Sharon Shore
3 Richview Court
Thornhill, Ont. L3T 7S9
Tel (w): (905) 764-8388, x18
Tel (h): (905) 764-6202

August 10, 2000

Ms Anne Coghlan
Executive Director
College of Nurses of Ontario
101 Davenport Road
Toronto ON M5R 3P1

Dear Ms. Coghlan,

This is to advise the College that I am revising my complaint against **Dr. Jean Reeder**, formerly the Chief of Nursing at the Hospital for Sick Children.

The reason for this complaint is her actions, inaction, and statements relating to the death of Lisa Shore on October 22, 1998, at the Hospital for Sick Children and the care provided by nurses employed at the hospital.

The complaints are as follows:

1) She failed to notify the College of the grossly substandard nursing care provided by Ruth Doerksen and Anagaile Soriano to Lisa Shore on October 22, 1998, at the Hospital for Sick Children

2) She failed to discipline nurses who she knew had provided grossly substandard nursing care.

3) She failed to terminate nurses who she knew had provided grossly substandard nursing care.

4) She failed to recognize how serious the breach of nursing standards and practice was in the grossly substandard nursing care provided by Ruth Doerksen and Anagaile Soriano to Lisa Shore. Alternatively, she did recognize the extent of the breach of standards and practice, and deliberately chose to ignore or conceal it, as evidenced by her allowing the nurses to continue working without any repercussions.

5) She failed to recognize how seriously nursing standards and practice were breached in the actions of Ruth Doerksen and Anagaile Soriano assuming full responsibility for a patient in the absence of any doctors orders or medical information about the patient. Alternatively, she did recognize the extent of the breach of standards and practice, and deliberately chose to ignore or conceal it, as evidenced by her allowing the nurses to continue working without any repercussions.

6) Dr. Reeder recorded various messages on a Hospital for Sick Children nursing hotline indicating her complete and unqualified support for the nurses who cared for Lisa and who were testifying at the inquest. At no time was there any indication or hint that any of the nurses involved had done anything in the least bit wrong; she complained instead about the unfair and inaccurate media coverage, implying that her nurses were being vilified. Given the grossly substandard nursing care that Ruth Doerksen and Anagaile Soriano gave to Lisa Shore, her enthusiastic support for them (when she, by her position, was mandated to objectively investigate and if necessary discipline them) was unprofessional at best and incompetent, unethical and immoral at worst.

7) No one at the Hospital for Sick Children did any investigation into the nursing care provided to Lisa Shore by Ruth Doerksen and Anagaile Soriano. Jean Reeder was the Chief of Nursing responsible for overseeing the adequacy of nursing care provided to patients at the hospital, and for ensuring that the nursing standards of practice were upheld. Her failure to conduct an investigation or to ensure that such an investigation was conducted, was negligent, unprofessional, and incompetent.

8) No one at the Hospital for Sick Children did any investigation into the nursing care provided by Ruth Doerksen and Anagaile Soriano to their other patients on October 21-22, 2000. The failure to conduct such an investigation, when the nurses' care with regard to at least one child was dangerously substandard, was negligent, incompetent, and potentially placed other patients in danger.

9) After the Coroner’s inquest was completed, Dr. Reeder placed herself in a serious conflict-of-interest position impacting on the profession and practice of nursing, by purporting to conduct a review of the actions and circumstances of Lisa's death at the same time as she was elsewhere expressing her unconditional support for the nurses involved.

10) Dr. Reeder placed herself in a second serious conflict-of-interest position impacting on the profession and practice of nursing, by stating in writing that one of her main responsibilities was to ensure that the standards of nursing practice were maintained and evaluated, and in the same document, expressing her and the hospital's commitment to support Ruth Doerksen and Anagaile Soriano.

Please contact me if you would like any additional information.

Yours very truly,

Sharon Shore
August 10, 2000

History
Lisa Shore went to the Emergency Dept. of the Hospital for Sick Children on the evening of October 21, 1998. She was admitted, given morphine, placed on a PCA morphine pump, and sent to ward 5A at approximately 1:45am on October 22nd. Ward 5A is the destination of choice at the hospital for children on morphine PCA pumps because of the unit's nursing expertise in this area.

The Emergency physician placed extensive monitoring orders in the hospital's computer system, including hourly vital signs, oximetry (continuous), and a heart/respiration monitor. In addition, the hospital also has written PCA morphine protocols which the nurses on 5A were familiar with, and which contain detailed monitoring instructions similar to what had been ordered by the doctor.

The 5A nurse assigned to Lisa was Ruth Doerksen, and Doerksen was relieved for several hours during the night by Anagaile Soriano. The following information is either apparent from reading the chart or else is not in dispute by any of the parties concerned.

- The nurses did not access or read the doctor's computer orders.
- The nurses did not inform their superiors of their failure to read these orders, and their superiors did not ask. Hospital administration says it did not learn of the orders until several months after Lisa's death, when Lisa's family questioned in writing whether such orders existed.
- It is unlikely that the nurses read the Emergency Dept. records, as one of the doctor's notes contained therein expressly said to check the computer orders, which was never done.
- The monitoring orders were not followed
- The PCA protocols were not followed.
- Vital signs were not taken as ordered or dictated by protocol
- Lisa experienced respiratory depression (charted by the nurses), and mandatory vital signs such as blood pressure were not taken, nor was any attempt made to awaken her
- Lisa experienced tachycardia (charted by the nurses), and mandatory vital signs such as blood pressure were still not taken
- O2 sat monitoring was ordered and not done
- A doctor was not contacted when Lisa's respiration first dropped below 11 breaths per minute, contrary to the doctor's orders and the PCA protocols
- When the doctor was eventually contacted, the nurse and the doctor have diametrically opposite memories of the conversation
- There is a post-mortem nursing note in the chart about a functioning apnea monitor in use on Lisa. Although an apnea monitor was found in Lisa's room the morning she was discovered to be vital signs absent, no alarms sounded on this monitor when Lisa died. As at least one of the alarms cannot be silenced on a working machine, there is no explanation for its failure except that the monitor was not turned on. The hospital has agreed (outside of the inquest) with the statement that "if there was a monitor in the room, it was not on when Lisa died". I (Lisa's mother) advised the hospital that no monitor was brought

into the room when Lisa was admitted, contrary to what the nursing note said. Circumstantial evidence strongly supports the position that there was no functioning monitor in use at any time.

