because Martha had not gone back, she thought no news was good news.

[00:04:33] Now in Ontario, the coroner's office reports adverse drug reactions to Health Canada. After Martha's death, that was part of what we asked them to do. But I think before that, for over 40 years, Health Canada had been asking people to report adverse drug reactions. And the coroner's office, who only deals in fatalities, the worst drug reactions possible, hadn't done the reporting. It's just unacceptable if a young person like Martha loses her life and the same thing keeps happening over and over again to other people because we're not reporting, because we're not identifying, because we're spending time and resources trying to cover these things up instead of fixing them.

[00:05:16] I think certainly at the time of Martha's death and afterwards there was quite a culture of denial and cover up. It was never about apology. To us, it's always been about changing things, to creating improvements. People have given their lives or they've suffered, and the least we can do for them is to report what happened and allow the analysis to occur so that we can prevent it from happening again.

[00:05:45] My daughter wasn't able to get married and have children and have the normal legacy that we all have. Nobody wanted a 22-year-old to die. No one intended to cause any harm. But when the harm occurred, the system didn't do its job to examine what went wrong and to figure out ways of prevention. It's like there was a big hole in a public park and my child fell in that hole and died. Every parent would do all they could to see that that hole was filled in, that no other child died from that hole.

[00:06:24] Everything that happened to Martha can, and I'm sure does, happen to other people. Maybe not in the same sequence, the same events, but it's happening to other people every

day. And so we have to take these horrific incidents and learn all we can to help prevent it from happening to others and improve things.

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