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March 9, 2001

Ms. Abby Katz Starr  
Registrar  
Health Professions Appeal and Review Board  
151 Bloor Street W., 9<sup>th</sup> floor  
Toronto, ON  
M5S 2T5

Re: Ms. Mary Douglas, RN, and the College of Nurses of Ontario

Dear Ms. Starr,

I am appealing the February 8, 2001 decision of the Complaints Committee of the College of Nurses of Ontario with respect to Ms. Mary Douglas, as set out in the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c.32. I received notification of this decision by mail on Monday, February 12<sup>th</sup>; submission of this appeal therefore falls within the allowable thirty-day period.

On August 10, 2000, I submitted seven allegations regarding Ms. Douglas to the College of Nurses of Ontario. These allegations concerned Ms. Douglas's actions and omissions in relation to a) the care that two nurses on the ward on which she worked provided to my deceased 10-year-old daughter, Lisa Shore, at the Hospital for Sick Children, and b) her conduct as a spectator at a Coroner's inquest. The Complaints Committee found that only one of the seven allegations raised significant concerns about Ms. Douglas's practice, and has issued a written letter of caution to her in that regard.

I am appealing the decision of the Complaints Committee because in my opinion it does not adequately reflect the severity of Ms. Douglas's professional misconduct.

The reasons I believe that the Committee reached an inappropriate decision are as follows:

- a) Some of its analyses were flawed;
- b) Some of its conclusions did not accurately reflect the facts;
- c) The Committee did not take into account the fact that the two nurses on the ward on which Ms. Douglas was the Nurse-Educator (and whose actions directly relate to the substance of my allegations against her) have been sent to discipline by the

College of Nurses of Ontario. Had it considered this information when evaluating Ms. Douglas's conduct and credibility, it would have reached different conclusions;

- d) The Committee did not take into account the fact that a coroner's inquest jury – a group of 5 laypersons - on learning of the actions and omissions of the two nurses on the ward on which Ms. Douglas was a Nurse-Educator, found that my daughter's death was a homicide. Had the Committee taken this information into account, its evaluation of Ms. Douglas's conduct and credibility would have led it to reach different conclusions.

Detailed information is attached. The original allegation is presented first, followed by the member's response, the Committee's views, and lastly the basis for my appeal.

Yours truly,

A handwritten signature in cursive script that reads "Sharon Shore".

Sharon Shore

cc: Paul Howe, RPN  
Chairperson, Complaints Committee  
College of Nurses of Ontario

**Incident #1 (excerpted)**

**“...If competent as a nursing-educator, Douglas would have seen that the care provided to [Miss L.S.] by [Ms. R.D.] and [Ms. A.S.] was grossly substandard...”**

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

**Incident #2**

**“Douglas failed to notify the College of Nurses of Ontario of the grossly substandard and/or negligent care provided by [Ms. R.D.] and [Ms. A.S.] to [Miss L.S.], which as a nursing-educator she was ethically and morally bound to do.”**

**Member’s response, incident #1 (excerpted):**

*...Based on the information available to her at the time, Ms. Douglas asserts that she had no reason to think that the care provided to Miss L.S. was “grossly substandard” ...*

*...Ms. Douglas was aware that Ms. R.D. had discussed the case with the appropriate management authority, the Unit’s Nurse Manager, Mr. B.K. She claims that it would have been Mr. B.K.’s responsibility, in turn, to make any necessary report to the Chief of Nursing...*

**Member’s response, incident #2:**

*Ms. Douglas indicates that she has never concluded that the care provided by Ms. R.D. and Ms. A.S. to Miss L.S. was “grossly substandard and/or negligent.”*

**Committee’s views, incident #1:**

*The Committee notes that the information available at the relevant time did not cause the member to be concerned that nursing care issues had contributed in any way to the death of Miss L.S. Moreover, there is no information to support the complainant’s contention that it was the member’s responsibility, as a Nursing Educator, to investigate nursing care issues or to take disciplinary steps against nurses.*

**Committee’s views, incident #2:**

*The Committee believes that the member’s assertion that she never concluded that the care provided by the named nurses was substandard or negligent is a complete answer to this alleged incident. However, the Committee would emphasize that, as part of their commitments to clients and to the nursing profession, nurses have a professional obligation to report incidents of unsafe practice or unethical conduct to their employers or to the College of Nurses.*

**Basis for appeal, incidents #1 and #2:**

*Ms. Douglas asserts that she had no reason to think that the care provided to Lisa Shore [Miss L.S.] was “grossly substandard” based on information available to her at the time.*

The Committee believes that since she had no concerns, there was no onus on her to report the nurses. The emphasis by Ms. Douglas and the Committee on the phrase "at the time" has led the Committee to a misinterpretation of the allegation and to a flawed conclusion.

