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August 10, 2000

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

Please consider this letter to be a revised letter of complaint against **Anagaile Soriano, RN**. This letter is to replace my original letter of complaint dated March 3, 2000.

A portion of the original complaint made reference to testimony given at the Coroner's inquest investigating my daughter, Lisa Shore'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.

Accordingly, I am restating the complaint to exclude the testimony given in coroner's court by Anagaile Soriano. The allegations contained herein are therefore based exclusively on the medical records and other documents. This is more than sufficient to encompass the grossly substandard care that Soriano provided to Lisa Shore, the lies she told and charted, and the deceitful actions in which she engaged in an attempt to cover up the evidence of her negligence.

It is apparent that had Lisa Shore been cared for on October 22, 1998, by a nurse who was even minimally competent, she would still be alive today. Soriano's actions, her omissions, her gross negligence, and her blatant disregard for protocols, procedures, and basic nursing caused Lisa's death.

The specific complaints are as follows:

- 1) Soriano failed to document important medical information regarding Lisa's condition which had been conveyed in a phone call from a nurse in the Emergency Department made at about 0130 hours.
- 2) She failed to check the computerized doctor's orders entered for Lisa's admission to Unit 5A when she received the phone call from the Emergency Department, when all patients admitted to the units from the Emergency Department have computer orders.

- 3) She failed to read and follow the doctor's hand-written orders directing staff to read the orders in the computer system (kidcom orders).
- 4) She failed to read Lisa's chart from the Emergency Department which outlined her vital signs and medical history prior to admission to the unit.
- 5) She accepted responsibility for the care of Lisa when she knew little, if anything, about Lisa's situation and health status.
- 6) She failed to follow the doctor's orders in that she did not:
 - Put Lisa on oximetry;
 - Put Lisa on an apnea monitor;
 - Take Lisa's vital signs as directed;
 - Assess Lisa's pain scale and sedation scale as ordered;
 - Immediately contact the physician as ordered regarding Lisa's deteriorating condition;
 - Take appropriate measures when Lisa demonstrated signs of respiratory depression.
 - Take appropriate measures when Lisa showed signs of tachycardia
 - Set Lisa's IV flow rate as ordered
- 7) She failed to follow the standard protocol and usual practice on the unit for patients on a PCA morphine pump in that she did not:
 - Put Lisa on oximetry (the written protocols state that it may be ordered at the doctor's discretion, and it was the usual practice at the hospital for patients on PCA morphine pumps to be on oximetry)
 - Put Lisa on an apnea monitor (the written protocols state that it may be ordered at the doctor's discretion)
 - Take Lisa's vital signs as directed;
 - Assess Lisa's pain scale and sedation scale as directed;
 - Contact the physician regarding Lisa's deteriorating condition as was ordered;
 - Take appropriate measures when Lisa demonstrated signs of respiratory depression.
 - Take appropriate measures when Lisa showed signs of tachycardia
- 8) She failed to check what medications Lisa had received in the emergency department and to evaluate the contraindications and interaction of these medications.
- 9) Failed to ensure that she had the knowledge, skill, and judgement required to evaluate the side-effects of the morphine and other medication administered, and to recognize when intervention was required.