Dr. Reeder acknowledged to the writer (outside of the inquest) substandard nursing care, failure to monitor Lisa's condition and vital signs, failure to check the doctor's orders, unsatisfactory documentation, and failure to do pain and sedation scores. She also stated in writing, in a nursing newsletter, that she was responsible for maintaining the standards of care at the hospital. In spite of this, she did not report the responsible nurses to the College, did not impose any internal disciplinary measures, did not terminate their employment, allowed them to continue working with full responsibility for patient care, and told me, "why punish innocent mistakes?"

Jean Reeder clearly did not see anything wrong with the care given by Ruth Doerksen and Anagaile Soriano. If this was her honest impression, she is incompetent both as a Chief of Nursing responsible for the welfare of the patients, and as a nurse in general. If she was aware that Ruth Doerksen's and Anagaile Soriano's care was grossly substandard, as she indicated to me, and nevertheless declined to discipline them, terminate them, or report them to their governing body, she is unprofessional, unethical and immoral, and unconcerned with the welfare of the patients at the hospital. Her unabashed support for these nurses in the face of a child's death is inconceivable in an individual of her position, education, and responsibility as Chief of Nursing. Protecting her nurses at any cost was of greater importance than the fact that a healthy child died who should not have.

The Chief of Nursing is responsible for the standards of nursing care practised at the Hospital. When the standards of care are not met, she must take immediate corrective action; failure to do so could jeopardize patient safety, destroy the community's faith in the hospital, and engender public chaos as families struggle to find alternate health care institutions where they can expect to receive competent nursing care.

The care given by Ruth Doerksen and Anagaile Soriano was so grossly substandard that a coroner's inquest jury investigating the circumstances of Lisa Shore's death returned a finding of homicide. The jury felt that her death was directly related to the care, or lack of it, that she received from the nurses in question. The inquest was a lengthy and difficult process, in that the hospital continuously attempted to withhold relevant information, and the nurses' testimony was evasive, contradictory, and riddled with inconsistencies. Although testimony at the inquest cannot be used in disciplinary proceedings, it is important to recognize that all of the information that was learned at the inquest was already known - to the hospital. Dr. Reeder attended the inquest every single day, was the hospital's primary liaison with its lawyer, and heard the same testimony that led the jury to its finding of homicide.

Dr. Reeder has spoken frequently of the improvements that the hospital has made since Lisa's death, particularly with regard to electronic monitoring. The hospital has implemented mandatory requirements for the use of these monitors, and publicly lauded itself on its stringent new regulations. They neglected to mention that these same

monitors were also ordered for Lisa, and the *only* reason they were not used was that the nurses failed to follow the then-existing orders and rules that were *already* in place. Not a single one of the hospital's improvements has anything to do with the real issue, that of nursing competence; study after study has shown that there is no substitute for good nursing and regular hands-on monitoring. Lisa showed evidence of medical crisis during the night, at least some of which was charted and ignored by the nurses responsible for her care. The nurses failed to practice basic nursing standards and should be held accountable for their actions.

Dr. Reeder's failure to see - or her deliberate decision to ignore or conceal - the gravity of the negligence is either gross incompetence or an unimaginable lack of personal integrity and ethical standards - or both.

Comments re specific complaints

Additional comments, item #1:
She failed to notify the College of the substandard and negligent care provided by Ruth Doerksen and Anagaile Soriano to Lisa Shore on Oct. 22, 1998, at the Hospital for Sick Children

At a meeting with Dr. Reeder and others on Sept. 30, 1999, prior to the inquest, she acknowledged to me that the nursing care provided to Lisa Shore on October 22, 1998 was substandard.

She went on to explain all the changes that had been made at the Hospital for Sick Children subsequent to Lisa's death, and made the following comments (per my notes taken at the meeting):

- The nurses have learned from their mistakes
- The nurse *inadvertently* neglected to check Kidcom
- Dr. Reeder agreed that substandard care was provided
- The nurses failed to monitor Lisa's condition and vital signs, but there was *selective monitoring*
- The nurses didn't do a pain score or a sedation score, because Lisa was in pain and they wanted to let her sleep. In hindsight, it was a mistake in judgement.
- Dr. Reeder said she was not satisfied with the quality of the documentation
- The two nurses involved have been assessed <when questioned further on this, she admitted that they had not been disciplined in any way>
- Why punish people for innocent mistakes?
- There are now weekly nursing rounds to focus on patients with serious conditions <committee is headed by Ruth Doerksen!>

Dr. Reeder was unquestionably aware of the substandard care provided to Lisa Shore. As Chief of Nursing, she is under an obligation to maintain the standards of practice of nursing of her nurses, to ensure the safety of patients, and to safeguard the public interest. Her failure to report the substandard care provided to Lisa Shore was unprofessional, unethical, and disgraceful.

Additional comments, item #2:
She failed to discipline nurses who she knew had provided substandard and/or negligent care.

This has been admitted, as per the notes above re item #1. Instead of imposing disciplinary measures or terminating the employment of nurses that she acknowledged as having provided substandard care, at least one of those nurses was given increased responsibility. Ruth Doerksen became leader of a weekly Nursing Practice Committee, whereby nursing practice and professional issues were discussed, and current practice and literature presented.

Dr. Reeder's acknowledgement that she did not in any way discipline nurses who she knew had provided substandard nursing care indicated a profound disregard for virtually all of the ethical and moral standards of the profession. Moreover, her lack of any effective action in response to the substandard care provided gave the appearance - and probably the actuality - that Dr. Reeder condoned the nurses' actions.

Additional comments, item #3:
She failed to terminate nurses who she knew had provided substandard and/or negligent care.
As per above comments re item #2

Additional comments, item #4:
She failed to recognize how serious the breach of nursing standards and practice was in the grossly substandard nursing care provided by Ruth Doerksen and Anagaile Soriano to Lisa Shore. Alternatively, she did recognize the extent of the breach of standards and practice, and deliberately chose to ignore or conceal it, as evidenced by her allowing the nurses to continue working without any repercussions.

Her question to the Shore family at the meeting of Sept. 30, 1999, in reference to the nurses' actions, was "Why punish people for innocent mistakes?"

This statement - coupled with her lack of action in the matter - indicates either an intentional disregard of the seriousness of the substandard care provided, meaning she deliberately played down or attempted to conceal the extent that standards were breached, or a sincere belief that the actions of the nurses constituted innocent mistakes of no great consequence. Intentional disregard constitutes unethical, unprofessional, disgraceful behaviour. An honest belief that the nurses' actions were "innocent mistakes" is clearly incompetence and an inability to recognize and maintain the standards of practice of the profession.

