

October 22, 1998

SHORE, Lisa
HSC#: 1631889
DOB: 20/11/87

REPORT: Dr. Markus Schily, Pain Fellow on call from October 21 - 22, 1998,
Department of Anaesthesia /Hospital For Children, Toronto

This report is only for the use of the CMPA or my personal lawyers.

About my person: I am a fellow in the Department of Anesthesia, HSC, Toronto, since July 1998. I was working until June 1998 as senior anesthetist in the Soroka Medical Center, Be'er-Sheva, Israel. I graduated in 1987 from Albert-Ludwig-University of Freiburg, Western Germany.

I was contacted at about 21:30-21:50 from the Emergency Room (Triage) for pain treatment for Lisa Shore.

The department knew about the possibility that Lisa could contact us this night for pain service - Lori, our pain nurse, had received the same day (21.10.1998) a phonecall from family Shore about increasing pains of Lisa Shore.

After consulting my staff and after having finished O.R. I went to the Emergency Room. The patient, Lisa, an 11 year old girl, was in room #5. She was known of suffering of chronic strong pain, and had been treated in our hospital and in Boston for post traumatic pain in her right leg. I found her moaning and complaining about 'stabbing pain' which was constant existing, keeping her from resting and sleeping. Parents request were a pain treatment. After consulting the staff of O.R., Dr. E. McLeod, we decided to start PCA overnight after titrating Morphine in the Emergency Room and lowering her reported pain level (close to 10) to about a pain level of 5. I ordered Morphine. I.V. in boluses of 2 mg for titrating in the emergency room before proceeding with the PCA-device.

Asking mom about the success of pain treatment she told me that Lisa is on Amitriptyline and Gabapentin - both were not helping to release her daughters pain, and mom reported that under this medication her daughter experienced increasing terrible pain and didn't sleep at night. She gave her daughter her medication by her own at about 23:00 - I said that I would prefer that changes in

the chronic medications would be done the following day by our chronic pain team. Lisa's mom didn't report any side effects of Lisa's pain treatment. I informed and discussed with Dr. McLeod (who was with me in the emergency room) that Lisa's mother gave her her normal medication and I discussed with Dr. McLeod my plan and the settings (dosages, lockouts and total dose limit) of the overnight PCA which would be started after giving Lisa pain killers in the Emergency Room. I asked Dr. McLeod if she wants me to discuss therapy and the problems with the Pain-staff on call, but she thought that right now is no need for involving another staff.

Dr. McLeod and I stayed during the initial treatment in the Emergency Room, and I helped the nurse (Pauline) to get the PCA pump, keys and PC line (the usual non-reflux-valve PCA-line was used). The PCA settings were: Morphine 1 mg in 1 cc volume (50 mg/50 cc). Bolus: 1.5 mg; lockout: 6 minutes; no background infusion; total-dose limit: 20 mg in 2 hours. About 3-4 ml of the 50 ml syringe were at least lost when the line of the PCA device was flushed, before we attached the PCA to the i.v. line. I discussed in detail the use and the dangers of the PCA device, mentioning that misuse may cause death. Both parents and the child as well heard the explanations.

I ordered saturation monitoring, apnea and vital signs monitoring, sedation - score-check up, emergency equipment and gave exact orders when to call me or call Anaesthesia O. R. desk.

The PCA was started in the Emergency Room - I don't recall the exact times, but I remember that some time after Lisa started the PCA I walked up to the O.R. to get dressed, and returned after that to Emergency Room for reassessing Lisa. This was at about 00:30 (I recall that I came home at about 01:00). I found Lisa awake, sitting in her bed, complaining still about strong pains in her leg which didn't really improve. She didn't want to sleep. (mother was skeptic about the effect of Morphine - she said that her daughter had been on Morphine in the past, and it didn't really help her). Before I left I asked again Pauline (emergency room nurse), not to DC Lisa from Emergency until she has a pain score of 5 and to check her vital signs and to follow vitals up for a certain time before discharging her to the ward. Back at home I was called from Emergency (about 01:30) and Pauline reported that Lisa is still complaining of strong pain (pain scores 7 and higher) and I asked her to send her despite the pain to ward 5A. The last reported Morphine Lisa received before 01:45.

At about 04:00 I was phoned from 5A. The nurse reported that Lisa's respiratory rate was just above 10 per minute. The nurse reported that all vital signs are good that Lisa is arousable, and when I asked if she needs me to come to 5A to assess Lisa the nurse said that there is no need for coming. (Our on-calls are not in hospital calls. We are supposed to work next day in OR and therefore supervise pain service during night from home) Again I reminded the nurse to look up saturation, and carefully check after sedation, respiration and all the other vital signs. I informed her that any further deterioration, especially problems with saturation, or sedation and respiration should be reported immediately to me. I asked the nurse to make sure that the PCA is off and to remove it from patient's bed (it was stopped before that, as the nurse said), and follow up vital signs, check the

saturation and respiratory rate and inform me if any further deterioration or need for reassessing of Lisa would be. I received no further calls during this night. I was in the hospital at 07:00, and prepared the O.R. as usual. At about 08:50 I received a call from 5A and was told that Lisa was found dead at morning rounds.

The resident who was called to help in the CPR told me that the whole dose of Morphine which Lisa received was 11mg (including the Morphine in the emergency room, boluses and PCA).

As well he told that the monitors weren't attached properly - no alarms went off when the orthopedic team entered the room, realizing first that Lisa was dead by noticing that she was 'pale'.

Lisa didn't receive any Morphine medications from the PCA device since 01:45 a.m., reported the resident who checked after the CPR the history of the PCA machine (this sort of PCA computer is locked with a key, and the history and settings are stored and cannot be erased without a key so far as I know).

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