

NAME OF INTERVIEWEE: Dr. Alan Goldbloom, Senior Vice President, Clinical & Academic Affairs

PLACE OF WORK: The Hospital for Sick Children

DATE INTERVIEWED: September 6, 2000

INTERVIEWED BY: C. Flear, CNO Investigator

PRESENT: Cathy Seguin, Vice President, Surgical Services

INTERVIEW SUMMARY: In Person

RE: **Anagaile Soriano, RN, Ruth Doerksen, RN**

Background Information:

At the time of the death of Lisa Shore, Mary Federau was the Vice President of Child Health Services, and was in charge of clinical services. Ms Federau is no longer employed at the hospital. Dr. Goldbloom took over responsibility for the clinical areas in January 2000. Cathy Seguin was the Director of the Surgical Program at the time. The Child Health Services Manager of Unit 5A was Bill Kreutzweiser. Mr. Kreutzweiser did not have a nursing background. He worked for the hospital until the end of the inquest into the death of Lisa Shore, but is no longer employed at the hospital.

There are two streams of reporting for nurses at the hospital. Child Health Services is divided into programs. Therefore, nurses working on Unit 5A reported to Bill Kreutzweiser as Child Health Services Manager, who reported to Cathy Seguin, Director of the Surgical Program, who then reported to Mary Federau, Vice President of Child Health Services. Dr. Jean Reeder was the Chief of Nursing. She was not in a line position in relation to the nurses working on the units. However, she was responsible for nursing standards and nursing education.

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Broad Overview of the Factors that Contributed to the Hospital's response to the Death of Lisa Shore:

It is Dr. Goldbloom's understanding that Mrs. Shore believes that the hospital did not adequately investigate the circumstances surrounding the death of her daughter, Lisa.

Several factors influenced the hospital's approach to the investigation. These factors included:

Having been admitted for pain management, Lisa's death was completely unexpected, and occurred on a unit which very rarely has dealt with deaths. Her death was a huge shock to the staff, and the staff was not well prepared for dealing with the immediate and longer term issues arising from the tragedy.

- Since Lisa's death was unexpected, the coroner's office was called right away. The coroner conducted the autopsy and seized the PCA pump used for Lisa. The hospital stepped back, thinking that the coroner's office would handle the investigation into her death, and would ask all of the right questions. They believed they had to wait for the results of the coroner's investigation, such as the toxicology results, before they could act. It was their understanding at the time, that they should not be involved in any kind of a separate investigation in order to not interfere with the coroner's investigation. Because most of the information, including autopsy results, was with the coroner, there was little the hospital could say about the circumstances of Lisa's death. As a result, the parents were left out of the loop since the hospital assumed that the coroner's office would be communicating with them.
- Many people at the hospital were thinking that Lisa's death was related to the Morphine infusion she received; that she probably died from a Morphine overdose, and concerns about nursing care were not immediately apparent.
- The hospital did not realize until January 1999, that the admitting orders written for Lisa's admission to Unit 5A had not been opened yet, that they were still suspended in the system. The anaesthesia department were doing their review regarding Lisa's death when they discovered there were no doctor's orders in her chart. They then realized that the orders had never been printed. This came as a surprise that orders could remain suspended with no prompt that they had not been opened. Lisa's death brought this flaw in the system to light.
- The coroner's office had the original copy of Lisa's chart. The hospital believed that they did not have access to her chart. They have since met with the coroner's office and realize that they could have made a copy of the chart for their own review.

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- The anaesthetists (pain team) did not have admitting privileges at the hospital. Therefore, Lisa was admitted to the orthopaedic service, even though the orthopaedic service was not directly involved in her pain management for this admission. When orthopaedics were making rounds on 5A on the morning that Lisa was found dead, they had not seen her prior to this point in time in this admission. The anaesthetists and the pain team now have admitting privileges.
- The nurses on Unit 5A\B have a lot of experience with the administration of narcotics through the use of a PCA pump. Most of the patients with PCA pumps on the unit are post-operative orthopaedic patients. Very few patients are admitted for management of chronic pain; most of these patients are managed on an outpatient basis. Lisa was a different kind of admission from the type of patients usually seen on the unit. She was experiencing a lot of pain, and was on a number of other medications already. Her diagnosis of Reflex Sympathetic Dystrophy (RSD) was somewhat uncommon, although rheumatology did see a number of these patients. Patients with this diagnosis have pain that is very difficult to treat.

The above factors may have influenced the actions taken by hospital staff after Lisa's death. The possibility that there were errors in the nursing care provided to her did not arise. It was not until the following August (1999) that the hospital learned from the coroner's office that the Morphine levels were within therapeutic levels. While waiting for the coroner's report, practices on the unit regarding the use of the corometric and apnea monitoring of patients on PCA pumps were reviewed. For example, in the past, the anaesthetists did not always order both forms of monitoring.