- 10) She failed to have the resources available to intervene when Lisa's condition deteriorated.
- 11) She failed to do a complete assessment of Lisa's vital signs when it was apparent that her vital signs had fluctuated beyond an acceptable level.
- 12) She failed to take action when Lisa's vital signs fluctuated beyond acceptable levels.
- 13) She failed to write nursing notes while responsible for Lisa's care for a period of time almost or equal to three hours during which time her vital signs indicated a deterioration in her condition.
- 14) She failed to notify the physician when the Lisa's vital signs deteriorated.
- 15) At 04:05, Soriano took a complete set of vital signs - heart rate, blood pressure, temperature, and respiratory rate - on a twelve-year-old child in the adjacent room who was relatively healthy, had not yet had any surgery, had received a very small dosage of morphine (only 2mg by IV many hours earlier), and was not on any concurrent medications. Per Lisa's nursing flowsheet, Soriano documented that she entered Lisa's room at the exact same time, 04:05, and took only one reading - Lisa's respiration.
- 16) She lied to the physician when she spoke to him at 04:05, by telling him that Lisa's vital signs were good and that Lisa was arousable. Most of Lisa's vital signs had not been taken, those that were taken were far from normal, and Soriano did not attempt to arouse Lisa.
- 17) Soriano lied to her superiors when she said she contacted a physician at 02:50; she did not.
- 18) She lied to her superiors when she said that Lisa was on a corometric monitor when she was admitted to the unit and throughout the night; Lisa was not on a corometric monitor.
- 19) With assistance from at least one other nurse, she falsified the nursing flowsheet by destroying the original and making a new one.
- 20) She did not voluntarily report her failure to follow nursing practices and protocols to Mary Douglas, the nursing-educator for ward 5A, or to Dr. Jean Reeder, Chief of Nursing, or to any other nurse superiors. She did not report that she:
 - failed to take all of Lisa's vital signs in accordance with doctor's orders and standard PCA protocols
 - neglected to access the Kidcom system and activate the doctors orders in spite of receiving a call from the Emergency Department about Lisa's imminent arrival.
 - did not look at Lisa's chart at anytime in the almost three hours that she was responsible for Lisa's care

- cared for Lisa without having any information about her such as the medications she was on and their actions and interactions
- failed to put Lisa on oximetry as ordered and as was usual practice
- did not contact a physician as per orders and protocols when Lisa's respiratory distress was first noted
- when she eventually spoke to a physician, she did not give him accurate information

21) She failed to initial or sign the patient flow sheet.

Please contact me if you require any additional information.

Yours truly,

Sharon Shore
August 10, 2000

Back-up to the complaint regarding Anagaile Soriano

History

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.

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, amitriptyline, 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.

At the time of Lisa's death, Soriano was a recent graduate who had only been working at the hospital for a few months.

Just before Lisa was transferred from Emergency to ward 5A, a call was made from an Emergency Department nurse up to the nurse who was assigned to Lisa. Although the assigned nurse was Doerksen, the call was taken instead by Soriano.

When Lisa arrived on the unit, both nurses Doerksen and Soriano remained in Lisa's room while Lisa was transferred from the stretcher to the bed and vital signs taken. The two of them checked the PCA morphine pump together. Although I was present and attempting to be helpful (asking, for instance, if they needed my help in transferring Lisa from the stretcher), neither spoke to me other than to respond curtly to my direct questions. I thought to myself that in comparison to the other 5A nurses I had met on Lisa's prior two admissions, these nurses were quite rude. I deliberately attempted some casual conversation in the hope that they would take notice of me and "lighten up".

Doerksen *never* spoke to me, not a single word. The only nurse who spoke to me was the one who I now know to be Soriano. As both nurses appeared equally involved in Lisa's 01:45 assessment, I assumed - incorrectly - that the one nurse who spoke to me was Lisa's assigned nurse.

Several minutes after Lisa's admission to the unit, both nurses left. One of them returned shortly after with linens for me (there is a couch in the room which doubles as a bed). No monitor was brought into the room at any time. Lisa was not attached to any equipment other than the IV and the PCA pump, which had both been set up in Emergency. No nurse returned to the room in the next fifteen minutes or so, at which time I closed the light and went to sleep, and Doerksen entered the Constant Care Room.

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.

Additional information, item #1

Soriano failed to document important medical information regarding Lisa's condition which had been conveyed in a phone call from a nurse in the Emergency Department made at about 0130 hours.

A nurse in the Emergency Department, in keeping with usual practice, called up to 5A about 01:30 to advise 5A of Lisa's imminent arrival. Typically, the Emergency nurse requests to speak to the nurse who has been assigned to care for the patient, and then provides the floor nurse with a full report. It is also usual practice to "activate" the kidcom computer orders at this time, i.e. to read and print them.

