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March 5, 2001

Chairperson
Health Professions Appeal and Review Board
151 Bloor Street W., 9th floor
Toronto, ON
M5S 2T5

Re: Dr. Jean M. Reeder, RN

Dear Sir or Madam,

I am appealing the February 8, 2001 decision of the panel of the Complaints Committee of the College of Nurses of Ontario with respect to the above-named individual, as set out in the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c.32.

I submitted ten allegations regarding Dr. Reeder to the College of Nurses of Ontario on August 10, 2000. These allegations concerned Dr. Reeder's actions and omissions in relation to two subordinate nurses on her staff, and the care they provided to my deceased 10-year-old daughter Lisa Shore. The Complaints Committee found that two of the ten allegations raised significant concerns about Dr. Reeder's practice. For those two allegations only, the Committee has issued a letter of caution and requires Dr. Reeder to appear before it for an oral caution.

I am appealing because in my opinion the decision of the Complaints Committee is inappropriate and does not adequately reflect the severity of Dr. Reeder'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 that the two nurses on Dr. Reeder's staff (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 Dr. Reeder's conduct and credibility, then it would have reached substantially different conclusions;

- d) The Committee did not take into account that a coroner's inquest jury – a group of 5 laypersons, on learning of the actions and omissions of the two nurses on Dr. Reeder's staff, found that the means of my daughter's death was homicide. Had the Committee taken this information into account, its evaluation of Dr. Reeder's conduct and credibility would have led it to reach substantially different conclusions;
- e) Where Dr. Reeder and I differed in our recollections, the Committee accepted Dr. Reeder's version of events and discounted mine. A more thorough review of the facts and the inconsistencies of Dr. Reeder's responses would have resulted instead in the Committee giving less weight to her credibility and more to mine;
- f) Although the College's investigation was commendably thorough, some errors of fact occurred. It is possible that these errors may have had some influence on the Complaints Committee's decisions.

Detailed information is attached.

Yours truly,

Sharon Shore

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

1) Errors and omissions in the Committee's analysis of allegations/incidents

Incident #1

“She failed to notify the College of the grossly substandard nursing care provided by [Ms R. D., RN] and [Ms A.S., RN] to [Miss L.S.] on October 22, 1998, at the Hospital for Sick Children.”

Member's response

“In an interview with the College Investigator, Dr. Reeder indicated that she reviewed the College of Nurses' guidelines and discussed reporting obligations with the College's Manager of Investigation before and during the Inquest into the death of Miss L.S. Dr. Reeder stated that she was assured that she had no legal responsibility to report the nurses, as their employment had not been terminated.

Committee's views

The Committee notes that there is no information to indicate that the member knew that there were any nursing practice issues to be reported. Furthermore, there is no indication that the member at any time believed that the nursing care provided to Miss L.S. was grossly substandard. Even if the member had been aware that the care provided was substandard, she had no obligation to report the named members to the College because they had not been dismissed from their employment. In these circumstances, the member did not engage in any inappropriate behaviour...”

Basis for appeal:

Dr. Reeder was aware of the following facts related to her nurses' care of my daughter, Lisa Shore <Miss L.S.> no later than February 1999:

- 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
- my letter to the coroner and the hospital stated that no monitoring devices had been placed on the patient (my daughter); this directly contradicted the nurses' version of events
- The doctor's account of a telephone conversation between him and one of the nurses at 4:05am directly contradicted the nurses' account of the conversation
- When my daughter died, no alarms sounded from the heart and respiration monitor that Dr. Reeder's nurse alleged she had attached. If the monitor had been on and functioning, one or more alarms would have sounded when my daughter's heart and respiration stopped, as at least one of the machine's alarms could not be disabled or turned off. The hospital verified that that there was no equipment malfunction on any of its monitors. Therefore, there was *no* plausible explanation to substantiate the nurses' version of events.

