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Ms Anne Coghlan
Executive Director
College of Nurses of Ontario
101 Davenport Road
Toronto ON
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Dear Ms. Coghlan,

This is to advise the College that I am revising my complaint against **Mary Douglas**, a registered nurse employed as a nursing-educator at the Hospital for Sick Children.

The original complaint made reference to testimony given by Douglas at the coroner's inquest investigating my daughter's death. I have been advised that under Section 42 of the Coroner's Act, the testimony of a witness cannot be used as a basis for disciplinary proceedings.

Douglas lied in her inquest testimony in an attempt to convince the jury that the negligent nursing care Lisa received from Ruth Doerksen and Anagaile Soriano did not fall below accepted standards. Her behaviour was unethical, dishonourable, and a disgrace to the profession of nursing. It is sad that the College is unable to do anything about it, and reprehensible that the Hospital for Sick Children condoned or possibly even encouraged her false testimony.

Nevertheless, I am restating the complaint to exclude the testimony that Douglas gave in Coroner's court. Other available documentation is more than sufficient to substantiate my complaint.

The specific complaints are as follows:

- 1) At the time of Lisa Shore's death on ward 5A, Mary Douglas was the nursing-educator for the ward. As such, it was her responsibility to ensure that the nursing care provided by the 5A nurses met acceptable standards. Douglas had a responsibility to perform the following actions and failed to do so:
 - a) She had a duty to review the nursing care given to Lisa Shore by nurses Ruth Doerksen and Anagaile Soriano (the subjects of separate complaints), for having

provided grossly substandard care. As Lisa's death was both unexpected and unexplained, it was incumbent on Douglas as the responsible nurse-educator to examine the nursing care provided, in order to determine whether that care may have been a factor in Lisa's mysterious death. This examination should have included a review of the nursing flowchart, the nursing notes and their adequacy and completeness, and the degree of compliance with doctor's orders. She did not do such a review.

If competent as a nursing-educator, Douglas would have seen that the care provided to Lisa Shore by Ruth Doerksen and Anagaile Soriano was grossly substandard, as follows:

- i. doctor's orders were not read or followed
- ii. standard PCA morphine protocols, which the nurses were expected to be familiar with, were not followed
- iii. the nurses failed to take mandatory, standard vital signs
- iv. the nurses failed to take appropriate vital signs such as blood pressure when respiratory depression occurred
- v. the nurses failed to take appropriate vital signs such as blood pressure when tachycardia occurred
- vi. the nurses failed to notice that the vital signs that were taken were abnormal and indicative of medical distress requiring immediate medical intervention and care
- vii. a physician was not notified in a timely manner as orders and protocol required
- viii. a physician was not notified when the patient was clearly in distress
- ix. the nursing documentation was clearly inadequate both in quality and quantity

Douglas's failure to make the determination that the care was grossly substandard, or in the opposite, her conviction that the care provided did meet acceptable standards, is demonstrable proof of her gross incompetence as a nursing-educator.

- b) Douglas had a duty, if she had competently fulfilled her responsibilities as nursing-educator and found that the care provided by Ruth Doerksen and Anagaile Soriano was grossly substandard as itemized above, to
 - i. report this substandard care, verbally and in writing, to her superiors including Dr. Jean Reeder, Chief of Nursing
 - ii. ensure that an evaluation or report noting Doerksen and Soriano's substandard care was placed in the nurses' respective personnel records
 - iii. ensure that immediate steps were taken to remove nurses Doerksen and Soriano from active duty, given that their actions had killed one child and

were sufficiently below the standard of care to endanger the lives of other patients

By failing to perform any of these duties, she demonstrated marked incompetence as a nursing-educator, she showed blatant disregard for the safety of other patients at the hospital, and she protected these two nurses from facing the legal or professional consequences of their negligent care.

