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June 28, 2001

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Health Professions Appeal and Review Board
151 Bloor Street West
9th Floor
Toronto, Ontario
M5S 2T5

**Re: Complaint Review - Nursing
Dr. Jean M. Reeder, R.N. and Sharon Shore
Board File No. 6617**

Attached are Dr. Reeder's written submissions for the consideration of the Board hearing the review (Tab 1). Also attached is a copy of the Professional Standards of the College of Nurses of Ontario as referred to in Dr. Reeder's submission (Tab 2).

As Dr. Reeder's counsel, I respectfully make the following submissions on her behalf:

Dr. Reeder's Review of the Findings Against Her on Allegations 7 & 8

Dr. Reeder does not challenge the adequacy of the College's investigation. The College investigator met with the President, Senior Vice-President and the Vice-President of Surgical Services (Record pp.112-120). In particular, the Vice-President of Surgical Services (Cathy Seguin) was Director of Surgical Services at the time of Lisa's death. Ms. Seguin was directly involved in the investigation of the care provided by the nurses in question.

Dr. Reeder respectfully submits that the decision of the Complaints Committee is unreasonable for the following reasons:

1. It suggests that she had a direct, personal obligation to investigate the death of Lisa Shore. This ignores the executive/management structure of the hospital and the fact that Lisa's death was investigated by others in the management team, including Ms. Seguin. As Chief of Nursing, it was not Dr. Reeder's responsibility to personally investigate allegations of substandard nursing care. She had a responsibility to ensure that these allegations were investigated, which she did and which investigation was conducted in this case.

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2. The College concluded that Dr. Reeder had not acted appropriately in the interest of other patients by not investigating personally, specifically suggesting that by failing to do so, she may have placed other patients at risk. This ignores the unchallenged evidence of Dr. Reeder of the many steps she took to determine whether it was appropriate for the nurses to continue to practice.
3. In coming to a decision that Dr. Reeder had to personally undertake this investigation, the College ignored the evidence of the hospital's President, Senior Vice-President and Vice-President of Surgical Services as to how the executive/management of the hospital was organized and how the investigation of this case was conducted. These executives made no criticisms of the role taken by Dr. Reeder.
4. The College came to its own conclusion about how a nursing executive should function, contrary to all of the evidence before it. This exceeds the College's jurisdiction, which is to make a decision based on the evidence before it. There was no evidence to suggest that Dr. Reeder had this personal non-delegable obligation. As well, based on publicly available information, none of the Complaints Committee members are listed as having executive or management responsibility, such that they had relevant experience or expertise with which to judge Dr. Reeder's actions.

Dr. Reeder accordingly submits that the decision of the Complaints Committee respecting allegations 7 & 8 should be set aside as unreasonable and the College directed to dismiss these complaints with no further action taken.

Mrs. Shore's Review Request of Allegations 1, 2, 3, 4, 5, 6, & 10

Mrs. Shore accepts the adequacy of the College's investigation, noting in her March 5, 2001 letter that the investigation was "commendably" thorough.

Therefore, the only issue is the reasonableness of the decision which was made by the College. Dr. Reeder submits that the decision to dismiss these complaints was reasonable and based on a careful analysis of all of the evidence before the College.

Mrs. Shore's essential complaint seems to be that the nursing care provided to Lisa was so substandard that no decision other than terminating the nurses and reporting them to the College could be supported. In making this allegation, Mrs. Shore does not provide any new evidence to the Board. The College appropriately considered all of the evidence and concluded that there was a reasonable basis for Dr. Reeder to have acted as she did. The College properly did not resolve the conflict between



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Mrs. Shore and the nurses as to what happened that night, but rather looked at the basis for Dr. Reeder's actions following Lisa's death and whether there was some reasonable basis on the evidence available for Dr. Reeder to have acted as she did. The Committee correctly concluded that there was a reasonable basis based on the information provided by Dr. Reeder and the other executives at the Hospital.

Dr. Reeder accordingly submits that Mrs. Shore's review should be dismissed.

Yours very truly,

PJH/hb

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JEAN M. REEDER, Ph.D., R.N., F.A.A.N.