At the Coroner's inquest which began in November 1999, Ms. Douglas in her testimony reviewed and commented on the nursing flowchart and other documents from Lisa Shore's medical chart. Ms. Douglas had been presented to the inquest by the Hospital for Sick Children as its nursing expert. Her lawyer – who also represented the Hospital for Sick Children - would have objected strenuously to Ms. Douglas giving her opinions on the nursing flowchart, unless she was presumed to be expert enough to do so. Although her inquest testimony is not the subject of discussion, it should be noted that in order to offer any opinions, Ms. Douglas was either already familiar with or became familiar with key documents in Lisa's medical chart and with the circumstances of Lisa's death. In addition, Ms. Douglas attended the twenty-one day inquest each and every day. She saw the same evidence presented and heard the same testimony that led the jurors to find that Lisa's death was a homicide.

When Ms. Douglas claimed she did not have enough information *at the time*, which "time" was she referring to? Lisa Shore died in October 1998. The Coroner's inquest began in November 1999 and concluded in February 2000. My complaint to the College was filed in March 2000 (and amended in August 2000). The Committee should reconsider whether Ms. Douglas was in possession of sufficient information *at any time* prior to the submission of my complaint to establish whether Ms. R.D. and Ms. A.S.'s nursing care met or fell below acceptable nursing standards. The Committee should not allow itself to be misled by Ms. Douglas's deliberately vague statements such as "based on the information available to her *at the time*."

Among the facts that Ms. Douglas knew *at the very latest* by the time of the inquest were the following:

- the nurses failed to access or read the doctor's orders at any time while they cared for Lisa
- the nurses failed to follow the hospital's written protocols for patients on PCA morphine pumps, with which they were expected to be familiar
- the nurses failed to take mandatory vital signs
- when Lisa died, no alarms sounded from the heart and respiration monitor that Ms. R.D. told Ms. Douglas she had attached to Lisa.
- Ms. R.D. had told Ms. Douglas that she had turned off the apnea (respiratory) alarm on the monitor that Ms. R.D. alleged she had attached to Lisa.
- Ms. Douglas knew or learned from the pathologist's inquest testimony that Lisa appeared to have died as a result of respiratory depression leading to cardiac arrest.

The monitor was a major issue at the inquest; the Hospital for Sick Children ultimately agreed that "if there was a monitor attached to Lisa, it was not on when she died". Therefore, it had either been turned off prior to her death, or (as is my contention) it was never used in the first place. If the monitor had been on and functioning, one or more alarms would have sounded when my daughter's heart and respiration stopped, because two of the machine's three alarms could not be disabled or turned off if the machine was functioning properly.

Ms. Douglas never at *any* time concluded, according to her statement of defence, that the care provided by Ms. R.D. and Ms. A.S. was grossly substandard and negligent. Wholly aside from the inquest jury's finding of homicide, the College of Nurses has decided to send the two nurses in question to Discipline, alleging that they failed to meet the standards of practice of the profession, and that their conduct was disgraceful, dishonourable and unprofessional. Even the (former) Chief of Nursing has reluctantly acknowledged that R.D. and A.S. made "errors in judgement".

The above information all relates directly to nursing practice and standards. The Committee's acceptance of Ms. Douglas's assertion that she never concluded that there was any substandard practice is hard to comprehend. In effect, the Committee is saying that ignorance - whether in good faith or in bad faith - is a valid defence for not upholding the standards of the profession. In criminal law, for example, the standard to which a defendant is held is that of "a reasonable person". Would a reasonably competent Nurse-Educator, knowing what Ms. Douglas knew or ought to have known, have acted as she did? Ms. Douglas's failure to conclude that the nurses' care was substandard or unsafe reflects an unimaginable degree of incompetence on her part - or a wilful disregard of nursing standards, practices, and patient safety - for which the College should hold her accountable. Furthermore, her inability to differentiate between acceptable and substandard nursing care calls into doubt her competency as a "nurse-educator", an individual who is responsible for educating and training other nurses.