- 2) Douglas failed to notify the College of Nurses of Ontario of the grossly substandard and/or negligent care provided by Ruth Doerksen and Anagaile Soriano to Lisa Shore, which as a nursing-educator she was ethically and morally bound to do.
- 3) Hospital professionals, particularly nursing-educators with many years of nursing experience, know that in a coroner's case, nothing in the deceased patient's room is to be touched, in order that the coroner can conduct a thorough and untainted investigation. Notwithstanding this, Douglas entered Lisa's room after the arrest code was completed, went to the corometric monitor that was in the room, unscrewed the underside with a tool to open it, read the settings, closed it and then left the room, in violation of the Coroners Act and contrary to acceptable nursing practice. Moreover, she did not segregate the monitor, also in violation of the Coroners Act and contrary to acceptable nursing practice.
- 4) By failing to advise anyone that there were potential problems with a monitor, thereby allowing it to be put back into general circulation to be used on another child, Douglas
 - a) showed disregard for the welfare and safety of other patients,
 - b) demonstrated incompetence, and
 - c) failed to maintain - or deliberately disregarded - basic nursing standards.
- 5) Douglas engaged in disgraceful, dishonest, unethical, and probably illegal behaviour in conspiring with Ruth Doerksen to cover up Ruth Doerksen's negligent nursing care and deceitful actions with respect to the false story about the use of a corometric monitor.
- 6) Douglas displayed incompetence as a nurse, nurse-educator, and Clinical Instructor by stating that the corometric monitor's upper heart-rate alarm setting of 160-180 beats per minute was appropriate for a child of Lisa's age.
- 7) Douglas was seen by inquest jurors to be coaching nurse Ruth Doerksen during Doerksen's testimony, by way of hand signals and body language. This signalling

was apparent both to jury members (who complained about it) and to family/friends of the Shores. The jurors notified Deputy Chief Coroner Dr. James Cairns about this behaviour. Dr. Cairns said in open court that the jury had brought this to his attention. He cautioned the audience that such behaviour was inappropriate and should cease immediately. Section 42 of the Coroners Act prevents a witness from being accountable to her governing body for her testimony, but does not restrict my right to file a complaint about her disgraceful and dishonourable behaviour that occurred not when she was on the witness stand testifying, but rather, in the audience as a spectator.

Please contact me if you would like any additional information.

Yours very truly,

Sharon Shore
August 10, 2000

Back-up to the complaint regarding Mary Douglas

Background information

Lisa suffered from reflex sympathetic dystrophy (also known as RSD, CRPS, or complex regional pain syndrome), which developed as a result of a broken leg she had sustained eight months earlier, in February 1998. RSD is a chronic pain condition thought to result from nerve damage from a fracture, sprain, or other trauma. Its primary symptom is pain, but it is in no way life-threatening or dangerous. In every other respect Lisa was a completely healthy and active 10-year-old.

As a result of the pain she was suffering, Lisa had two admissions at Sick Kids in February and March 1998, totalling about three weeks. Approximately 1/2 of this period was spent on Ward 5A/5B, so Lisa was known to most of the staff on the ward. Ruth Doerksen, although she was working on 5A/5B at that time, did not provide direct nursing care to Lisa, but would certainly have known of her.

One of the treatments that was tried in an effort to reduce Lisa's pain was a short trial of morphine, orally and via PCA pump. This did not ameliorate her pain and was quickly discontinued. (Lisa had no further experience with opioids until October 21, 1998, several hours before she died.)

Hospital staff then diagnosed Lisa's pain as psychogenic and made no attempts at further treatment. She was subsequently diagnosed with RSD by Children's Hospital in Boston, and given medications which helped control her pain - gabapentin, amitryptiline, and carbamazepine.

In October 1998, Lisa experienced a severe flare-up of pain and was brought to the Emergency Department of the Hospital for Sick Children on the evening of October 21st. There she received 14.5mg of morphine in one and one quarter hours (via IV bolus and PCA pump), after which she fell asleep and was brought up to ward 5A.

Ward 5A (and its counterpart 5B) is a general surgery/orthopedics/ear nose & throat unit. Nurses rotate interchangeably through 5A and 5B, and may do one shift on the first ward and the next shift on the other.

The doctor who treated Lisa in Emergency, the one who administered the morphine and set up the PCA pump, entered detailed monitoring orders for her care into the computer system and put a handwritten note into the chart that said to refer to the computer orders. Lisa was admitted to ward 5A - under the care of nurse Doerksen - at approximately 01:40am. She was found vital signs absent at 07:15 the next morning by doctors on rounds.

Excluding a Constant Care Room which had a full-time attending nurse (and who was not allowed to leave it), ward 5A had nine patients including Lisa that night. Care for these nine patients was assumed by two nurses, Ruth Doerksen and Anagaile Soriano. It was a relatively quiet night with no medical emergencies (other than Lisa Shore). This is my

personal observation, as no monitor alarms went off nearby during the remainder of the night, the intercom was never used (no one calling for assistance, for keys to the locked medication storage, etc.), and I have spoken with two of the other eight patient's mothers and they both stated that it was quiet on the ward that evening. The hospital has not suggested otherwise or offered this as a reason to excuse the nurses' actions.

I am a light sleeper, and would have awakened had there been any noises in the room such as alarms, conversations, or attempts to wake up Lisa up.