It is not in dispute that Soriano took the 01:30 call from the Emergency nurse. Although she evidently received important information about Lisa (probably about her medications, level of pain, the amount of morphine she had received, etc.), Soriano did not make any written notes.

Why did Soriano even take the call, when she was not Lisa's nurse? Since it was not her but someone else that would be assuming primary care for Lisa, it was all the more important for her to document the information received from Emergency.

The nursing notes written by the charge nurse at 01:50 regarding Lisa's admission to the unit contain no information other than comments about this admission. In addition to Soriano's failure to make any notes, there is no evidence that she conveyed any of the information she obtained from Emergency to the other nurse in charge of Lisa's care.

The call up to the ward from Emergency is supposed to be taken by the nurse in charge of the patient. If another nurse assumes this responsibility, this other nurse, Soriano, should also assume responsibility for ensuring that the other admission requirements are completed, i.e. ensuring that relevant information is documented in the patient's chart.

Additional information, item #2

She failed to check the computerized doctor's orders entered for Lisa's admission to Unit 5A when she received the phone call from the Emergency Department, when all patients admitted to the units from the Emergency Department have computer orders.

- The Kidcom system has been in use at the Hospital for Sick Children since 1993
- Children arriving on a ward from Emergency always have Kidcom computer orders placed in the system; if for some reason orders failed to arrive, it would be incumbent upon the nurse to phone the doctor to question him or her about them.
- All doctors orders for the wards are placed in the Kidcom computer system
- The written policy for the Kidcom system states that the doctor in Emergency should call up to the ward when a patient is being admitted. The current practice, in existence for several years, is for the nurse to call up. The reason for this change is that doctors frequently move around the hospital, go to sleep, go into surgery, etc., and it is far more consistent and reliable to have a nurse who is on a regular shift make this phone call.
- In Lisa's case, two different doctors - an Orthopedics resident and the Pain Service physicians - entered orders into Kidcom relating to her care. Neither of these doctors contacted the ward nurses.
- A phone call was made by an Emergency Department nurse regarding Lisa, and taken by Soriano.

- The Pain Service doctor who saw Lisa in Emergency, Dr. Schily, had been working at the hospital for approximately seventeen hours when he left for home around midnight, and he was due to return only a few hours later, early the next morning. He was not in the hospital when the Emergency Department nurse contacted the nurse on ward 5a. This is a perfect example of why the practice was changed, notwithstanding the written policies.
- Wards 5A/5B are general surgery wards that have regular admissions from Emergency and are experienced with the required routines
- Ward 5A/5B is the destination of choice for patients on PCA morphine pumps due to their expertise in this area.
- The CEO of the hospital, Michael Strofolino, personally advised me that he is not aware of any other instances where a nurse neglected to check the doctor's orders

The call up to the ward from Emergency is supposed to be taken by the nurse in charge of the patient. If another nurse assumes this responsibility, this other nurse, Soriano, should also assume responsibility for ensuring that the other admission requirements are completed, i.e. checking and activating the Kidcom orders.

Additional information, item #3 -5

She failed to read and follow the doctor's hand-written orders directing staff to read the orders in the computer system (kidcom orders).

She failed to read Lisa's chart from the Emergency Department which outlined her vital signs and medical history prior to admission to the unit.

She accepted responsibility for the care of Lisa when she knew little, if anything, about Lisa's situation and health status.

- The hospital's Emergency Department is not fully integrated into the Kidcom computer system
- Emergency Department orders are hand-written and are for use in Emergency only, a fact well-known by all ward nurses who deal with Emergency and emergency admissions.
- Emergency Department nurses have no access to the Kidcom system, so a notation in the Emergency Department orders to refer to Kidcom was a) specifically directed to the ward nurses, and b) an additional prompt or flag over and above the standard requirements.
- The page containing the doctor's hand-written orders consisted of nine lines only. In the middle of these lines was the sentence, "see Kidcom Orders"

The chart from Emergency consisted of only a few pages; it did not contain any prior period records. Whether Soriano was the nurse assigned to Lisa or not, Soriano was

Lisa's only nurse from 02:00 - 05:00, approximately three hours. Since we know that Doerksen did not read the Kidcom orders or check the Emergency chart, Doerksen obviously was unable to give Soriano a comprehensive report on Lisa. Therefore, it was incumbent on Soriano to have read through the Emergency chart when assuming responsibility for a patient for several hours. Had she done so, she would have seen the doctor's notes to refer to the Kidcom orders, and should have then activated and read them herself.