June 28th, 2001

Health Professions Appeal and Review Board
151 Bloor Street West
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**Re: Complaint Review - Nursing
Dr. Jean M. Reeder, R.N. and Sharon Shore
Board File No. 6617**

While I will be attending at the Board Hearing on July 16, 2001, I wanted to provide the Board with brief written comments in support of my review request and also in answer to Mrs. Shore's review request.

Background

At the relevant time, I was Chief of Nursing at the Hospital for Sick Children. This was an executive level position, in which I was responsible for leading the practice and profession of nursing at the hospital. This was not an operational or traditional line position. I was not responsible for nurses working on the units, but rather acted as the principal consultant and advisor to the President and CEO. I collaborated routinely and regularly with the Vice-President for Patient Services and her subordinates, who directed the patient care operations provided by all clinical staff, including registered nurses.

Mrs. Shore's allegations relate to my involvement in the investigation and legal proceedings following the death of her daughter Lisa on October 22, 1998. In this regard, there are certain unchallenged facts which I wish to bring to the Board's attention. This is based on my recollection, as supported by the College's interviews of the Hospital's President and Senior Vice-President (Record, pp.112-120):

- I had no involvement with Lisa or her parents while Lisa was a patient at the Hospital. I had no knowledge of her at any time prior to her death.
- While I was made aware of Lisa's death shortly after it occurred, I was initially told that the death was thought to be due to a morphine overdose and that the pain service was appropriately looking into it. It was not until late February 1999 (i.e. 4 months later) that I was made aware that there were nursing issues associated with her death. To that point, senior management and the executive team at the Hospital collectively thought that the death

was due to a morphine overdose and that it was being investigated by the Coroner's office.

- As soon as I was made aware that there were nursing issues, I took various steps to ensure that the nurses involved in Lisa's care were safe practitioners. They had not previously been taken off duty as a result of Lisa's death. I needed to assure myself that there was no need to take action pending the investigation and legal proceedings. My specific actions are detailed in my interview with the College investigator (Record, pp.504-10) and my written response (Record, pp.603-17). In summary, I did the following:
 - reviewed Lisa's hospital chart with one of the pain service nurse practitioners.
 - met with nurses Doerkson and Soriano, initially on March 1, 1999 and subsequently on a number of occasions
 - reviewed the personnel of files of these nurses
 - met with their director, manager, nurse educator and several of their colleagues
 - kept in regular contact with these nurses and other nurses on their floor throughout the investigation and legal proceedings

Based on all of these inquiries, I was satisfied that the nurses were safe practitioners and that there was no need to take action pending the investigation. Their personnel files demonstrated satisfactory performance in the past. The opinion of their director, manager, educator and colleagues was that they were safe practitioners. From my own meetings with them, they were clearly devastated by the tragic death, had learned much from it and continued to engage in reflective practice.

The College's Decision to Caution Me Respecting Allegations 7 & 8

I responded to these two allegations jointly in my written response (Record, p.615-6).

Both allegations relate to the investigation that was conducted at the Hospital following Lisa's death. Mrs. Shore alleges that no investigation was conducted into the nursing care provided to Lisa (Allegation No. 7) and the Hospital did not do any investigation into the nursing care provided by the two nurses to other patients on the same shift (Allegation No. 8). Against me, she alleges that, as Chief of Nursing, I should have either conducted the investigation or ensured that one was conducted.

The College concluded that I had a professional obligation, as the Hospital's Chief of Nursing, to conduct a thorough investigation of the matter and specifically to conduct an investigation of the nursing care provided by the named nurses to other clients. The College's conclusion is, therefore, that I had a personal, professional obligation to conduct the investigation myself. In my view, this

conclusion is unreasonable as it ignores the evidence provided by myself, Mr. Strofolino and Dr. Goldbloom as to the management structure of the Hospital and how the investigation of Lisa's death was undertaken. It also ignores the College's own professional standards for nurses acting in administrative roles.