- a) In light of these facts, it is difficult to understand how the Committee reached the conclusion that there was no information to indicate that Dr. Reeder knew that there were any nursing practice issues to be reported. All of these points refer to basic nursing practice issues.
- b) In light of these facts, it is equally difficult to understand how the Committee could state that there was no indication that Dr. Reeder at any time believed that the nursing care provided to my daughter was grossly substandard. Certainly the College of Nurses of Ontario, by deciding to send the two nurses to discipline, believes that the care was grossly substandard. If Dr. Reeder did not believe that the care was grossly substandard – given the facts that she knew - then the logical conclusion for the Committee to make would be that she was incompetent in her nursing practice.
- c) Dr. Reeder notes in her response to this incident that she contacted the College's Manager of Investigations *before* and during the inquest (which began in November 1999). The College's Manager of Investigations should be able to corroborate approximately when it was that Dr. Reeder first contacted her.

If Dr. Reeder did call the College before the inquest began to discuss reporting obligations, the Committee cannot in good faith state that "*there is no information to indicate that the member knew that there were any nursing practice issues to be reported.*" Why would Dr. Reeder have called the Manager of Investigations if she had no reason to believe that there was anything that needed to be investigated or reported?

If Dr. Reeder did not contact the College before the inquest began, then her statement of defense is untrue. The Committee should then reconsider the remainder of her statements and weigh her credibility and veracity accordingly.

- d) The Committee states that Dr. Reeder had no obligation to report nurses even if she was aware their care was substandard, since they had not been dismissed. The Health Professions Procedural Code of the Nursing Act, 1991, defines an act of professional misconduct as "*...failing to report an incident of unsafe practice or unethical conduct of a health care provider to the employer...or the College*". The basis of my complaint is not that Dr. Reeder had a legal responsibility to report, but that she had a ***professional, ethical and moral responsibility*** to do so.

The College operates under the presumption that responsible nurses will always put the welfare of their patients ahead of their own interests or that of their colleagues. It assumes that Chiefs of Nursing, when they learn of nurses whose practices may pose a danger to patients, will always report the offending nurses to the College and take remedial steps to ensure that patient safety is not jeopardized. Dr. Reeder has completely subverted this "honour system", yet the Committee finds her behaviour to be appropriate.

If the Committee feels that dismissal of employees is the only criterion for reporting to the College – even if the member knew or ought to have known that the care was substandard – how can the College effectively fulfil its mandate to protect the public?

Incident #2

“She failed to discipline nurses who she knew had provided grossly substandard nursing care.”

Member’s response

“...Dr. Reeder notes that there is a difference between supporting nurses and defending their actions. The nurses involved in Miss L.S.’s care admitted that they made errors. This was obvious from reading the chart. Ms R.D., RN, admitted to Ms M.D., RN, Nurse Educator, that she turned off the alarm on Miss L.S.’s monitor, and that she did not know why she did so. Furthermore, the vital signs taken from Miss L.S. were incomplete.

In Dr. Reeder’s opinion, Ms R.D. and Ms A.S. admitted their mistakes, and engaged in reflective practice. Otherwise, they were considered to be good nurses. Based on the information available at the time, there was insufficient cause to terminate their employment. Although the nurses made errors in judgment, they had demonstrated remorse, and a willingness to learn. Dr. Reeder expressed her philosophical belief that people should not be punished for their mistakes when they demonstrate that they have learned from their mistakes.”

Committee’s views

“The Committee notes that the member admits that she did not discipline the nurses who, according to Ms Shore, provided substandard care to her daughter. However, it is not within the College’s mandate to dictate what disciplinary measures should be imposed in a workplace environment.”

Basis for appeal:

The Committee’s reference to “according to Mrs. Shore” clearly conveys the Committee’s position that the substandard care was only an unproven allegation made by me, the complainant. Instead, the Committee should consider that its own body, the College of Nurses of Ontario – as well as a coroner’s inquest jury – both believe that grossly substandard care was provided to my daughter.

The Committee noted that it is not within the College’s mandate to dictate what disciplinary measures should be imposed in a workplace environment. I do not expect the Committee to dictate what disciplinary measures should be imposed, and that was not the basis of my complaint. My complaint alleges that Dr. Reeder did not discipline the nurses in any manner whatsoever; I expect the Committee to fairly review what Dr. Reeder did and did not do in light of the known facts, and render an opinion on whether her actions or omissions were in keeping with the professional, ethical and moral standards of her position specifically and the nursing profession in general.