Soriano took full responsibility for almost three hours for a patient she knew nothing about. Since Doerksen knew nothing about Lisa, and went on a three hour break minutes after Lisa was admitted to the ward, it was actually Soriano who assumed responsibility for Lisa in deed if not in name.

She did not:

- read the Emergency chart
- check the doctor's orders,
- know whether or not the administration of any medications had been ordered,
- know or learn any information on the medications Lisa was concurrently on or their interaction with morphine

Lisa's respiration on admission to the unit was 16 breaths per minute. One hour later it was down to 8-10 breaths per minute. When Lisa came into the hospital, her respiratory rate as charted was 20. Lisa's blood pressure in Emergency was last charted as 106/84, and on admission to the unit it was 90/60. A diligent nurse who had read the emergency chart would have become very concerned about the serious decline in vital signs and greatly increased the level of monitoring.

Additional information, item #6-7

Self-explanatory

Additional information, item #8-9

She failed to check what medications Lisa had received in the emergency department and to evaluate the contraindications and interaction of these medications.

She failed to ensure that she had the knowledge, skill, and judgement required to evaluate the side-effects of the morphine and other medication administered, and to recognize when intervention was required.

- Lisa was taking three medications other than morphine - amitryptiline (a tricyclic antidepressant), gabapentin, and carbamazepine. According to the CPS,
*"Morphine should be used with caution and in reduced dosage in patients who are concurrently receiving other opioid analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, **tricyclic antidepressants***

*and other CNS depressants (including alcohol). **Respiratory depression, hypotension and profound sedation or coma may result.***"

- Amitriptyline is a highly sedating medication, and it is relatively commonly prescribed. Even without checking, Doerksen should have been aware of its sedating properties and its potential interaction with morphine. A competent nurse using her own clinical judgement would have increased the monitoring levels over and above what the doctor had ordered, instead of decreasing monitoring to significantly less than what was ordered.
- Gabapentin and carbamazepine, Lisa's other medications, are both used in the treatment of epilepsy, and less commonly for neuropathic pain. It would be unlikely for a nurse on a general surgery ward to have much if any knowledge of these medications. A competent nurse would have checked into these medications, their actions and interactions with morphine, and increased her monitoring of the patient. A competent nurse who did not check into these medications, aware that her patient was on medications that she did not know much about, would likewise in the default have increased, not decreased, her vigilance.

The most dangerous side effect of morphine is respiratory depression, which untreated can lead to death. All nurses should know this, but the nurses on ward 5A were supposed to be the most experienced in the hospital with morphine and patients receiving morphine via PCA pumps.

Where respiratory depression occurs in a sleeping patient who has received a very high amount of morphine, as Lisa had, the most important thing to do initially is to attempt to arouse the patient and assess her level of consciousness. This was not done, and the failure to do so demonstrated gross incompetence and/or extreme negligence.

Additional information, item #10

She failed to have the resources available to intervene when Lisa's condition deteriorated.

Respiratory depression in a patient on a high dosage of opioids calls for immediate medical attention, e.g. measurement of oxygen saturation levels, stat call for a physician, and possible administration of nalaxone. As Soriano was not sufficiently competent to assess her patient and determine that she was deteriorating, none of these resources or opportunities for intervention were available to Lisa.

Additional information, item #11-12

She failed to do a complete assessment of Lisa's vital signs when it was apparent that her vital signs had fluctuated beyond an acceptable level.

She failed to take action when patient's vital signs fluctuated beyond acceptable levels.