Additional comments, item #5:
She failed to recognize how seriously nursing standards and practice were breached in the actions of Ruth Doerksen and Anagaile Soriano assuming full responsibility for a

patient in the absence of any doctors orders or medical information about the patient. Alternatively, she did recognize the extent of the breach of standards and practice, and deliberately chose to ignore or conceal it, as evidenced by her allowing the nurses to continue working without any repercussions.

At the above-referenced meeting of Sept. 30, 1999, she said to the Shore family in reference to Ruth Doerksen not reading the doctor's orders, "the nurse accidentally forgot to check the orders".

According to Michael Strofolino, CEO of the Hospital for Sick Children, there have been no other known instances at the hospital of a nurse neglecting to check a doctor's orders. A nurse who assumes responsibility for a patient without knowing or checking for doctor's orders - particularly a nurse who has approximately fourteen years of experience at that hospital - is a nurse who is so negligent that she should not be entrusted with the care of any children. This nurse's failure to check or follow orders - coupled with her failure to follow standard, mandatory protocols - contributed to or caused a healthy child's death. Dr. Reeder's failure to comprehend this gross violation of basic nursing standards of practice demonstrates significant incompetence and her own failure to maintain the standards of practice. If she did comprehend the significance of the nurse's actions and deliberately chose to downplay or ignore it, she behaved unprofessionally, unethically, and disgracefully.

Additional comments, item #6

Dr. Reeder recorded various messages on a Hospital for Sick Children nursing hotline indicating her complete and unqualified support for the nurses who cared for Lisa and who were testifying at the inquest. At no time was there any indication or hint that any of the nurses involved had done anything in the least bit wrong; she complained instead about the unfair and inaccurate media coverage, implying that her nurses were being vilified. Given the grossly substandard nursing care that Ruth Doerksen and Anagaile Soriano gave to Lisa Shore, her enthusiastic support for them (when she, by her position, was mandated to objectively investigate and if necessary discipline them) was unprofessional at best and incompetent, unethical and immoral at worst.

Dr. Reeder left these taped messages on her nursing hotline (813-7777, press #3), which was available to anyone inside or outside of the hospital who had a touch-tone phone.

Transcripts of the messages for the period January 26 - March 8, 2000 are attached, as well as the hospital's Public Affairs Department information updates for February 24 and March 6, 2000. An audiotaped recording of these messages is also included for verification purposes.

In these messages (and again in the nursing newsletter which is also enclosed), Dr. Reeder expressed her unqualified support for Ruth Doerksen and Anagaile Soriano, called the jury's finding of homicide “unfortunate and sad”, and labelled the press reporting as "mean-spirited" and “inaccurate”. At no time whatsoever is there any reference to or acknowledgement of any substandard care or nursing errors.

These messages clearly demonstrate her lack of objectivity and competence by the degree to which she aligned herself with the nurses involved in Lisa's care. They show her failure to maintain the standards of practice of nursing by her unethical decision to protect these two nurses instead of first considering the welfare of the hospital's patients and her obligation to protect the public. Lastly, the messages are evidence of the moral blindness implicit in her choosing to ignore the direct role these nurses played in the wrongful and needless death of a healthy child under their care.

Additional comments, item #7

No one at the Hospital for Sick Children did any investigation into the nursing care provided to Lisa Shore by Ruth Doerksen and Anagaile Soriano. Jean Reeder was the Chief of Nursing responsible for overseeing the adequacy of nursing care provided to patients at the hospital, and for ensuring that the nursing standards of practice were upheld. Her failure to conduct an investigation or to ensure that such an investigation was conducted, was negligent, unprofessional, and incompetent.

As Chief of Nursing, it was her duty to ensure that guidelines, protocols, and chains of command were in place to notify her in a timely manner of serious nursing practice and competency issues. If any of her subordinates did know of the nursing issues and did not inform her, then those nurses should likewise be held accountable for their breach of nursing ethics. Either way, Dr. Reeder's actions were in violation of standards - she failed to investigate when she should have, or, by not being informed by subordinates of serious nursing issues, was not competently fulfilling the key responsibilities of her position.

Once Dr. Reeder was made aware by whatever means that there were nursing issues she should have, as Chief of Nursing, ensured that a thorough internal investigation was conducted. It was mandatory to conduct such a nursing investigation to determine what had actually transpired, since there were obvious errors and discrepancies in the nurses' accounts, e.g. my account of events (as stated in our family's questions sent to the hospital) directly contradicted that of the first nurse, and the doctor's account of his conversation with the second nurse directly contradicted her account of the conversation. No one could explain how a functioning electronic monitor, if there really was one, could fail to alarm when Lisa's heart stopped.

Additional comments, item #8

No one at the Hospital for Sick Children did any investigation into the nursing care provided by Ruth Doerksen and Anagaile Soriano to their other patients on October 21-22, 2000. The failure to conduct such an investigation, when the nurses' care with regard to at least one child was evidently substandard, was negligent, incompetent, and potentially placed other patients in danger.

Given Dr. Reeder's eventual admission to me that the care provided was substandard, the need to investigate the care given to the other patients of Ruth Doerksen and Anagaile

Soriano should have been paramount. If the care given to Lisa was so substandard, surely there was a distinct possibility that other children's lives might have been endangered as well. Allowing Doerksen and Soriano to continue working and caring for other patients clearly jeopardized the safety of patients and was in violation of nursing standards.

If an investigation was conducted and the care of other patients was found to be acceptable, then the grossly substandard care given to Lisa indicates that the neglect was deliberate and intentional, and that Lisa was singled out. Failing to take action in light of this is further evidence of the unprofessional, disgraceful behaviour of Jean Reeder and her utter failure to fulfil the ethical and moral responsibilities of the Chief of Nursing.

If no such investigation was conducted (which I believe to be true), this is further indication of Dr. Reeder's lack of concern with the ethical and moral responsibilities of her position.

Additional comments, item #9
After the Coroner's inquest was completed, Dr. Reeder placed herself in a serious conflict-of-interest position impacting on the profession and practice of nursing, by purporting to conduct a review of the actions and circumstances of Lisa's death at the same time as she was elsewhere expressing her unconditional support for the nurses involved.

At a press conference held by the Hospital for Sick Children immediately following the inquest, Dr. Alan Goldbloom, HSC Vice President, Academic & Clinical Development, stated in response to a question from the press that "…Our Chief of Nursing, now that all of the facts are out and now that the inquest is over, is going to be reviewing all the details around the actions and circumstances of Lisa's death. She will also be seeking the advice of the College of Nurses of Ontario which is the body responsible for the standards and practices of the profession." These words were repeated by the Public Affairs department on its February 24th taped message for staff and the public, and again in writing by Dr. Reeder herself in the Hospital for Sick Children's Spring 2000 nursing newsletter. Such public statements would only have been made with the express awareness and approval of Dr. Reeder.