Dr. Reeder does not acknowledge at any time, in any of her responses, that her nurses' care was substandard. She has said that they made "errors in judgment." I would suggest that the Committee ask Dr. Reeder directly if the failure to check doctor's orders - a failure she was fully aware of - was an "error in judgment". I would further suggest that the Committee ask Dr. Reeder if the failure to follow standard, written, hospital protocols with which the nurses were expected to be familiar was an "error in judgment." The Committee should ask Dr. Reeder if failing to take mandatory vital signs was an "error in judgment". The Committee should ask whether Dr. Reeder believed it was an error in judgment when Miss R.D. stated that she had turned off a respiratory alarm - designed to warn of respiratory distress - on a patient on morphine who died from respiratory depression.

Dr. Reeder's failure to take any action whatsoever against these nurses was a gross "error in judgment" which constitutes disgraceful, dishonourable, and unprofessional behaviour, for which she should be held accountable by the College.

Incident #3

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

Member's response

"...Dr. Reeder also indicates that she was not responsible for hiring and firing staff nurses. In any event, she indicated that she believed that there was insufficient cause for dismissing these nurses."

Dr. Reeder notes that, if she had to do it again, knowing what she knows now, she might have disciplined these nurses by imposing a probationary period or a learning plan. However, she continues to believe that she would not dismiss them. She indicates that the nurses deserved a second chance."

Committee's views

"The Committee notes that there is no information to indicate that the member had the power to dismiss the named nurses from their employment. In any event, the Committee cannot conclude that sufficient cause for dismissal existed, based on the information that was available to the member at the time."

Reason for appeal:

The Committee erred in both of its comments:

- a) The Committee noted that there was no information to indicate that Dr. Reeder had the power to dismiss the named nurses from their employment. It is impossible that the Chief of Nursing of an accredited tertiary care centre does not possess the ability

to terminate non-unionized nurses where sufficient cause exists. If the Committee is not able to independently confirm or deny this, it should review the position's job description, directly question Hospital for Sick Children senior executives, and evaluate the situation logically and realistically.

Dr. Reeder is playing with words and intentionally misleading the College by claiming that she was "not responsible for hiring and firing staff nurses". Not having the general responsibility for hiring and firing is substantially different than having the authority to fire two specific nurses who provided grossly substandard care. Although Dr. Reeder might have the actual act of dismissal performed by another, it was wholly within her responsibility to recommend or initiate termination of nurses where warranted.

- b) The Committee was unable to determine whether sufficient cause for dismissal existed based on the information available to Dr. Reeder *at the time*. Which "time" is the Committee referring to? Lisa Shore died in October 1998. The Hospital for Sick Children learned in January 1999 that the two nurses had not read or followed doctor's orders or standard protocols, not taken mandatory vital signs, and that there were contradictions between my statements and the nurses' and between the doctor's and the nurses'. Dr. Reeder learned this information, according to her, in February 1999. 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 August 2000).

The Hospital for Sick Children – including Dr. Jean Reeder - was in possession of virtually all of the same information that led the College of Nurses to prosecute and a lay inquest jury to find my daughter's death a homicide. Notwithstanding the fact that Dr. Reeder chose not to conduct an investigation into the contradictions and discrepancies of the nurses' statements, the Complaints Committee should reconsider whether or not Dr. Reeder was in possession of sufficient information at any time prior to my complaint of March 2000 to take action.

Incident #4

"She failed to recognize how serious the breach of nursing standards and practice was in the grossly substandard nursing care provided by [Ms R.D.] and [Ms A.S.] to [Miss L.S]."

Member's response:

Dr. Reeder does not recall that she made the statement, "Why punish people for innocent mistakes?" She recalls that she acknowledged the mistakes that the nurses had made and advised Ms Shore that the nurses' practices had been reviewed and steps had been taken to improve their practices. Dr. Reeder denies that she intentionally disregarded the seriousness of the nurses' errors.

Committee's views

The Committee notes that the substance of this allegation involves Ms Shore's perception of the member's attitude towards alleged improprieties of nursing colleagues. The Committee is not in a position to assess or confirm the manner in which the member considered the situation.