- Over the course of the evening, Lisa's heart rate - while sleeping - went from 90 in Emergency, to 72 on admission to the ward, to (as charted) 120, 130, 134, 126, 126. Blood pressure was taken on arrival to the unit at 01:45 and never again.
- Soriano's failure to take Lisa's vital signs in accordance with what had been ordered by the physician and equally by written protocol has been discussed above. However, regardless of that deficiency, once Lisa's vitals - the ones that *were* taken - were abnormal, any minimally competent nurse would at least then have taken a blood pressure, done a detailed respiratory assessment, attempted to awaken Lisa, and contacted the doctor. The Coroner's Pediatric Death Review Committee stated in its report that

"...Even though the monitoring was insufficient, that which was done demonstrated cause for clinical concern. The response to this monitoring by nursing staff was insufficient in the opinion of the committee - the tachycardia and the falling respiratory rate required timely medical attention."

- As discussed in item #8, it appears that the failure to do a complete assessment on Lisa was deliberate. Soriano clearly knew what constituted an appropriate vital signs assessment
- According to the doctor's orders and the mandatory PCA protocols with which Soriano was expected to be familiar, the doctor was to be notified when Lisa's respiration fell below 10-12. The doctor was not called. Was this also deliberate?
- Soriano documented "increased sedation" at 04:05, yet made no attempt to awaken Lisa
- At 04:15, Lisa's heartrate had increased to 134, and her respiration decreased to 10. Soriano did not take a blood pressure or contact a physician.
- She returned to the room five minutes later and recorded Lisa's respiration as being 16, 12. If she was concerned enough to come back in so quickly, why didn't she take any action? Why didn't she take Lisa's blood pressure? Why didn't she take her heart rate again, given that it was so extraordinarily high five minutes earlier?

Additional information, item #13

She failed to write nursing notes while responsible for Lisa's care for a period of time almost or equal to three hours, during which time her vital signs indicated a deterioration in her condition.

- The only nursing notes written while Lisa was alive were done within minutes after Lisa arrived onto the ward at about 01:45am (by the primary nurse, Doerksen)
- A second nursing note was done, post-mortem, at 09:00, almost two hours after Lisa was found vital signs absent (by the primary nurse, Doerksen)
- During the nearly three hours that Soriano looked after Lisa, Lisa experienced respiratory depression, fluctuations in respiratory rate and tachycardia, yet Soriano made no notes or documentation about them

- Two hours after assuming responsibility for Lisa's care, and long after orders and protocol dictated she do so, she paged and spoke to the pain service physician. She made a brief note indicating that she called him, "Pain Service aware..." but failed to document what she told the doctor or what his response and instructions were.
- It was a quiet night and no one was unusually pressed for time; no alarms sounded and there were no emergencies (other than Lisa), so Soriano had ample opportunity to write notes.

Additional information, item #14

She failed to notify the physician when the patient's vital signs deteriorated.

Soriano failed to take proper vital signs, so her ability to see when the patient's vital signs and condition deteriorated were diminished. However, to again quote the Coroner's Pediatric Death Review Committee, "...Even though the monitoring was insufficient, that which was done demonstrated cause for clinical concern. The response to this monitoring by nursing staff was insufficient in the opinion of the committee - the tachycardia and the falling respiratory rate required timely medical attention."

Lisa was clearly experiencing respiratory distress and tachycardia. The doctor should have been called to come in at 02:50 when the respiratory rate is recorded as 8,10 (down from 16 on admission, down from 20 in the Emergency Department). Even though Soriano was clearly too incompetent to recognize Lisa's medical crisis (or in the alternative, she recognized it and chose to ignore it), the PCA protocols should have applied.

Additional information, item #15

At 04:05, Soriano took a complete set of vital signs - heart rate, blood pressure, temperature, and respiratory rate - on a twelve-year-old child in the adjacent room who was relatively healthy, had not yet had any surgery, had received a very small dosage of morphine (only 2mg by IV many hours earlier), and was not on any concurrent medications. Per Lisa's nursing flowsheet, Soriano documented that she entered Lisa's room at the exact same time, 04:05, and took only one reading - Lisa's respiration.