It is also my contention that in light of the information known by Ms. Douglas, she had a duty to report Ms. R.D. and Ms. A.G. to the College of Nurses of Ontario. Her failure to do so showed that she placed the interests of her nursing colleagues ahead of concerns about patient safety. It is my belief that her claim that she had no responsibility to report Ms. R.D. because Ms. R.D. had discussed the case with her manager is an unacceptable defence. Ms. Douglas was not a party to the discussion between Ms. R.D. and her manager and therefore could not know what Ms. R.D. had told him nor what action he would take, if any. It is also foolhardy to assume that a nurse who may have engaged in unsafe or substandard nursing practice would necessarily be completely truthful in explaining her actions to her manager. Furthermore, this manager was not a nurse and was not accountable to the College; he was an administrator who may not have even understood nursing practice issues. Ms. Douglas's reference to Mr. B.K. as the "Unit's Nurse Manager" implies he was a nurse and is therefore deliberately misleading. It was Ms. Douglas's responsibility as a registered nurse and a nursing-educator to ensure that patient safety was paramount, a responsibility she cannot abdicate to someone who is not accountable to any regulated health profession body. Ms. Douglas failed to take

obligatory reporting steps and should be held accountable by the College of Nurses of Ontario.

**Incident #3**

**Accepted; no appeal**

**Incident #4:**

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

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

**Member’s response (excerpted):**

*Ms. Douglas explains that it is common practice for nurses and other health care staff to touch pieces of equipment during the clean-up following the death of a client...*

*...With respect to incident #4, Ms. Douglas indicates that she was aware that the Coroner had been called and that Miss L.S.’s room had been sealed off for purposes of the Coroner’s investigation. The monitor was in the sealed room, and Ms. Douglas claims that she was entitled to expect that the Coroner would undertake whatever investigations were appropriate under the Coroner’s Act, including all aspects of the care of equipment, including the monitor.*

*Ms. Douglas further indicates that she was aware that Ms. R.D. had documented in her nurse’s notes the use of the monitor and had reported to her Manager that she had turned off the apnea alarm. Ms. Douglas states that HSC Management would have taken whatever steps were appropriate to investigate the monitor. The action suggested by the complainant would not have been appropriate for the Nurse Educator...*

*Ms. Douglas states that it was fortunate that she visually reviewed the settings on the Corometric monitor before the monitor was put back into general circulation...*

**Committee’s views:**

*With respect to Incident #4, the Committee believes that was not the member’s responsibility, as a Nurse Educator, to make any recommendations regarding potential problems with, or the future use of, the Corometric monitor. In any event, there is no information to indicate that the member had anything to do with the decision to place the monitor back into general circulation at the Hospital.*

**Basis for appeal:**

The Committee does not understand the substance and seriousness of my complaint and the degree to which patient safety was compromised by Ms. Douglas's failure to act.

The circumstances that Mary Douglas would have been aware of on the morning of Lisa Shore's death were as follows:

- Lisa had died unexpectedly and for reasons unknown
- Ms. Douglas knew that Ms. R.D. claimed to have placed Lisa on a heart and respiration monitor (a "Corometric" monitor) which she said was on and functioning all night
- Ms. R.D. told Ms. Douglas that she had turned off the apnea (breathing) alarm on the Corometric monitor.
- Although Lisa had allegedly been attached to a Corometric monitor, no alarms went off when she died (as one would have expected would occur with a working heart and respiration monitor).
- Ms. R.D. repeatedly told Ms. Douglas of her bewilderment about why the monitor's alarms did not go off when Lisa died <i.e., the alarms other than the apnea one which Ms. R.D. alleged she had previously disabled>.

The Corometric monitor has three alarms, only one of which, the apnea alarm, can be disabled or turned off. If a monitor that was supposed to be on and functioning did not apparently work at a critical moment, i.e. when Lisa Shore's heart stopped, this indicated a potentially malfunctioning piece of equipment.