As Chief of Nursing, I was not directly responsible for managing or directing the nurses involved in caring for Lisa. As staff nurses, they reported to a Child Health Services Manager, Bill Krutzweiser, who was not a nurse. In turn, he reported to the Director of Surgical Services (Cathy Seguin), who was a registered nurse, and she reported to the Vice-President of Child Health Services (Mary Federau), who was not a nurse. As per my job description (Record, p.513-5), my role was to provide strategic direction and leadership, to promote and improve the practice of nursing at the Hospital. In any situation involving the practice of a specific individual nurse, my role was consultative and I worked together with their educator, manager, director and the Vice-President within the management structure of the Hospital. All of these people, with the exception of the Vice-President, were below me in the chain of command under the Vice-President's line of authority.

In making the decision to caution me, the College has indicated that I had a personal obligation to investigate. This is contrary to the management structure of the Hospital. It ignores the evidence which I gave, which was uncontradicted and was supported by Dr. Goldbloom and Mr. Strofolino. The direct responsibility for conducting this investigation rested with other people at the Hospital. As Chief of Nursing, I had a responsibility to ensure that such an investigation was conducted, but I was not responsible to personally conduct it. I was satisfied that the investigation was being conducted. The evidence is that there was an investigation conducted by others at the hospital and that actions were taken to improve monitoring policies, documentation, staff education, etc. (Record, pp.643-5).

As well, as Chief of Nursing, I had a responsibility to determine whether the nurses were safe practitioners and whether or not they could continue to practice pending the investigation. As summarized above, I made a number of reasonable and appropriate inquiries. This was my foremost duty and I did it.

The College also specifically criticizes me for not personally reviewing the care provided by two nurses to other patients that night. As set out above, the direct responsibility for the investigation into the circumstances of Lisa's death rested with other people at the hospital. Rather than focussing on the specifics of that care, which others were doing, what I focused on was the general practice of the nurses in question and whether they could continue to work. This involved reviewing their personnel files and consulting with their colleagues and supervisors. They were satisfied and I was satisfied that the nurses could continue to practice.

As I read the letter of caution drafted by the College, I maintain that I did everything which they have set out in that letter of caution. As soon as I became aware that there were nursing issues, I made sure that an investigation was being conducted and made sure that the nurses were safe practitioners.

The College's standards for nurses in administrative roles require that we create and maintain environments that are conducive to meeting professional practice standards and that we monitor the application of professional standards. In my involvement with Lisa Shore's death, this is precisely what I did.

Mrs. Shore's Review of Allegations 1, 2, 3, 4, 5, 6 & 10

Mrs. Shore has requested a review of all other allegations against me.

For reasons detailed in my interview with the College investigator and my written response, I disagree with her allegations and maintain that these complaints should be dismissed.

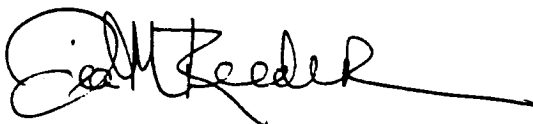
In reference to all of these allegations, Mrs. Shore's essential complaint is that I supported the nursing staff, instead of disciplining or terminating them. My response to this allegation is that, as Chief of Nursing, I must both support the nursing staff and taking action regarding their errors. The two are not opposites. While I must recognize and deal appropriately with the errors, which I believe I did, I must also provide support to the nurses as colleagues and employees when they are involved in very stressful legal proceedings.

I do not, and have not at any time, condoned or defended the nurses' actions. I recognize that they made serious errors. I have stated this publicly and privately to the Shores. I have also explained the steps that the hospital has taken to help them improve their practice and ensure that they are safe practitioners. However, recognizing and stating this does not take away from my duty to support them as colleagues and people. I believe that I can and must do both.

As I stated numerous times to the College investigator and in my written response, I have always known that there are two different versions of the events that occurred that night. I cannot resolve that conflict. I submit that I acted reasonably based on the evidence available to me. My actions were supported by the management and executive team at the hospital. Even if Mrs. Shore disagrees, there was reasonable and credible evidence to support the decisions that were made. These decisions involved myself and many others at the hospital, collectively deciding what to do. I still believe that we made appropriate decisions.

I would accordingly ask that Mrs. Shore's review be dismissed.

Sincerely,

A handwritten signature in black ink, appearing to read "Jean M. Reeder", with a long horizontal line extending to the right.

Jean M. Reeder, Ph.D., R.N., F.A.A.N.