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Dr. James G. Young
Chief Coroner for Ontario
26 Grenville St.
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BY FAX

Re: Sanchia Bulgin inquest

Dear Dr. Young,

I have reviewed the list of expert witnesses who will be testifying at the Bulgin inquest, and would like to propose that the coroner's office consider adding one more expert to the list.

A common element in both Lisa's and Sanchia's deaths was the failure of nurses to recognize abnormal vital signs and take appropriate action. One of Lisa's two nurses was a newly hired recent graduate. In the Hospital for Sick Children's October 20, 2000 internal review report investigating the death of Sanchia Bulgin, one of its recommendations was to provide better support and education for novice nurses. From this I infer that Sanchia's nurses were mainly inexperienced recent graduates.

The hospital recommendation continues with "Basic skills in physical assessment and interpretation of vital signs must be the foundation of all nursing orientation and ongoing education programs within the hospital..." Nurse Sharon Deutsh's report, item 4 of the section entitled Other Comments and Recommendations, concludes that "The hospital's orientation and ongoing education programs may need to be reassessed, but the hospital should not have to teach its nurses the skills that are universally taught in first year nursing school."

It would seem to be in the public interest for the inquest to explore the possible causes of the nursing failure to recognize abnormal vital signs, a problem that can have tragic consequences. There is presently disagreement between the hospital's belief that the

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nursing problem is the result of inadequate hospital orientation and education, and Ms. Deutsh's belief that the hospital has hired nurses whose nursing skills appear to be virtually non-existent rather than in need of more education. My suggestion, therefore, would be for the coroner's office to call a nursing professor from one of the local nursing schools as a witness. This person could discuss in general terms how and when the standard nursing curriculum covers such things as patient monitoring and assessment. She could also talk about the skills that a newly graduated nurse is expected to possess and the areas where a new nurse might need further education and training. Moreover, when testimony about nursing education is heard in conjunction with testimony about patient care provided by novice nurses and hospital education and training efforts, the inquest jury may be able to make valuable recommendations relating to nursing education and training that will have applicability throughout the province.

On a separate note, you requested at the pre-inquest meeting that all documents relating to standing requests should be submitted to the coroner's office in advance of the standing hearing. I am therefore enclosing a chart I drew up regarding the Lisa Shore inquest jury recommendations in further support of my request for standing. The chart shows which recommendations were initiated by the jury, the Crown, counsel for the hospital (which included the nurses), counsel for the doctors, counsel for GE Marquette, and the Shore family. The purpose of this chart is to bolster my argument that if given standing I can contribute to this inquest in a meaningful way.

Lastly, I have requested from the various parties seeking standing that they copy me on any written submissions they make to the coroner's office relating to my request for standing. In case they forget to do so, could the coroner's office please fax copies of any such documents it may receive to me.

Yours truly,

Sharon Shore

cc: A. O'Marra
Counsel to the Chief Coroner

INQUEST RECOMMENDATIONS AT THE SHORE INQUEST:

Rec. no.	Recommendation category:	Recommendations initiated by:					
		HSC (incl. nurses)	CMPA	Crown	Monitor mfg'er	Shore Family	Jury
1	Manufacturer and hospital					X	
2	Hospital-re: Kidcom					X	
3	Hospital-re: Kidcom					X	
4	Hospital-re: Kidcom					X	
5	Hospital-re: Kidcom						X
6	Hospital-re: Kidcom						X
7	Hospital-re: Kidcom						X
8	Hospital-re: Kidcom						X
9	Hospital-re: Education					X	
10	Hospital-re: Education						X
11	Hospital-re: Education					X	
12	Hospital-re: Monitoring						X
13	Hospital-re: Monitoring					X	
14	Hospital-re: Monitoring						X
15	Hospital-re: Charting					X	
16	Hospital-re: Charting				X*	X*	X*
17	Hospital-re: Charting						X
18	Hospital-re: Monitors						X
19	Hospital-re: Monitors						X
20	Hospital-re: Paging/Communication						X
21	Hospital-re: Paging/Communication						X
22	Hospital-re: Paging/Communication						X
23	Hospital-re: "Clinical Judgement"						X
24	Hospital-re: Staffing						X
25	Hospital-re: Staffing						X
26	Hospital-re: Staffing						X
27	Hospital-re: Coroner's Case						X
28	Hospital-re: Coroner's Case					X*	X*
29	Hospital-re: Coroner's Case					X	
30	Hospital/Coroner's Office-re: Coroner's Case					X	
31	Coroner's Office-re: Pediatric Review Committee						X
32	Coroner's Office-re: Coroner's Case					X	
33	Coroner's Office-re: Coroner's Case						X
34	Office of the Chief Coroner						X
35	Office of the Chief Coroner						X
Total initiated by:		0	0	0	1	13	24

* Variations of recommendations initiated by more than one party