Although doctor's orders called for Lisa to be put on oximetry and an apnea monitor (a Corometrics monitor, which the hospital refers to as a "corometric monitor" or simply, a "corometric"), neither of these orders were followed. There is no dispute about the lack of oximetry; the hospital admitted in its letter of March 3, 1999, that the nurses involved - Ruth Doerksen and Anagaile Soriano - did not put Lisa on oximetry at any time. Although Doerksen states that a corometric monitor was applied to Lisa on admission to the unit, I was in the room with Lisa and will swear under oath that there was no monitor attached to Lisa on admission to the unit. If a monitor was brought in later and attached, it was never turned on. Had it been turned on, a self-test alarm would have sounded, and I would have been awake instantly. I am a light sleeper, and there were no beeps, alarms, or conversation in the room. A monitor was found attached to Lisa when she was discovered vital signs absent, but the hospital has agreed that it was not on at the time Lisa died. Since Doerksen worked elsewhere or was on break from 02:00 until 04:30 or 05:00, and I was awake and saw no monitor at 02:00, the earliest time that Doerksen could have brought that monitor into Lisa's room was after 04:30. It is my belief that Doerksen (the subject of a separate complaint) brought a monitor into the room and attached it to Lisa after discovering Lisa was dead, in an attempt to mitigate the evidence of her negligence. I further believe that Doerksen was unable to turn on the monitor that she had attached, as Lisa's lack of vital signs would have caused several alarms to go off simultaneously and awakened me.

It is my belief (and incidentally, also that of the inquest jury) that Doerksen brought the corometric monitor into Lisa's room and attached it to her at approximately 07:00, after entering the room to do her 07:00 patient check and discovering she was dead. It is also my belief that because the doctors had started or were about to start on rounds, she did not have time to check the alarm settings on the monitor - which requires that the machine be turned over and opened up with a tool.

Since Doerksen did not know the settings, and would clearly be expected to know them, she discussed the problem with Douglas and sent Douglas (or Douglas volunteered to go) into Lisa's room to check what they were. The settings that she found were not appropriate for a child of Lisa's age (upper heart alarm set to go off at 160 or 180 beats per minute), but those were the settings that they "had to live with".

The hospital wrote a letter to the coroner in response to questions that we asked relating to Lisa's medical care, copy previously sent to the College. In this letter, it was noted that after the arrest, the "Clinical Instructor" (who we know to be Douglas) entered the room,

checked the settings on the monitor, and left. This instructor remembered the monitor's lower heart rate alarm setting as 50 beats per minute, and the upper heart rate alarm as 160 or 180 beats per minute.

Douglas has been employed at the hospital as a nursing-educator for the fifth floor (which included the unit Lisa was on) for the past several years, and has extensive nursing experience at the hospital and elsewhere.

Items 1 and 2

Self-explanatory, no additional information offered

Additional information on items #3-5

Hospital professionals, particularly nursing-educators with many years of nursing experience, know that in a coroner's case, nothing in the deceased patient's room is to be touched, in order that the coroner can conduct a thorough and untainted investigation. Notwithstanding this, Douglas entered Lisa's room after the arrest code was completed, went to the corometric monitor that was in the room, unscrewed the underside with a tool to open it, read the settings, closed it and then left the room, in violation of the Coroners Act and contrary to acceptable nursing practice. Moreover, she did not segregate the monitor, also in violation of the Coroners Act and contrary to acceptable nursing practice.

By failing to advise anyone that there were potential problems with a monitor, thereby allowing it to be put back into general circulation to be used on another child, Douglas:

- a) showed disregard for the welfare and safety of other patients,*
- b) demonstrated incompetence, and*
- c) failed to maintain - or deliberately disregarded - basic nursing standards.*

Douglas engaged in disgraceful, dishonest, unethical, and probably illegal behaviour in conspiring with Ruth Doerksen to cover up Ruth Doerksen's negligent nursing care and deceitful actions with respect to the false story about the use of a corometric monitor.

There is no possible reason for Douglas on her own to have gone into Lisa's room after the code was completed simply to check the settings on a corometric monitor. Although Lisa was ostensibly attached to an apnea monitor which has three separate alarms (respiratory rate, upper and lower heart rate), no monitor alarms sounded when Lisa died. Douglas either knew nothing about potential problems with the monitor, or she knew that alarms had not sounded. If she knew nothing, she would not have had any reason to go