Dr. Reeder had already shown herself to be strongly biased in favour of the nurses by her comments to the Shores and the messages left on her nursing hotline. Given her knowledge and acknowledgement to us that the nursing care provided to Lisa was substandard, she still chose to fully support her nurses, and then announced that she was going to conduct an investigation. This "investigation" could not be impartial, and is yet another example of Dr. Reeder's highly unethical behaviour.

It was professional misconduct and a serious conflict of interest for her to state that she would conduct a review after the inquest. Dr. Reeder could not adequately discharge her responsibilities to the profession of nursing and to patient safety because she was so clearly biased and partisan in favour of her nurses. Given how biased and partisan she

was, she had a moral and professional obligation to ensure that someone else – someone who was unbiased and impartial - conduct the review. For Dr. Reeder to accept the responsibility to do a review when she knew or ought to have known that she could not do it properly was a serious breach of her duties as Chief of Nursing, as someone responsible for nursing standards.

The evidence adduced at the inquest was already known by the hospital – the reason for the inquest was for others outside of the hospital to learn all the facts that the hospital had chosen not to volunteer. The statement that a review was going to be conducted by the very individual who had been most instrumental in supporting and protecting the nurses was a public relations exercise designed to "whitewash" the nurses and their actions.

After hearing about this upcoming investigation, I stated on a television show and posted on my Lisa Shore website (which is regularly and frequently visited by staff from within the Hospital for Sick Children) that Dr. Reeder's investigation could not be impartial or objective. We also stated that we could predict with near certainty what the results of her investigation might be, and characterized it as putting the fox in charge of the henhouse.

Within days of making these remarks, the hospital announced that Dr. Reeder would no longer be conducting the investigation. In its place, the nurses' governing body, the College of Nurses of Ontario, was to be asked to review the nurses' actions.

Additional comments, item #10

Dr. Reeder placed herself in a second serious conflict-of-interest position impacting on the profession and practice of nursing, by stating in writing that one of her main responsibilities was to ensure that the standards of nursing practice were maintained and evaluated, and in the same document, expressing her and the hospitals commitment to support Ruth Doerksen and Anagaile Soriano.

In the Hospital for Sick Children's Spring 2000 nursing newsletter, page 2 (a copy has already been provided), Dr. Reeder stated that one of her main responsibilities was to ensure that standards of nursing practice were maintained and evaluated. However, several paragraphs later, she again emphasized her support for Ruth Doerksen and Anagaile Soriano by writing "Please know that the hospital is committed to supporting the nurses involved in this event". One cannot maintain standards of nursing by supporting nurses whose actions were grossly substandard and by failing to report incidents of materially substandard care to the College of Nurses.

Note: The portions of the transcribed messages relating to Lisa Shore are shown in larger font, and unrelated information is shown in a smaller font.

WEDNESDAY JAN. 26, 2000

Hi, this is Jean Reeder at -- what time is it -- five minutes after 7:00 on Wednesday, January 26. There are three things I'd like to talk with you about briefly. First of all, I'm spending my time this week, next week, maybe even the next week after that at the Lisa Shore Inquest. Our staff that have testified thus far have done -- you'd be very proud of them in terms of their clarity, the poise with which they have maintained under duress and the information that they're sharing in the courtroom regarding the circumstances around Lisa Shore's death. You will, I suspect, read more and hear more in the media in the coming days because nurses who were involved in Lisa's care are now -- have begun to testify. I urge you to continue to access the inquest hotline, which is 813-8999 for daily updates that are recorded by 6:00 p.m. at night.

Secondly, I would like to remind everyone about the Centre for Nursing annual open house which is being held tomorrow from 2:00 to 4:00. Our team in charge of the open house has done a spectacular job in terms of developing displays, on-line information about the accomplishments of nurses over the past year with special attention paid to the amount of financial support that nurses have acquired to support conferences, workshops and their academic pursuits. It's very exciting and so even if you have 10 or 15 minutes sometime tomorrow between 2:00 and 4:00, do come down and grab something to eat and see what -- the Centre for Nursing has lots to be proud of on your behalf. You will see photographs of your colleagues as well as "Little Miracles" clips will be showed, a number of different posters and it's a chance to shine.

Finally, I would like to clarify a rumour that has been going around this week that was brought to my attention at the RN Council on Monday and several times since then. Apparently some nurses are discussing the fact or have expressed concern and worry that the retention bonus that was put in place last year and discussed very openly with you by Mike Strofolino may be jeopardized because of current financial strains.

I have discussed this with Alan Goldbloom, the senior Vice-President, as well as confirmation from HR. There is nothing that changes our commitment to nurses part-time and full-time around the original retention bonus plan. We expect to meet our commitment to you, but please remember this does not kick in until the next fiscal year, and so there's yet another year before anyone receives the retention bonus. And so I would ask that you temper any speculation about the retention bonus, because at this point in time, we intend to fulfil our commitment to nurses who are on staff here at the Hospital for Sick Children who qualify for the retention bonus as it was originally presented to you in handouts as well as in the open forum that we hosted. I would suggest that if you have any questions about this to consult your manager or your HR representative, and if you need to have the original written information that was provided by HR last year I'm sure your HR representative can get that.

So again, I'm going to wrap up by saying we have lots of reasons to be proud of nursing staff and other staff here at Sick Kids. Whether it's in the courtroom, at the Centre for Nursing open house, most of all I see it every day on the units, in the clinics, the work that you guys do is spectacular. So I'll say goodbye for now.

FRIDAY, FEB. 4, 2000

Hi, there. This is Jean Reeder on Friday, Feb. 4th at about 5:30 in the afternoon. I haven't recorded a message in several weeks because I have been focused day after day after day after day on the coroner's inquest around Lisa Shore's death. This has consumed about twelve to fourteen hours of my time each day as it has for many other people from the hospital involved supporting the inquest. I'm tired, I know that all the individuals involved in this are very tired for different reasons. I know several nurses have expressed to me their frustration and sadness at the public media portrayal of nursing, or nurses and nursing care at Sick Kids during this inquest. I share your frustration in no uncertain terms. I sit in there and I listen to what's being said, and that's not exactly what's being portrayed in the media. When I testify I will be talking about a lot of the things that we have done here at Sick Kids to improve the practice and care of children on monitors, improve the Kidcom, improve nurses' communications, many things. It's important for you guys to know that the nursing staff who have been involved in this long, very difficult ordeal, have received a lot of support from their peers, from myself, from many other members in the hospital. It's been a very difficult time for our nursing colleagues and I know it's been difficult for you as well. I think this is one of those times where we need to band together and be very strong and support each other and believe in all the good work that we do.

