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March 17, 1999

Dr. James G. Young
Chief Coroner for Ontario
26 Grenville St., 18th floor
Toronto, Ont.
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Re: Lisa Shore, your file no. R 12799/98

Dear Dr. Young,

The Hospital for Sick Children has chosen to provide me with a copy of its response to the twenty-four questions posed by my family regarding Lisa's death (as set out in Mr. Gomberg's letter of Dec. 11, 1998 to your colleague Regional Coroner Lucas).

I have had an opportunity to thoroughly review this material. I have several additional questions which emerge from our review of the answers to the original twenty-four questions. I feel that these additional questions are relevant and should be addressed by your office and considered by the Paediatric Review Committee and at an inquest. (*Note: quotes from the hospital document are in italics*):

- 1) Item number 7, "*A Corometric monitor...was working properly up to and until the 6:00 check... Why did the alarm not sound when Lisa's heart stopped? We don't know the answer*", and item number 8 "*The Corometric monitor was not sequestered following Lisa's death*".

If the monitor was not working when Lisa's heart stopped, for reasons unknown, did the hospital immediately conduct an investigation into all of its other monitors to see if they might be similarly defective? If not, did the hospital send this particular monitor for repair (and if so, what was wrong with it)? If not, did the hospital re-use a potentially defective monitor on another child?

- 2) The hospital states in item number 5 that "*The protocol includes apnea and heart rate monitoring ... The monitoring orders were placed on the hospital computer system*"

Attached you will find three separate hospital computer records for Lisa from March 1998 showing computer system monitoring orders as per protocol. The supposedly complete records provided to me by the hospital for the period Oct. 21-22 1998 do not include any comparable orders. Can the hospital produce a copy of computer records to support the existence of monitoring orders in its Kidcom computer system?

- 3) Item number 6, *"The blood pressure was ...not taken for the remainder of the shift. This was possibly an attempt not to awaken Lisa once she had begun to rest."* and item number 17, *"the nurse awoke Lisa and took an oral temperature."*

If the nurse woke Lisa to take her temperature, why would she not awaken her to take her blood pressure - particularly when the pulse rate was highly elevated?

- 4) Item number 5, *"Computer orders for Lisa included oxygen saturation monitoring. This monitor was not applied... The sedation scale and pain scores... also part of the protocol were not recorded."* and *"The nurse relieving for break concurs that the Corometric was attached..."*

If the relieving nurse can recollect that a Corometric monitor was attached, then why was she not alert enough to realise that the oxygen saturation monitor that was allegedly ordered had not been applied? Why did the relieving nurse *also* neglect to follow standard protocols for documentation, monitoring, sedation and pain scores?

- 5) Item numbers 1 and 2, *"The nurse set the alarms at 50-60 bpm for the low heart rate and 160-180 bpm for the high heart rate as appropriate to Lisa's age"*, and item number 13, *"In a child of Lisa's age, the low heart rate will generally be set about 50-60 beats per minute and high heart rate at 160-180 beats per minute"*.

Assuming that a monitor was present and applied, the nurse states that the low heart rate alarm was set at 50-60 beats per minute. Shouldn't the upper alarm level have been set so that the sleeping rate on entry to the ward (72bpm) reflected the mid-range value? Why would the lower alarm be set at 12-22 beats less than actual but the upper at 88-108 beats more than actual, well over double the actual rate? Can the hospital provide any protocols or guidelines for monitor settings? I have asked a paediatric nurse with many years of experience what monitor settings she would use for a child of Lisa's age, and her setting for the upper alarm was very significantly lower than 160-180 beats per minute.

I hope that the questions above will be included as part of your ongoing investigation into my daughter's death. If you feel that the points made are worthwhile and would like to discuss these or any other aspect thereof, I would be glad to contribute in any way that I possibly can.

Yours truly,



Sharon Shore

cc: Dr. James Cairns
Dr. William Lucas
Dr. Morton Reingold
Mr. Frank Gomberg

Deputy Chief Coroner for Ontario
Regional Coroner for Toronto
Investigating Coroner
Teplitsky, Colson