The nurses involved with the care of Lisa that night indicated that there was a corometric monitor attached and running. Ms Soriano and Ms Doerksen stated there was a monitor. Mary Douglas, Nurse Educator, said she saw the monitor in the morning. Everyone was focused on attempting to resuscitate Lisa. The coroner's office did not ask for the corometric monitor. Within 24 hours of Lisa's death, it was realized that the monitor had not been seized by the coroner's office. However, by this time, the monitor was no longer available in Lisa's room since it had gone for cleaning. As a result, all of the corometric monitors used at the hospital were tested; such things as their alarm settings were looked at. None of the monitors were found to be malfunctioning.

Dr. Goldbloom noted that Dr. Yee, an orthopaedic resident who was present at the resuscitation, commented that there was a presence of electro-mechanical disassociation (EMD). This can only be seen if looking at a monitor. Another doctor testified that there was a monitor in the room, but that it was not alarming.

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Ruth Doerksen and Anagaile Soriano have been on paid leaves from the hospital since the start of the inquest. They remain on leave as a result of the finding of homicide at the coroner's inquest.

Regarding the Internal Investigation Conducted by the Hospital:

The Nurse Manager of 5A failed to debrief the staff who cared for Lisa that night. If he had done so, perhaps some issues regarding the care they provided may have come to light. However, the staff on Unit 5A were accustomed to using PCA pumps. Ruth Doerksen had several years of experience and was very aware of the protocol to be followed when a narcotic was administered with the use of a PCA pump. Even without looking at the admitting orders, Ms Doerksen already knew what nursing measures were required because she knew the protocols well. Anagaile Soriano did relieve Ms Doerksen for a period of time that night. By their charting, the nurses caring for Lisa that night, appeared to have done an assessment every hour. No one suspected any problems with the practice of the nurses caring for Lisa that night.

The anaesthesia department did their own review of Lisa's death in January 1999. When no admitting orders were found on the chart, it was then that it was discovered that the admitting orders for Lisa were still suspended (unopened) in the system. This was the first clue that something was wrong. Up to this time there had been no formal review of Lisa's death by the nursing department. Dr. Reeder had not been involved in any type of follow-up. Problems regarding the nursing care provided to Lisa needed to be identified before the Chief of Nursing would have been notified.

The unopened admitting orders alerted people to the possibility that there may have been some nursing issues regarding the care provided to Lisa the night of her admission to Unit 5A. However, the hospital believed that an investigation of their own would be inappropriate at this time, since they were in the midst of a civil suit and a coroner's inquest. Also, they trusted that the coroner's office would review the care provided to Lisa that night and would communicate with the family. The hospital learned later that the latter (communicating with the family) was not done in a timely fashion.

The hospital always suspected that Lisa had died from a Morphine overdose and was awaiting information from the coroner's office that would or would not confirm this. Dr. Goldbloom noted that they still do not know the cause of Lisa's death. The autopsy showed therapeutic levels of Morphine in her system.

When asked by this investigator, Dr. Goldbloom indicated that very few children died of a Morphine overdose at the Hospital for Sick Children. There were no errors in the administration of medication to Lisa that night. However, the combination of drugs received by Lisa prior to her arrival on Unit 5A was very unusual.

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When asked by this investigator, Cathy Seguin indicated that the expectation is that the nurse in the emergency department would give a verbal report over the phone to the unit receiving a patient being admitted to the unit. The ER nurses do not always accompany the patients when they are transported to the admitting unit.

Steps Taken by the Hospital Since the Coroner's Inquest:

The hospital has reviewed its policies and procedures to prevent a reoccurrence of a lack of an internal investigation in the future. For example, a patient monitoring taskforce met in August 1999 to look at the issue of the use of monitors and equipment. The task force issued a full report with recommendations. The hospital believes that no other paediatric centre had done this type of review. They are now in the process of piloting the recommendations on a couple of the wards at the hospital. Dr. Goldbloom will provide a copy of these guidelines.

The hospital also reviewed the handling of critical incidents, especially on units that were not accustomed to such events occurring. They produced a flow sheet that indicates specific issues that could arise, and identifies the steps to be taken in dealing with these issues. The specific chain of accountability is clarified as part of this flow sheet. With the use of this flow sheet, they have attempted to better attend to the needs of the families involved.

The jury at the coroner's inquest has made 33 recommendations, most of which were directed at the Hospital for Sick Children; some recommendations were made in regard to the coroner's office as well. Different staff and committees from various areas of the hospital have been assigned to develop responses to the specific recommendations. In light of these recommendations, they have been asked to review and make changes to policies, clinical care, staffing, and to the computer system. The suggested changes in policies and practices have been forwarded to the coroner's office, and most have already been implemented.