You might be interested to know that this is one of three deaths that has happened on 5A in the past eleven years, and so a lot of people don't have a lot of familiarity with what coroner's deaths entail in terms of managing them. It doesn't surprise me at all. I've certainly learned a lot in the courtroom and I know every nurse that has been there has as well. I've asked that as many nurse-educators as possible can be rotated through so that they can share their learning and experience with new nurses as well as seasoned nurses here. I was very pleased that Sue Williams, who's the president of the RNAO, was there today to support me when we thought I was going to testify. As well, Dr. Alan Goldbloom and Dr. John Wedge, the Chief of Surgery, were there as well. So, if all things go well, I will probably be testifying late Monday morning or early Monday afternoon, but then again, that can change. And so I just want everybody to hang in there like I'm doing, like your nursing colleagues Anagaile and Ruth are doing, and I know they and I appreciate all the concern and support that you guys have given during this very tough time. I continue to marvel at the wonderful work nurses and other staff do here at Sick Kids. We have so many outstanding, brilliant successes; we can never lose sight of that.

On a more upbeat note, I encourage all of you who were involved in the fire that seems so long ago now to attend the staff appreciation breakfast on Thursday morning, but actually all staff can attend as well. We have a couple of sponsors underwrite it, which means they pay for the breakfast so we don't have to take it out of our operating fund and we have also invited representatives from police, fire, ambulance as well as the other two hospitals that supported us during that time. It's a wonderful way for us to extend our grateful thanks to our community and colleagues for assisting us during a tough time.

Thanks to all of you that made it to the Centre for Nursing open house last week. I for one was not there because I was in the courtroom. However, the Centre for Nursing staff did a terrific job in putting together a very creative portrayal of what we do in nursing here at Sick Kids.

Finally, I'm pleased that the rumour that was being passed around the past few weeks about the retention bonus has been clarified, and as was discussed in a recent hospital leadership forum there has been absolutely no discussion at all to not be forthcoming with the commitment and promise that Mike Strofolino made last year for the retention bonus.

And so, I'm going to call it a day now, and I wish you all a happy, healthy, safe weekend, and thanks for being nurses at Sick Kids. Bye.

FRIDAY, FEB. 18, 2000

This is Jean Reeder on Friday, February 18th at 4:10 in the afternoon. I wanted to provide a quick update to a number of things that are going on here at Sick Kids.

First of all, don't forget nursing grand rounds with Kathleen McMillan on Monday next week from 2:00 to 3:00 in the large auditorium. Kathleen will be talking about her vision for nursing in Ontario in her role as the Chief Nursing Officer of the province.

I want to thank Adrienne Winslow, who is a staff nurse on NICU, for helping to arrange for Kathleen to join us and I have it on the QT that Kathleen would be very interested in popping up to see Adrienne's unit, the NICU, after her presentation. So I hope as many of you as possible can come listen to Kathleen's important message.

Secondly, it's time again to nominate deserving staff for this year's humanitarian awards. They call it "Caring Promotes Healing." We've had a few nurses in the past who have received these awards and it's a profound honour for any staff member here at Sick Kids. This year they have two new awards, one for student humanitarian awards to recognize a part-time or full-time student that has been educated here at Sick Kids for a minimum of one semester, as well as the Family Advisory Committee award that we've seen before.

And finally there's a new award called the "Robert Salter Humanitarian Award" and this, too, is available to any staff member who has worked here during the past year. I think these are terrific opportunities for us to recognize our nursing colleagues as well as other staff who have made outstanding contributions in caring practices and role model what it is to mean to be a humanitarian. And so please go to Foundation for your applications, they are probably on the website and we have a few in the Centre for Nursing office.

A pitch for the RN Council; abstracts are being solicited for national nursing week in May. If any of you have presented, research or special projects, innovative practice, things in your practice before, please dust those abstracts off so that you can share your good work with your nursing colleagues. Even though the abstracts are due on Monday and, by the way, if you have posters, too, consider submitting an abstract for a poster presentation. I'm sure the RN Council will gladly accept abstracts that are late for a few days.

Please note that the safety and practice exhibit is mandatory in terms of legislated safety and practice issues. The legislated information you must update yourself on as far as fire safety, WIMS (??), as it relates to sectioning and new infection control practice guidelines, and we also are profiling other safety related information such as the violence and harassment policy, as well as the new sedation policy and monitoring policy.

It's open 24 hours a day in the rotunda until February 29th, and Tim Horton's catering is providing complementary coffee on

the 17th, 21st, 24th and 28th, so please find the time to go there, encourage your colleagues that have not been to attend and recognize this as an expectation I have for nurses to maintain their competence in nursing practice.

Finally, let me say again how much we appreciate the support you and many other people within and outside the hospital have provided to myself as well as the other nurses who have testified at the Lisa Shore inquest.

We're in a holding pattern until the jury comes back with their findings and recommendations next Thursday.

That afternoon Sick Kids will be having a press conference so that we can get our key messages out to the public as well that same night for the evening news.

I regret very much that I will not be here on the day the inquest findings are made public; I have a previous commitment in Vancouver and I must fulfil that commitment.

I know all of you will support one another - particularly the nurses on Wards 5A and 5B - and I've asked the ATM's, the nurse educators, and I know the managers will be available to talk with staff in small groups, to provide debriefing.

If you need to have support from occupational health they are certainly able to do that.

And just know that we can never forget all the wonderful things that nurses and many other people do for kids here - for kids and families. And so, it's been a tough time, but like other tough times we'll get through it, and I think we'll be stronger and better nurses for it.

So I'll say goodbye for now.

FRIDAY, FEB. 25, 2000

Hi, it's Jean Reeder on Friday the 25th of February. It is a quarter after 5:00. So yesterday morning I was in Vancouver having a little breakfast at the one-day conference I had flown out for when I received a page. And I knew what it was about because I, knowing that I was going to be gone, I had planned for someone to notify when the Coroner's Inquest presented its findings and recommendations. And I was notified of the very unfortunate and I would say very sad decision that the jury made with respect to homicide as the means of death, and quite frankly I was -- I knew it could happen, but I was still shocked and I was shaking like a leaf, let's put it that way.

I was with Linda McGillis-Hall, who many of you know as a former staff member here at Sick Kids for many years and now on the faculty at the Faculty of Nursing at U of T.