Basis for appeal

The Committee is in error in its belief that the substance of this allegation involves my perception of Dr. Reeder's attitude. The allegation is a statement of fact – Dr. Reeder did not recognize how serious the breach of nursing standards and practice was. Whether she was unable to recognize the gravity of the errors due to incompetence, ignorance or intentional disregard on her part is irrelevant to the substance of the complaint. Clearly the College of Nurses of Ontario, which is prosecuting the two nurses, and an inquest jury that returned a finding of homicide both recognized how serious the breach of standards and practice was. If the Chief of Nursing could not or would not do the same, she should be held accountable to her professional body.

Dr. Reeder, in her statement of defense, remembers that when she met with my husband and me she acknowledged mistakes that her nurses made and that steps had been taken to improve their practices. This is wholly untrue. According to her, all the mistakes were "inadvertent" or "accidental" or "innocent". Dr. Reeder made no mention whatsoever about any steps to improve her nurses' practices; it was such an overt omission that I pointedly asked her exactly what had been done. Rather than answering my very specific question, she started talking in generalities. At this point, a third party - a retired judge - interjected and told Dr. Reeder that she was not answering the question that had had been asked. Dr. Reeder then admitted that nothing had been done about the nurses' practices.

Furthermore, the Committee has chosen to accept that Dr. Reeder does not remember making the statement "why punish people for innocent mistakes?" Rather than accepting Dr. Reeder's conveniently faulty memory – particularly in view of the other misleading or inaccurate statements that she has made – the Committee should reflect upon the circumstances in which Dr. Reeder's comment was given: This was the first meeting my husband and I had had with the hospital and any of its staff, almost one year after our daughter's death. We already knew from reviewing the records about the substandard nursing care she received, and had been informed by the Deputy Chief Coroner that the nurses had not read the doctor's orders or followed standard protocols. Expecting to hear some expression of apology and regret, my husband and I were stunned to hear instead Dr. Reeder's callous comment about not punishing innocent mistakes. My husband can also attest to Dr. Reeder's having made that comment.

I suggest to the Committee that it should disregard Dr. Reeder's faulty memory and accept instead that my and my husband's recollection of events is accurate. Dr. Reeder's heartless comments are etched in our hearts forever.

Incident #5

“She failed to recognize how seriously nursing standards and practice were breached in the actions of [Ms R.D.] and [Ms A.S.] to [Miss L.S.] assuming full responsibility for a patient in the absence of any doctors orders or medical information about the patient. Alternatively, she did recognize the breach of standards and practice, and deliberately chose to ignore or conceal it, as evidenced by her allowing the nurses to continue working without any repercussions.”

Member’s response:

“According to Dr. Reeder, she does not recall when she first learned that the Kidcom orders had not been activated by the nurses who cared for Miss L.S. on the night in question.

...She believes she did the right thing by treating people with respect, and believing that they were innocent until proven guilty. Based on her discussions with the nurses and their supervisors, it never crossed Dr. Reeder’s mind that these were bad nurses who had intentionally harmed Ms. L.S.”

Committee’s views:

The Committee notes that the substance of this allegation involves Ms Shore’s perception of the member’s attitude towards alleged improprieties of nursing colleagues. The Committee is not in a position to assess whether the complainant’s interpretation of the member’s assessment of the situation is proper.

Basis for appeal

The basis for appeal is identical to that of incident #4. The Committee is in error in its belief that the substance of this allegation involves my perception of Dr. Reeder’s attitude. This allegation is a statement of fact: Dr. Reeder’s two nurses took responsibility for a patient without reading the doctor’s orders and without having any knowledge about their patient’s condition. Furthermore, in the absence of doctor’s orders, there was a written hospital protocol that applied but which they failed to follow. Their patient died. If this is not a serious breach of nursing standards and practice, then what would the Committee consider to be a serious breach? Whether Dr. Reeder was unable to recognize the gravity of the errors due to incompetence, ignorance or intentional disregard on her part is irrelevant to the substance of the complaint. If the College of Nurses and an inquest jury both agree that the nursing errors were egregious, why then does the Complaints Committee not feel qualified to render a decision on whether Dr. Reeder’s behaviour was appropriate?

Dr. Reeder believed that the nurses were innocent until proven guilty. Dr. Reeder, by her own admission, did not conduct an investigation to resolve the many discrepancies in the nurses’ version of events or to discover what had really transpired. Accordingly, the nurses would have “remained innocent” in her eyes indefinitely.