Ms. Douglas, in her capacity as a registered nurse – not to mention as a Nurse-Educator – should have been so alarmed at the possibility of a malfunctioning piece of monitoring equipment that she should have immediately alerted her superiors. She was certainly thinking about the monitor. Why else would she - a Nurse-Educator who had no involvement whatsoever in Lisa's care, nor any responsibility to "clean-up" the room - have gone into a "sealed room" to check the monitor settings? Knowing that no alarms had sounded from the monitor, a reasonable person would have concluded in these circumstances that it had somehow malfunctioned. A reasonable person would have been concerned about the possibility that such a malfunctioning piece of equipment might very well have played a part in the unexpected and unexplained death of Lisa Shore. If she was concerned enough to check the monitor, why wasn't she concerned enough to report that the monitor seemed not to be working properly?

The coroner would have no way of knowing that the monitor was or was not malfunctioning unless someone like Ms. Douglas chose to inform him. In any event, whether or not he was aware is irrelevant; it was not his responsibility to ensure the safety of other patients, only to investigate Lisa's death. In Ms. Douglas's response to my complaint, she admits that she knew the monitor was put back into general circulation.

As a registered nurse – and a nurse-educator – she should be aware of the potentially fatal consequences of using malfunctioning equipment in a hospital setting. Assuming that management would take care of it – particularly when she had no assurance that management would even be aware of any problems – was not only a wholesale abdication of her duties to protect the safety of patients, but was also grossly incompetent. For one thing, Ms. Douglas herself, as a Nurse Educator, was "management". Secondly, how could anyone expect that a nurse whose patient has just died unexpectedly and for no known cause to be calm and rational and thinking clearly? It was likely that Ms. Douglas, having had Ms. R.D. confide in her about what had happened, was the only one who knew enough about the situation to realize that the monitor had apparently malfunctioned. The Committee erred in saying that there is no information to indicate that the member had anything to do with the decision to place the monitor back into general circulation. An apparently malfunctioning monitor went back into general circulation expressly because Ms. Douglas failed to act or to warn anyone of the danger.

Where was her responsibility to the next child who might be placed on this monitor that might not work if his or her heart stopped? Ms. Douglas was blithely unconcerned about that possibility. Her defence is predicated entirely on the notion that it was not her responsibility to do anything. However, it was most certainly her responsibility as a registered nurse who knew that patient safety may have been profoundly jeopardized to do something.

It is my allegation that her failure to act and her concomitant denial of responsibility endangered patient safety and was disgraceful, dishonourable, unethical, and unprofessional.

#### **Incident #5**

**Accepted; no appeal**

#### **Incident #6**

**“Douglas displayed incompetence as a nurse, nurse-educator, and Clinical Instructor by stating that the Corometric monitor’s upper heart-rate alarm setting of 160-180 beats per minute was appropriate for a child of [Miss L.S.]’s age.”**

#### **Member’s response:**

*Ms. Douglas indicates that this alleged incident is apparently based on evidence given by Ms. Douglas at the Coroner’s Inquest. She states that at the time of this incident, there was no protocol in place with respect to appropriate settings of Corometric monitors. With respect to the practice on the Unit at the time, the heart rate settings on the Corometric monitor were left to the judgement of the individual nurse. However, the settings would not necessarily be at normal rates, but would be beyond the normal range to allow for individual variations.*

**Committee's views:**

*The information supports that the member confirmed the monitor's settings, but there is no information to indicate that the member made this comment other than in good faith. Furthermore, there is no documentation to confirm that the settings were inappropriate for the client. In any event, absent further information, the Committee is not in a position to say whether or not the monitor's settings were appropriate in a clinical setting."*

**Basis for appeal:**

Whether the comment was made in good faith or in bad faith is irrelevant to the substance of the complaint: Was the statement appropriate to the nursing standards expected by the College of Nurses for a competent nurse or nurse-educator in her practice?

In order to determine this, the College must first assess the appropriateness of the monitor settings. If the College of Nurses of Ontario is not in a position to say whether a monitor's alarm settings - which are set by registered nurses in the performance of their duties - are appropriate or inappropriate, then who is? This is unequivocally a nursing practice issue and must therefore be considered by the College.