I called back and got a little more information and by that time, the conference had started and I really wasn't focusing. And then who taps me on the shoulder but Judith Shamian who, as you know, is the Chief Nursing Officer for Canada. And Judith looked at me and said, "Jean, what's wrong with you?" And I got a little teary and she literally dragged me out of the conference room and she says, "What's wrong, Jean, talk to me."

So I told her what happened and she was very supportive and expressed one more time the esteem with which she holds nurses at Sick Kids as well as the professionalism that our organization exudes for the practice and the profession of nursing.

So the long and the short of it is that I decided to fly back, it would be hard for me to stay in Vancouver under the circumstances, so I got back late last night. When I got back, I had a number of voice mails and I wanted to share with you some of the messages that I have got in support, wanting me to extend their support, wishes for courage, wishes for strength for nurses and sadness that all of this has happened.

In the past three days, I've gotten calls from Doris Grinspun, who is the Executive Director of the RNAO; last night Sue Williams, who is the President of the RNAO, left a voice mail for me saying that she's -- of course, she was at the inquest several times but Sue has been a great support for me personally and she wanted me to know that we were in her thoughts.

Dr. Judith Skelton-Green, who has been very active in Ontario nursing for years, called. She's now a consultant and she, too, left a message of support shortly after she read the Globe & Mail this morning at breakfast.

Dr. Gail Donner, who many of you know as a former director of nursing research here in practice who is now the dean of the Faculty of Nursing called me and we talked today about what was going on and she wanted to be remembered to nursing staff. She remembers what it was like during the time of the Dubin Report and the inquest around deaths of babies and she just wanted to say that she

has great respect for the nursing care here, for my leadership and wanted to be remembered to the staff.

Later on this morning, I got a message from Kathleen McMillan. Many of you heard Kathleen speak with us earlier this week in her role as Chief Nursing Officer of Ontario and she wanted to say that her thoughts were with us during this tough time. I talked with Doris Grinspun in person and she expressed her concern, what can they do as an organization. She offered the opportunity to come over and meet with staff, either formally or informally, to talk about supports that are available through the RNAO, and if this would be helpful for any of you, I'd love to arrange that. So the messages go on.

I got a nice phone call from Jenny Miron who many of you know as a -- she's on maternity leave right now but, as well, Jenny was a clinical nurse specialist on the surgery units and then transferred to diagnostic imaging as a manager. Sylvia Shipka, who left us recently, who was one of our CHS directors called, as did MaryJo Haddad who is one of our new vice-presidents and will be rejoining the staff in mid-March. I talked with Linda McGillis-Hall, as I said, when I was in Vancouver yesterday and Judith Shamian expressed her regard for nurses here and all that we're going through. Dr. Peter Cox, who chairs the medical staff association, sent me an e-mail saying he would like to -- "I and other members of the MSA would like to express our support and appreciation to the nursing and professional staff of the hospital. What would be the best way for us to do this formally? Please advise." And I did speak with Peter and I made a few suggestions that all physicians could be doing right now.

I think the most touching acknowledgement I received was a lovely letter from Ann Cameron who is president of the women's auxiliary here at Sick Kids. So let me close by reading this. "Dear Jean: We want you and all of your nurses to know we are thinking of you today. We can only imagine how difficult it must be to read the papers and listen to the radio with all the fuss swirling about you. We know what an excellent job you all are doing. We witness it daily in many areas where we work together. Keep up the good work, you should be very proud of your profession and the wonderful work you do at the Hospital for Sick Children. Sincerely, Ann Cameron on behalf of the Women's Auxiliary."

And so even though many of us are feeling mad, feeling sad, feeling torn, second-guessing ourselves, maybe over-functioning, fielding questions from parents, from our own families and friends, we can never forget the wonderful work we do here at Sick Kids.

And so I thought it may be good to share with you some of the positive feedback that I've had from people throughout the day, in between my discussions with many nurses on several of the units. So hang in, guys, it may get worse before it's better, but in the end, we'll continue to give the fabulous care and I believe in you and I believe in the work we do here at Sick Kids. Thanks.

Wednesday March 1, 2000

Hi, it's Jean Reeder on Wednesday, March the 1st at 6:35 p.m. I'm updating very briefly my 777 line because I've gotten some feedback that nurses don't have enough up to date information in terms of post-inquest activities.

When I hit the ground running after returning last Thursday night, late, from my less than 24-hour trip to Vancouver, I, of course, made some rounds and began to re-engage with the organization, who is still reeling with the impact of the homicide verdict from the inquest.

Since Monday of this week, I have spent approximately 95 percent of my time meeting with individuals, working on preliminary steps to formulating our recommendations, responding to requests for information and my advice from Mike Strofolino, from Alan Goldbloom, from Risk Management and, as well, I have made rounds many times on 5A and 5B and tried to talk with as many nurses informally as possible, but I haven't gotten everywhere.

I did call the College yesterday, the College of Nurses yesterday and our nursing colleagues involved in the inquest have not yet been reported as of yesterday. We will provide nurses many more details and responses to your questions and concerns at two nursing forums that will be held tomorrow on Thursday, March the 2nd, one from 10:00 to 11:00 in the morning and the other from 12:00 to 1:00 in the morning in the large auditorium. The reason these times were selected were that this is the only time the large auditorium was available. So if everyone can send at least one representative from your unit, from your clinic, from all different areas, I think it would be really important for you guys to bring information back to your colleagues who are not able to attend.

I've also asked a number of different people that can provide some consultation with regard to specific questions that you might have to be there from EAP, from HR; there have been issues around dealing with challenging families that are afraid themselves from what they have read in the press.

I know that many nurses here, probably most nurses, have experienced a high level of stress, anger, sadness, many emotions. Some of you who were here during the Dubin Inquiry have told me that your remembrances of the Susan Nelles days have come back and it has been invoking those very difficult memories as well, so I'm very aware of how nurses are feeling around this. I feel your anger and frustration with the press reports.

Interestingly, there has been nothing in the press for a couple of days and I think that public affairs can help you understand our strategy in terms of not responding to the press that was so difficult and quite frankly, mean-spirited and in some instances, incorrect, last Friday. So come to the open forum; if you can't, we'll get something out.

We have -- also we'll be bringing information about the RNAO legal assistance program to the open forum and, as well, a question and answer sheet that you can take away and share with your colleagues. That's more specific for issues related to nurses' questions.

So I thank you for all the questions and feedback that you have provided me and others in the organization. I certainly appreciate the words of support and concern that you have given me. Me, personally, it has been a very difficult time; in fact, I'd say the most difficult time in my career in terms of providing leadership. And, again, you continue to have the utmost respect and support from the organization for all the wonderful work that nurses do here and most of all, from me. So I'll say good-bye for now. Thanks, bye.