She clearly knew the required protocols for all patients. Her failure to take Lisa's vital signs, especially given Lisa's respiratory depression and tachycardia, had to have been deliberate. She could not have forgotten basic nursing in one room and remembered it in the next one - at the same time. Knowingly and intentionally neglecting Lisa and failing to provide basic nursing care is a violation of everything that the profession of nursing stands for.

Additional information, item #16

She lied to the physician when she spoke to him at 04:05, by telling him that Lisa's vital signs were good and that Lisa was arousable. Most of Lisa's vital signs had not been taken, those that were taken were far from normal, and Soriano did not attempt to arouse Lisa.

Dr. Schily wrote a note recollecting the night's events immediately on returning to the hospital on October 22, 1998 (after Lisa had been pronounced dead). I believe what he says, and disbelieve everything that Soriano says.

- He wrote, "The nurse reported that Lisa's respiratory rate was just above 10 per minute. The nurse reported that all vital signs are good, that Lisa is arousable, and when I asked if she needs me to come to 5A to assess Lisa the nurse said that there is no need for coming. Again I reminded the nurse to look up saturation, and carefully check after sedation, respiration and all the other vital signs. I informed her that any further deterioration, especially problems with saturation, or sedation and respiration should be reported immediately to me. I asked the nurse to make sure that the PCA is off and to remove it from patients bed (it was stopped before that, as the nurse said), and follow up vital signs, check the saturation and respiratory rate and inform me if any further deterioration or need for reassessing of Lisa would be. I received no further calls during this night."
- Soriano made no notes about her conversation or any notation on the flowchart, except for "Pain Service aware of decreased respiration, increased sedation"
- The only vital sign that Soriano had taken for Lisa was her respiratory rate. She could not have reported anything to the doctor except that, or if she did, she was lying to him. A competent doctor (which Dr. Schily's orders clearly show him to have been), on hearing a nurse say that the patient's respiratory rate was 12, 14, would have said, and what about the other vital signs? He would not necessarily have asked for further information if he had been given the blanket statement that her vitals are good, assuming incorrectly that the nursing care was competent, vital signs were appropriately taken, and that the patient was on oxygen saturation as he had ordered.

Additional information, item #17

Soriano lied to her superiors when said she contacted a physician at 02:50; she did not.

- There is no notation in the flowchart that a doctor was called. A competent nurse always documents attempts to contact a doctor
- The doctor says he never received a page at 02:50
- When the doctor was paged at home by the nurse in the Emergency Dept. at approximately 00:30, he immediately responded.
- The hospital had access to a log of all outgoing calls from the hospital. If a call was made from the 5A nursing station to the pager at 2:50am, it would be recorded. No such evidence was ever supplied to "substantiate" this false claim.
- Had Soriano paged the doctor and he did not respond, she should have tried again or contacted someone else (the doctor's orders contain a list of alternates specifically in case the doctor cannot be reached).

- The doctor did receive a page from Soriano at 04:05. If asked, the doctor will advise that during that conversation, no reference was made to Soriano having tried to call him earlier.

Additional information, item #18

She lied to her superiors when she said that Lisa was on a corometric monitor when she was admitted to the unit and throughout the night; Lisa was not on a corometric monitor.

- There was no monitor brought into the room from the time Lisa was admitted to the ward, at least up to 02:00 when I went to bed. Soriano and Doerksen both state that the monitor was applied on admission to unit, by Doerksen. This is a lie.
- Doerksen delegated care of the 5A patients to Soriano no later than 02:00, and then was in the Constant Care Room which she was not allowed to leave. She could not have brought a monitor then.
- After Doerksen finished in the Constant Care Room, she left on break and did not begin charting on her patients (including Lisa) until 05:00.
- If a monitor was brought into the room while I was sleeping, sometime after 04:30, it was never turned on. The monitor emits a short burst of alarm when turned on as it cycles through a “self-test”. Such a noise would have awakened me instantly.
- There are 11 lines of data on the nursing flowchart, representing 11 times one or the other nurse was in the room. On five of those occasions, only respiration was noted. If there was a functioning monitor, why wouldn't the heart rate have been noted as well (particularly when it was rapidly increasing to dangerous levels)?
- There are 20 separate entries for heart rate and respiratory rate. Every one of them is an even number, which is exactly what you would get when taking these measurements manually. If you were taking them off a monitor, it is statistically almost impossible that every one of those 20 measurements would be an even number.