into Lisa's room, check the settings, and leave. If she did know that no alarms had gone off, why would she then go into the room, check the monitor's settings, and leave? The low heart rate alarm cannot be turned off - which Douglas well knew - so the heart alarm should have sounded when Lisa's heart stopped regardless of the monitor's settings. Accordingly, the actual settings of the monitor were irrelevant to the concern that the alarm did not sound. A reasonable person and a competent nursing-educator would have touched nothing, and notified both the coroner and her superiors, including Dr. Jean Reeder, the chief of nursing, that there was a potential problem with this monitor. Douglas did not do that - she came in, checked the settings, and left. If she was really concerned about the monitor, why didn't she notify Biomedical Engineering to take the monitor away to test it? If she was really concerned, why didn't she turn it on to let it run through its start-up self-test, to see if it appeared to be working properly, rather than check the settings? Surely a monitor that did not work properly was a potential danger to other patients, and perhaps may have played a role in Lisa's death. Why did she not feel an urgent need to discuss this with anyone or take corrective action? Why did she not ensure that this information formed part of Lisa's permanent record?

Instead, Douglas went into Lisa's room, with Lisa lying there dead, checked the settings on the monitor (which can be done only with deliberate effort by opening its underside with a tool), and then left the room. Douglas was obviously not concerned about the monitor functioning properly and the potential harm that could befall other patients on whom it would next be used. Her exclusive concern was to see what the monitor alarm settings were.

There is only one possible reason to have checked the monitor's alarm settings - and nothing else - with the body of a child who had just been pronounced dead of no known cause lying in the room, not even cold yet. Douglas needed to determine what the monitor's settings were, because Doerksen - in her haste to get the monitor into the room after Lisa had died and before the doctors on rounds found her - did not have time to open its underside to see what the alarm settings were. Doerksen thought that the coroner would seize the monitor, as he did with the other equipment in the room. Believing that she would be questioned about the events and the monitor in great detail, she realized that her deceptions would be quickly discovered if she was unable to provide basic information such as what settings she used on the monitor. By getting Douglas to go in the room and check what the monitor's settings were, opening the monitor in a room that Douglas knew was to be left untouched until the coroner arrived, Douglas chose to help Doerksen with her lie about attaching a functioning monitor to Lisa.

Douglas showed utter disregard for the welfare and safety of other patients on Ward 5A by failing to advise anyone that there were potential problems with the monitor, thereby allowing it to be put back into general circulation to be used on another child.

She showed complete disregard for basic nursing standards, and incompetence as a nurse by failing to inform anyone that there was a potential problem with a piece of medical monitoring equipment.

Additional information on item #6

Douglas displayed incompetence as a nurse, nurse-educator, and Clinical Instructor by stating that the corometric monitor's upper heart-rate alarm setting of 160-180 beats per minute was appropriate for a child of Lisa's age.

According to Whaley and Wong's "Nursing Care for Infants and Children", the reference book used by nurses on the wards at the Hospital for Sick Children, the range for a 10-year-old's resting heart rate is 60-90 beats per minute. The letter from the Hospital for Sick Children explaining the circumstances of Lisa's death stated that the corometric monitor's upper heart-rate alarm setting of 160 -180 beats per minute was appropriate for a child of Lisa's age. This statement came from Douglas, the nursing-educator who went in to confirm the monitor settings when Lisa died, as per the hospital's letter of March 3, 1999. Given that Douglas saw alarm settings of an upper heart-rate of 160 or 180 beats per minute, as a competent nursing-educator she should have known that this setting was totally and inarguably inappropriate for a child of Lisa's age, particularly one who had a sleeping heart rate of 72 beats per minute on admission to the ward (as per the chart).

The settings Douglas saw should have dictated some action on her part. She should have notified her superiors, including Dr. Jean Reeder, that the settings were inappropriate. Her inability to recognize and report that the settings on the corometric monitor were inappropriate was either indicative of 1) her incompetence as a nursing-educator, or 2) a deliberate attempt to cover up Ruth Doerksen's substandard actions by stating, falsely, that what Doerksen had done was acceptable. The first represents a failure to meet the standards of the profession, and the second is disgraceful and dishonourable conduct. Regardless of which is correct, she also fell below the standard of care in that her failure to note the inappropriate settings placed other patients in potential jeopardy.

It should be pointed out that on October 22, 1998, within *minutes* of Lisa having been pronounced dead (i.e. after resuscitation attempts were discontinued), multiple corometric monitors were brought onto the unit. A child in the room adjacent to Lisa's, who was approximately the same age and also in for pain management, was shortly thereafter placed on a monitor. The child's flowsheet notes a monitor setting for the upper heart rate alarm as 120 beats per minute, significantly lower than the number allegedly set for Lisa. (The patient's mother provided me with this information. A copy of her child's medical chart, given to me by the child's mother with permission to use it, can be provided to the College).

Item 7

Self-explanatory, no additional information offered