MONDAY, MARCH 6, 2000

This is Jean Reeder on Monday March 6, at 6pm. I'm updating my 777 line to inform my nursing colleagues and others here at Sick Kids. On Friday morning I self-reported to the College of Nurses. For the past several weeks my nursing leadership as well as ethical conduct has been questioned more than once in the public's eye. I guess most recently it was on a television show with Collins (sic), Thursday night, I saw part of it. I decided that it's important to me and I think necessary for the organization and particularly for nursing staff that my ethical conduct and professional judgement be beyond reproach as I've always tried for it to be. So I decided to self-report to the College to have the opportunity for the College to review my actions during before the time and during the time of the Lisa Shore Inquest. At the same time I will tell you that Ruth Doerksen, Anagaile Soriano and Mary Douglas, as well through their attorney, self-reported to the College in anticipation that the Shore's attorney will also be reporting them, and they did so as we expected on Friday afternoon.

I think it's important to share with you that I've already told you my rationale for doing that. It's unusual, actually, I think the College told me on Friday that no one's ever self-reported before, but they've said it certainly is my right to do so. As we all know it's a privilege to practice nursing and that privilege is granted through our registration that is reviewed and renewed every year. I believe it's equally important to fulfil my obligation to the public to engage in the highest level of nursing practice that I can impart. As far as the process, it's pretty detailed. I did get a lot of details from the College today. But suffice to say that, there are several opportunities for me to share information as well as Ruth, Anagaile and Mary, that the College will take under advisement the reports that we have filed and look at the issues that the Shores filed as well to determine a reasonable cause for misconduct, because it is professional misconduct that they have complained about, myself in particular. I think it's also important for you to know that the College determines what needs to be investigated because that's what they deal with. I also fully expect that this will take a period of time, generally the College needs to take about 4-6 months after filing to conduct their investigation and to determine the next steps for the College. There

is nothing that precludes all of us from continuing to practice nursing because our privileges have not been suspended and most likely will not be. And I think its premature in my professional judgement for Anagaile and Ruth and perhaps still Mary to return to work as this has been very devastating for them in a different way than Lisa's death was devastating to the Shore family.

I'm also aware that maybe the fact – maybe there are some nurses at Sick Kids that have criticized my leadership, feeling that I have not been as supportive or involved in looking at other instances of professional practice. It would be helpful to have this feedback directly rather than anonymous messages or indirectly, but I'm also aware that in a leadership role you're not there to necessarily please everyone but to provide a consistent message and to carry out in actions an everyday consistency in terms of the values and philosophies and key messages that I need to continue to share with nurses so that they understand the motivation and other things that underlie my decisions. Just as so many times I have said in the past and will continue to do so, we are all responsible and accountable for the decisions that we make and the actions that we take. And that's one of the many things it means to be a professional nurse. I also know that nurses continue to be exceedingly stressed, not only due to the impact and post-inquest discussion of informal rumours and constant pressures that nurses and physicians are being subjected to by some families who continue to scrutinize, criticize, and second-guess and even in some instances harass people about their care.

It is exceedingly unfortunate but I guess it shouldn't be surprising seeing that the media attention that has continued to focus and the information that is available and I'll also say that I urge you, if any of you are choosing to read the website, to please be reminded that not every piece of information in there is factual in terms of the evidence that was provided for the inquest. I've seen a few things that have been on the website, and some is I would say perceptions and opinions of Mr. and Mrs. Shore as well as their attorney. And they have, you know it's not unexpected that they would give their own perceptions and opinions. I would just urge a healthy dose of caution with respect to construing that as the absolute facts. That's not at all calling them liars, but it is their opinions and perceptions, and I would say in a fair number of instances. I think it's also important to know that some of these opinions and perceptions about my leadership and nursing practices are now being shared on the Internet in various North American websites. We can't stop this from happening but I think that's an important piece of information for you to know.

I actually have another open forum scheduled, the monthly ones I have scheduled on Monday, March 13th, 2:00 in the afternoon. So this is another opportunity for us to engage in ongoing dialogue about things that are important for you to know. So thank you. At this point in time please seek primary source information to clarify misinformation. Thank you.

TUESDAY, MARCH 7, 2000

Hi, it's Jean Reeder on Tuesday, at ten after 6:00 on March the 7th. I just wanted to leave a very brief -- my radio talk show, if you will, or my 777 line, I would like to encourage as many of you as possible to, number one, review the audio -- no, the videotapes from the open forums that we had last week. They're being made available to each of the Child Health Services Manager and also just a reminder that on Monday, March 13th, between 2:00 and 3:00 is my regularly scheduled nursing forum.

I've also extended an invitation for Doris Grinspun, who has offered support and information from the RNAO, to pop in for a few minutes and she will also be bringing information from the RNAO.

Thanks to all of you who have extended your support and concern about Anagaile, Ruth, Mary and myself. I think it's fair to say we have up and down days and up and down hours. It is a hard time, but don't forget that it's also a tough time for Mr. and Mrs. Shore, who are trying to find meaning in Lisa's death and do what's right as parents.

I will tell you also that Mike Strofolino met with the Shores today and he characterized it as a cordial meeting, I think that was his word, but -- and I'm glad Mike met with them, as well, and hopefully Mr. and Mrs. Shore were. So you can tell by the way I'm talking I'm pretty tired at this point in time and so thanks again for all your support. Bye for now.

WEDNESDAY, MARCH 8, 2000

Hi, it's Jean Reeder on Wednesday, March 8 at a quarter after 12:00 in the afternoon. I have decided to cancel my monthly open forum this coming Monday. I have decided to go visit my family sooner rather than later and I think all of you can appreciate all the reasons why and besides, I have a real craving for Mexican food in Arizona, so I just wanted to give you enough lead time so that people wouldn't be coming in on their off days to come to an empty room. At any rate, I will be gone for, I think, around two weeks or so and I look forward to coming back renewed and refreshed, as all of us need to do when we go on holiday. So anyway I'll just say good-bye for now and we'll see you soon.

PUBLIC AFFAIRS MESSAGE, FEB. 24, 2000

This is Jonathan Noyak (ph.) of the Public Affairs Department with an update on the Lisa Shore inquest.

The jury at the Lisa Shore inquest delivered its verdict in 35 wide-ranging recommendations on Thursday, February 24th. The inquest was held to examine the circumstances of the sudden and unexpected death of ten-year-old Lisa Shore.