There were no Hospital for Sick Children guidelines in existence at the time of Lisa's death, but there are often no guidelines in areas where sound nursing judgement is expected to be the norm. Largely because of Lisa's death, the ward on which she died, Unit 5A, now uses guidelines for setting the upper monitor alarm heart rate at 150% of the patient's pulse on admission to the unit. Lisa's pulse on admission to Unit 5A was 72 beats per minute, and she had no fever or infection that would have suggested that an elevated heart rate was likely to occur. In her case, using Unit 5A's current guidelines, 150% of her pulse on admission to the unit would have been 108 beats per minute. An alarm set to go off if her heart rate reached 160 or 180 beats per minute - 2 ¼ to 2 ½ times Lisa's actual heart rate - was clearly inappropriate on a piece of equipment intended to give a warning of imminent problems.

I have submitted information from Whaley and Wong's pediatric nursing textbook to the College; this book is used as the primary nursing reference by nurses at the Hospital for Sick Children. The College should also look to its own pediatric nursing experts for their opinions. The College should contact the pediatrician from the Coroner's Pediatric Death Review Committee and the physician/pharmacologist who testified at the Coroner's inquest; both testified that they felt the monitor's upper alarm setting to be inappropriate and would no doubt reconfirm their opinions to the College.

Douglas's defence that the monitor's alarm setting is up to the judgement of the individual nurse is also irrelevant to the substance of my complaint. This complaint is not about whether what another nurse did was appropriate, but whether what Ms. Douglas *said* was appropriate. Ms. Douglas told staff at the Hospital for Sick Children that the upper heart rate alarm setting of 160 to 180 was appropriate for a child of Lisa's age; this comment was attributed directly to her in the hospital's letter of March 5, 1999.

According to Whaley and Wong, the normal heart rate for a sleeping child of Lisa's age is 60-90 beats per minute. Without knowing the specifics of Lisa's vital signs, an upper alarm setting of 160-180 represents at least double the "normal range". Douglas talks about allowing for "individual variations" as if this explains why such a high alarm setting was appropriate. However, had she taken into account the most basic of individual variations - Lisa's actual heart rate of 72 - that would have dictated that the alarm be set lower than usual rather than higher. The setting on the monitor was so far above normal - with or without "individual variations" - that it is difficult to see how the Committee reached its decision to take no action on my allegation. It is my belief that Ms. Douglas's statement that she deemed the alarm setting she saw to be appropriate reflected her desire to protect Ms. R.D. from being censured for below-standard performance rather than a comment that was made in good faith.

Ms. Douglas is incorrect that I am using her inquest evidence as a basis for this allegation. As mentioned above, it is based on her statements to Hospital for Sick Children staff when they interviewed her; the inquest testimony merely corroborated what was already known. Ms. Douglas also feels it was "fortunate" that she visually reviewed the settings on the monitor. In my opinion, it is equally "fortunate" for her that her inquest testimony cannot be directly quoted in this complaint, because it would have offered much greater substantiation for my allegations of Ms. Douglas's incompetence and unprofessional behaviour.

#### **Incident #7**

**"Douglas was seen by inquest jurors to be coaching nurse [Ms. R.D.] during [Ms. R.D.]'s testimony, by way of hand signals and body language. This signalling was apparent both to jury members (who complained about it) and to family/friends of the Shores. The jurors notified Deputy Chief Coroner Dr. [J.C.] about this behaviour. Dr. [J.C.] said in open court that the jury had brought this to his attention. He cautioned the audience that such behaviour was inappropriate and should cease immediately. Section 42 of the Coroner's Act prevents a witness from being accountable to her governing body for her testimony, but does not restrict my right to file a complaint about her disgraceful and dishonourable behaviour that occurred not when she was on the witness stand testifying, but rather, in the audience as a spectator."**

#### **Member's response**

*Ms. Douglas explains that approximately eight to ten members of the nursing staff were in attendance at the Inquest on any particular day. Ms. Douglas claims that due to "repetitive and outrageous questioning", particularly by counsel for the Shore family, members of the audience may have expressed their empathy and frustration through the use of body language. However, she states that she never made any attempt to influence in any way the testimony that was being provided.*

*Ms. Douglas stresses that the Coroner did not identify her or anyone else as an audience member identified by the jury as attempting to influence witnesses. Furthermore, Ms. Douglas states that the Coroner did not conclude that there was any inappropriate conduct. He simply indicated that if there were an attempt to influence witnesses, such activity would be inappropriate.*

**Committee's views:**

*The Committee notes that the information indicates that the Coroner did not identify that Ms. Douglas or any other person had engaged in inappropriate conduct while witnesses were testifying at the Inquest. However, the information from Mr. L.P. and Ms. G.A. indicates that the member used perceptible body language before and while witnesses were answering questions. In her response to the Complaints Committee, the member does not specifically deny that she did so. While it is unable to assess the member's intent in using such body language, or to determine if the witnesses were influenced in any way as a result of such activity, the Committee would confirm that such behaviour, if it occurred, would be inappropriate and unethical.*

**Basis for appeal:**

In my opinion, the Committee's letter of caution did not adequately address the severity of Ms. Douglas's inappropriate and unethical behaviour.