I believe that the other nurse, Doerksen, brought a corometric monitor into the room and attached it to Lisa when Lisa was already dead, at approximately 07:00 when Doerksen was doing her regular nursing checks. I believe that Soriano conspired with Doerksen to fabricate the story about the corometric monitor being used throughout the night. I believe that since neither Doerksen nor Soriano voluntarily notified their superiors that they had not read the doctor's orders or followed the mandatory PCA protocols, their actions were dishonest and deceitful, and the falsehoods about the monitor concocted in an attempt to hide or minimize the evidence of their negligence.

Additional information, item #19

She falsified the nursing flowsheet.

I believe that:

- The major change in the rewritten chart was the removal of blood pressures (minor changes included among others the addition of 'os', and changing the time that the temperature was taken from 04:05 to 05:00). The nurses were pressed for time, and they were afraid that if they made too many alterations they might be detected.
- Lisa's blood pressure was taken one or more times in the night after 01:45 and was seen to be dangerously low, although no blood pressures are shown on the chart except for the one taken at 01:45 on admission to the unit.
- Doerksen and Soriano, knowing that their care had been negligent, decided that the sin of omission would be less serious than the sin of commission. The most obvious indication on the flowchart that Lisa was in medical distress would have been her falling blood pressure. Fluctuations in heart and respiratory rates could be explained away as still falling within normal ranges (they thought), but not so with a dropping blood pressure. Therefore, if they rewrote the chart and removed the blood pressures, they might get in trouble for failing to take all the vital signs, but could not be accused of charting and ignoring obvious signs of medical crisis. Their actions would be seen as stupid, but not negligent, which is by far the lesser "crime".
- I further believe that analysis of the other patient charts would show that all of them except Lisa Shore had their blood pressures taken at or around 04:05 by Soriano.
- The temperature charted by Doerksen as taken os (by mouth) at 05:00 was not taken at that time, and was added in the revised version. Lisa was such a sound sleeper, even without any medications, that she would sleep through alarm clocks. The amitriptyline that she took was prescribed largely for its sedative abilities, so she could sleep at night even though she was in pain. It would have been impossible to awaken Lisa that night - assuming that she was not already near death - without screaming in her ear and shaking her vigorously. And had she been successfully awakened, Lisa would have opened her eyes and then gone right back to sleep, unable to hold a thermometer in her mouth.
- I believe that this temperature was taken at 04:05 (by ear, and not by mouth) by Soriano – along with blood pressure – when Soriano did her rounds on all the patients. I believe that the 04:05 temperature was moved to 05:00 in the revised chart in order to make it look as if Doerksen was doing an adequate assessment at 05:00. The hospital, in response to our question as to why Lisa did not have her blood pressure taken, said that perhaps the nurses did not want to wake her up. How could Doerksen have awakened Lisa to take an oral temperature, yet "not want to wake her up" to take her blood pressure?
- I believe that Soriano was intentionally dishonest and deceitful, and that the chart was falsified in an attempt to hide or minimize the evidence of her negligence.

A forensic document examination will be conducted at the Centre for Forensic Science at the end of August 2000.

Additional information, item #20

She did not voluntarily report her failure to follow nursing practices and protocols to Mary Douglas, the nursing-educator for ward 5A, or to Dr. Jean Reeder, Chief of Nursing, or to any other nurse superiors...

Self-explanatory

Additional information, item #21

She failed to initial or sign the patient flow sheet.

Self-explanatory