Lisa suffered from chronic pain related to a broken leg. She was admitted to Sick Kids through the emergency department on October 21st, 1998, for pain management and she died the next morning. After hearing testimony from various witnesses over four weeks, the jury has concluded that the name of the deceased was Lisa Shore; the date and time of death was October 22nd, 1998, between 6:20 a.m. and 7:00 a.m.; the place of death was the Hospital for Sick Children; the cause of death was probable complex drug interaction leading to cardiac and respiratory arrest; and by what means, the jury returned a verdict of homicide.

Coroner's juries are required to choose from five causes of death: accidental, undetermined, natural causes, suicide or homicide. "Homicide" means that a person dies as a result of the actions of another person. Coroner Jim Cairns said the jury's findings are findings of fact and there is no fault or legal responsibility included. A coroner's jury cannot find fault. Rules of evidence are much different from that of a criminal or civil trial.

The hospital is profoundly sorry that we failed Lisa Shore and the Shore Family. There is nothing we could ever do to ease the sorrow and feelings of loss experienced by the Shore Family. We are determined to do everything humanly possible to ensure that such a tragedy never happens again.

The hospital is surprised and deeply saddened with the jury's verdict, particularly in light of the fact that Crown Counsel recommended a verdict of accidental or undetermined death. In fact, Crown Counsel has said during the inquest that, "Suicide and homicide have no place here." The hospital does acknowledge that human error occurred with tragic outcome.

Now that the inquest is over and all the facts are out, the hospital's chief of nursing, Dr. Jean Reeder, will review all of the circumstances surrounding Lisa's death, including the nurses' actions, and she will meet with the nurses. Dr. Reeder will also seek advice from the College of Nurses of Ontario, the body responsible for the standards of the profession. In the meantime, the nurses involved will continue on paid leave and the hospital will continue to support them in this process.

The jury's recommendations cover a broad range of issues, including the hospital's Kidcom computer system, the interactions between certain drugs, monitoring protocol, staffing, communication between the hospital and the coroner's office and nursing practices. The hospital will take these recommendations seriously. We will review them carefully and implement as many as are feasible.

Since Lisa Shore's death, the hospital has pro-actively and thoroughly investigated the issues that led to Lisa's death and has already addressed some of the issues involved in the jury's recommendations.

The hospital has accomplished and is undertaking the following: In the past year, over 100 nurses have been added to our staff and the nurse to patient ratio has been improved. Protocols for pain management have been rewritten and nursing education enhanced so that every child receiving morphine infusion will have his or her heart and breathing monitored.

Our patient care computer system has been modified so that doctors' orders will print automatically on the ward when a patient is admitted. The hospital is absolutely committed to ensuring that we do everything possible to meet the expectations of the coroner's office. We will meet with the coroner as soon as possible.

An educational program is being developed for all staff regarding their specific roles when a coroner is involved. A comprehensive review of health care practices involving medical technology and devices is underway. Another patient care information systems task force is being developed to bring together doctors, staff nurses and computer experts to examine how the system might be more effective in helping the hospital safely care for children.

The hospital has thoroughly reviewed Kidcom and made a number of changes. Many procedures and policies have been changed, particularly those around suspended orders and increased education is now mandatory for all patient care staff.

The hospital has reviewed its pain management practices and has revised its policies on drugs that have the potential to be highly toxic such as narcotic medications like morphine. The use of monitors is now mandatory when a child is receiving narcotic medication such as morphine.

A number of changes have been made to ensure that the nursing staff on unit 5AB receive the support they need when caring for critically ill patients. A special education program has been instituted for nurses treating patients with chronic pain who are now admitted to the unit by the department of anaesthesia. The hospital will review patient care policies surrounding unexpected or unexplained death to ensure that information is collected in a timely manner and we are strengthening all of our policies about unexpected events in our hospital so that we investigate thoroughly and promptly.

The hospital plans to reach out and help others, including colleagues in other hospitals, the Ministry of Health, Health Canada, the deans of the Faculties of Nursing, Medicine and Allied Health Professionals and other parties who may learn from this case.

During the inquest, some of us may read, seen or heard reports of an alleged cover-up of facts by Sick Kids. For the record, the hospital fully co-operated with the Coroner's Office. We did our best to provide to the best of our ability and to the best of our knowledge what information was necessary

to facilitate an open and fair investigation of Lisa's death. Unexplained deaths requiring the involvement of the Coroner's Office are a rare occurrence at the Hospital for Sick Children, and certainly on the unit where Lisa died. The process was new to the staff on the unit.

This has been a difficult and stressful time for all of our staff, and in particular, our nursing staff. The hospital is proud of its nursing staff and everyone involved in providing patient care. Throughout the inquest, all of our staff continued to meet the highest of professional standards and provided the excellent care our patients have come to expect. That is a real tribute to their commitment.

This news release is available on the hospital's Intranet site, in the "In the News" section, under the "Lisa Shore Inquest".

PUBLIC AFFAIRS MESSAGE, MARCH 6, 2000

This is Jonathon Noyak (ph.) of the Public Affairs Department, with an update to the events surrounding the Lisa Shore inquest. It's Monday March 6th. Registered nurses Ruth Doerksen and Anagaile Soriano, the two nurses involved in the care of Lisa Shore, self-reported to the College of Nurses of Ontario on Friday March 3rd. The Hospital for Sick Children also formally reported the two nurses to the College and asked for a review of the nursing care provided. Chief of Nursing Dr. Jean Reeder and Nurse-Educator Mary Douglas self reported to the College on Friday as well.

Michael Strofolino, President & CEO of the hospital, said, "In order to fulfill our mandate to the public, The Hospital for Sick Children believes that it must be able to assure all families that the standards of nursing care at HSC meet the highest expectations. We believe it is essential that we turn to the body which is responsible for the standards of the nursing profession, and request that they review the actions of the nurses involved in this case."

Dr. Reeder explained her decision to self-report by saying, "My leadership and ethical conduct has been questioned publicly. As a registered nurse in a leadership role, I welcome the opportunity to be reviewed by my regulatory body and independent experts."

The College of Nurses of Ontario is the governing body for nursing in the province. It sets requirements to enter the profession, establishes and enforces standards of nursing practice, and promotes the quality of practice of the profession and the continuing competence of nurses.

Mr. Strofolino added, "We apologize again to the Shore family for the pain we have caused them. They can be sure that the College will review the nursing issues in detail."

Based on evidence collected, the issue may go to the College's Discipline Committee which may decide whether to dismiss the case or to find that a member has committed professional misconduct or is incompetent.