Dr. Reeder says that “it never crossed her mind that these were bad nurses who had intentionally harmed Miss L.S.”. Dr. Reeder is playing with words by responding to an

allegation that was never made. This implication – that I am alleging that the nurses caused intentional harm – is untrue; I have never, ever made such statements. This implication may well have caused the Committee to erroneously conclude that my allegation centred around fault-finding, blame, and my “perception of the member’s attitude”. The Committee is free to assess the member’s attitude itself on the basis of her actions and her statements. However, if it wishes to address my complaint all it needs to consider is whether it was appropriate for Dr. Reeder to take no remedial action whatsoever despite knowing all that she knew about the nurses’ actions and omissions.

Additionally, Dr. Reeder has stated in her response that she does not recall when she first learned that the doctor’s computer orders (“Kidcom) had not been read (“activated”) by the nurses. Dr. Reeder may not remember precisely when she first learned of it, but her own statements of defense clearly show that it was some time in February 1999. In Dr. Reeder’s response to incident #2, she states that the hospital’s risk manager informed her of certain facts about the case. If Dr. Reeder then “tried to backtrack in order to obtain some understanding of the circumstances leading to Ms. L.S.’s death”, then I suggest that the logical conclusion is that Dr. Reeder learned that the doctor’s orders had not been read sometime in February 1999. To further substantiate this, Dr. Reeder states in her response to incident #7 that she learned that there were “nursing issues” in February 1999. It is exceedingly unlikely that the risk manager or a nursing colleague who discussed “nursing issues” with her would have withheld such vital information about the nurses not having accessed the doctor’s orders. Certainly in September 1999, at my and my husband’s meeting with Dr. Reeder and others, she confirmed to us that “the nurses accidentally neglected to check the orders.” This was many months before my complaint was filed; the fact that Dr. Reeder cannot pinpoint the exact date when she learned these facts should not lead the Committee to the erroneous conclusion that she was unaware of them.

Incident #6

Accepted; no appeal

Incident #7

Accepted; no appeal

Incident #8

Accepted; no appeal

Incident #9

Accepted; no appeal

Incident #10

“Dr. Reeder placed herself in a second serious conflict-of-interest position impacting on the profession and practice of nursing, by stating in writing that one of her main responsibilities was to ensure that the standards of nursing practice were maintained and evaluated, and in the same document, expressing her and the hospital’s commitment to support [Ms R.D.] and [Ms A.S.].

Member's response:

Dr. Reeder does not deny this allegation. However, she indicates that there is a difference between supporting the nurses and defending their actions.

Committee's views:

The Committee is not in a position to confirm that the member's statement was improper.

Basis for appeal:

If the Complaints Committee of the College of Nurses of Ontario is not in a position to confirm whether or not Dr. Reeder's statement was improper, then who is?

The Committee has already concluded that Dr. Reeder failed to conduct an investigation into the nursing issues relating to the circumstances of my daughter's death. It has already concluded that Dr. Reeder should have conducted an investigation into the nursing care that the named nurses, Ms R.D. and Ms A.S., provided to their other patients. Notwithstanding that a thorough investigation was not done, many facts were already known (as discussed on previous pages). In light of the known facts, does the Committee find that Dr. Reeder's comments about upholding her responsibilities to ensure that the standards of nursing practice were maintained to be truthful and accurate? Why does the Committee feel it is unable to confirm whether Dr. Reeder's statement was improper? If the Complaints Committee of the College of Nurses is unable to decide whether Dr. Reeder's written statements are improper or inappropriate, then presumably all College members are free to speak and write anything they choose about nursing standards and practice, whether appropriate or not.

2) Errors and omissions of fact**a) The post-mortem results**

i) "...The gabapentin concentration was well in excess of the reported therapeutic range. However, serious toxicity is not identified with blood concentrations as much as five times higher than that found in Miss L.S."

Gabapentin is a drug that has only come into extensive use for pain control in the last few years, and even more recently for pediatric pain control. It was originally developed as a drug for epilepsy, and the Hospital for Sick Children, at least at the time of Lisa's death, did not generally use this drug in treating neuropathic pain. Gabapentin is now commonly prescribed for control of neuropathic pain at significantly higher dosages than was previously thought to be efficacious. If the Hospital for Sick Children did not possess expertise in the use of this drug for Lisa's medical condition, it is probable that the Centre for Forensic Science also used older, outdated standards. The gabapentin concentration in Lisa's blood correlated appropriately to the dosage prescribed by pediatric pain control specialists at Children's Hospital in Boston and was not in excess of current acceptable therapeutic

ranges. The College may verify this information by contacting doctors and/or nurses at the Pain Clinic at Children's Hospital in Boston, telephone (617) 355-6995.