Ms. Douglas may feel that counsel for the Shore family's questioning of witnesses was "repetitive and outrageous". I feel, on the other hand, that the evasions, untruths, and inconsistencies of the nurses' testimony – including hers - were outrageous and offensive. Unless Ms. Douglas is prepared to allow inquest transcripts to be presented to the Committee and to the Appeal Panel so that they may decide for themselves, it is inappropriate to even present this as a justification for her behaviour. Furthermore, no other nurses were seen to be expressing their emotions by signalling to witnesses who were in the midst of testifying.

I would also point out that in addition to the jury forewoman and the lawyer who were interviewed by the College, others saw Ms. Douglas engage in overt signalling. Because they were related to me, I did not offer their names to the College. One of those other witnesses, my sister, is a physician herself, and accountable to the College of Physicians and Surgeons. Her testimony would be truthful and honest, should anyone wish to interview her and obtain her corroboration of Ms. Douglas's actions at the inquest.

Ms. Douglas, in her appeal of the College's decision, mentions that the College failed to interview any of the witnesses alleged to have been influenced by her. This is akin to asking a suspected buyer of illegal drugs if the drug dealer was selling drugs to him. An answer in the affirmative would implicate the suspected buyer, so why would anyone have confidence that the buyer would answer truthfully? The only witness that Ms. Douglas was able to signal before the Coroner cautioned the audience (a caution that was meant specifically for her) was [Ms. R.D.], who herself has been sent to Discipline by the College of Nurses of Ontario.

Ms. Douglas has also stated in her appeal that it is inappropriate for the College of Nurses to sanction her with respect to conduct during the course of the Coroner's inquest. It should be stressed that Ms. Douglas's actions occurred while she was a spectator at the inquest. She was under no obligation to attend except when required to give testimony. The behaviour which gave rise to this complaint and which resulted in the College's letter of caution was outside the scope of the inquest. The Coroner had no authority to "make findings and appropriate rulings" about the conduct of a spectator who was not at the time involved in the inquest.

The reasons I believe that the College's letter of caution is insufficient to address the severity of Ms. Douglas's misconduct are as follows:

- a) A letter of caution designed to help a member improve her practice may be sufficient where a member has acknowledged her error or expressed regret. Ms. Douglas has done neither of these things.
- b) In order to communicate with a witness who is in the midst of giving testimony, the method of communication between the parties must be planned in advance. Ms. Douglas's coaching of the witness was not only disgraceful and dishonourable, but was consciously premeditated.
- c) Ms. Douglas's blatant coaching of [Ms. R.D.], RN, in her inquest testimony was a deliberate attempt to subvert and obstruct the inquest process. This particular inquest was an investigation into the circumstances of my 10-year-old daughter's death, and the inquest jury made a finding of fact that her death was a homicide. Since [Ms. R.D.] was Lisa's primary caregiver, Ms. Douglas's coaching of [Ms. R.D.] in her testimony was an attempt to mislead the Coroner and the public to prevent the extent of [Ms. R.D.]'s grossly substandard nursing care from being discovered. Her actions were inherently disgraceful and dishonourable.
- d) Ms. Douglas is a registered nurse who, at the time of the inquest, was pursuing her Master of Nursing degree. In light of her higher than average academic achievement and her position as Nurse-Educator at the Hospital for Sick Children, the standard to which she should be held is even greater than that of an inexperienced nurse - and her misconduct is therefore all the more heinous.
- e) The coaching incident was mentioned on the CTV 6:00pm news (a videotape of the broadcast is available). Although the newscast did not specifically name Ms. Douglas, all of the media present were aware that the Coroner was referring to the actions of Ms. Douglas. To have such disgraceful conduct mentioned on a television newscast brings the entire profession of nursing into disrepute.