The College may have interpreted this post-mortem comment about being in excess of therapeutic range as indicative of a medication error, either accidental or deliberate. As information is provided elsewhere that I, Lisa Shore's mother, was the one who administered Lisa's medication to her, it is possible that my credibility may have been wrongly undermined.

ii) "...There was also some evidence that Miss L.S. had a viral infection, which affected her myocardium. While such an infection, by itself, would not likely cause sudden death, it may have contributed to some interaction involving the four therapeutic drugs that were administered to Miss L.S. for pain relief."

Further testing was done at Toronto General Hospital to confirm or refute the hypothesis that a viral infection affected Lisa Shore's myocardium and may possibly have contributed to her death. These tests conclusively showed that a) there was zero infection of the myocardium, and b) the quantity of lymphocytic infiltrates was too minimal to even categorize as a "viral infection". (Confirming documentation is on file at the Office of the Chief Coroner of Ontario.)

A viral infection was conclusively ruled out. No cause of death was found. The pharmacologist subsequently theorized that a possible cause of death was the morphine given at the Hospital for Sick Children, which may have caused some interaction with Lisa's three prescribed medications.

Both of these facts are important to the Committee's evaluation of my complaint and its concurrent assessment of Dr. Reeder's credibility. Dr. Reeder in her statement of defense did not acknowledge anywhere that her nurses' actions were substandard. Since the Complaints Committee was given inaccurate information about possible viral infections or medication overdoses, this could have led them to believe that those items were factors in Lisa Shore's death. Dr. Reeder's statements should be re-reviewed by the Complaints Committee in the context that there were no known reasons or even suggested possibilities for Lisa Shore's death.

b) Information provided by Dr. A.G., Senior VP at HSC

Dr. Goldbloom stated that he only took over responsibility for the Hospital's clinical areas in January 2000, and that he did not occupy his current position at the time of Lisa's death. This may possibly account for the inaccuracies in the information he provided.

i) "...many people at HSC thought that Miss L.S.'s death was related to the morphine infusion she had received, and that she may have died from a morphine overdose. Dr. A.G. stated that the concerns about nursing were not immediately apparent."

This statement was true – but only for a very short period of time. The Coroner’s office advised the Hospital and our family *within five weeks of Lisa’s death* that based on the preliminary toxicology results, the cause of death did not appear to be a morphine overdose.

If the Hospital had been truly concerned about the possibility of a morphine overdose, then other patients could have been at serious risk. Why didn’t the hospital immediately conduct an investigation? If anything, the hospital should have placed an even greater priority on learning how a morphine overdose might have occurred and how a repetition could be prevented. How could the hospital be sure there was no criminal action involved unless it conducted an investigation?

Furthermore, if the hospital claims it did nothing because it believed the cause of death was a morphine overdose, why did it continue to take no action when it learned that Lisa’s death was not attributable to a morphine overdose?

- ii) *“The Coroner’s Office had the original copy of Miss L.S.’s chart. The Hospital believed that it did not have access to her chart, but now realizes that it could have made a copy of the chart.”*

The statement is inaccurate.

The Coroner’s Office did not seize the chart until mid December, fully two months after Lisa died. In the interim, the hospital made a complete copy of the chart for me upon my request.

Most of the relevant documents in Lisa’s chart were from the hospital’s Kidcom computer system and could have been easily reprinted at anytime by hospital employees. Copies of relevant non-computerized documents, such as the nursing flowsheet, were included with a letter I sent to the Coroner’s office on December 11, 1998. This letter was passed on by the Coroner’s Office to the Hospital for Sick Children shortly thereafter, with the copy of the flowchart.

In my meeting with Dr. Reeder in September 1999, the hospital clearly had copies of all the relevant records in its possession. Dr. A.G.’s statement seems to imply that the hospital did not see Lisa’s records until some indeterminate future time; this is fundamentally untrue.