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September 27, 2000

Ms. Doris Grinspun  
Executive Director, RNAO  
438 University Avenue, Ste. 1600  
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Dear Ms. Grinspun,

I am the mother of Lisa Shore, the 10-year-old who died at the Hospital for Sick Children in October 1998, and whose death was the subject of a coroner's inquest.

It has come to my attention that Ms. Sue Williams has been giving presentations to hospitals entitled "When Bad Things Happen to Good Nurses", using my daughter's death as a prime example thereof.

As Ms. Williams is speaking as an executive member of the RNAO, I assume that her message reflects the opinions of the organization and not her personal opinion. Although the RNAO has not seen fit to make any public comments about the case, it apparently feels no such hesitation when speaking with its own members and other nurses.

The organization is fully entitled to present its opinions and interpretations to its membership. I wholly support its unfettered right to do so. However, Ms. Williams is unaware of or has deliberately chosen to omit many of the relevant facts of the case. If Ms. Williams and the RNAO wish to present Lisa's death as an example of good nursing, then they have a moral and ethical obligation to inform their audience of all of the salient facts.

In her presentation of September 26, 2000, at Sunnybrook Hospital, Ms. Williams stated that there were many issues involved in this case. She specifically referred to problems with doctors' electronic orders that for some reason did not get transmitted to the ward, and commented that she did not think there were any hand-written monitoring orders. The facts of the matter are as follows: The emergency doctor hand-wrote orders for the nurses on the ward specifically telling them to check the electronic monitoring orders he had placed in the computer. The nurses neglected to read those hand-written orders.

Notwithstanding their failure to read the doctors' hand-written orders, *all* children admitted to a ward from the emergency department have electronic orders placed in the hospital's Kidcom computer system - as was done for Lisa Shore. These orders were available on the computer system at all times for the nurses to access and read throughout Lisa's admission. There were no system errors - the nurses simply neglected to read the orders. It should be noted that there are no other known instances of nurses at the Hospital for Sick Children having failed to access and read the electronic orders. I enclose copies of the handwritten orders, (A), and the unread electronic orders, (B).

Although the nurses failed to access the electronic orders, they testified that they were familiar with written hospital monitoring protocols that were substantively similar to the unread doctors' orders. Those monitoring protocols were not followed. I enclose a copy of these protocols, (C).

Ms. Williams further mentioned that the nurses monitored Lisa during the night and documented their monitoring on the flow sheet. I enclose a copy of the flow sheet, (D). This flow sheet clearly shows that Lisa was in respiratory and cardiac distress, and that her vital signs - the ones that were selectively taken - were deteriorating throughout the night. All of this occurred while the nurses were ostensibly monitoring her. The mere act of marking down data without taking necessary corrective action does not constitute monitoring by any standard of acceptable nursing practice. Furthermore, the repeated failure of nurses to take the blood pressure of a patient who was in obvious respiratory and cardiac distress is an act of gross negligence.

The issues that Ms. Williams mentioned about the use of a monitor and turning off of the apnea alarms are ones that should not be raised unless she is prepared to review in detail all of the inquest transcripts and exhibits. If this were to be done, she would be able to more clearly understand why the inquest jury reached its conclusion that the nurses were lying about ever having used a monitor - a conclusion that helped this jury find that Lisa's death was a homicide.

Another crucial issue that was raised at Ms. Williams' presentation was that of nursing ratios. Ms. Williams is factually incorrect. There were no issues of nursing ratios that had anything to do with Lisa's death, and the hospital never claimed that there were. The nurse in charge had five patients including Lisa Shore. The second nurse had four patients. Both nurses testified that it was a quiet night. No one was overworked and the ward was fully staffed. In fact, when Lisa arrived on the ward at 01:45, it was so quiet that both nurses attended on her.

I hope you will thoroughly review the documentation I have enclosed. The nurses in charge of Lisa's care were not good nurses, and were not victims of systemic problems. They were grossly incompetent and negligent, and they tried to cover up their negligence by fabricating evidence and lying under oath in coroner's court. This behaviour should be condemned by the RNAO; it appears instead that the RNAO condones it.

I have little doubt but that the police investigation - which is still ongoing - will result in criminal charges being laid, and deservedly so. In my opinion, continuing to discuss the Lisa Shore case in the context of "good nurses" is both unprofessional and unethical. If Ms. Williams wishes to continue discussing the case, it would be good nursing practice to distribute copies of the nursing flow sheet and the doctor's orders so that her audience may realistically evaluate them and reach an informed conclusion.

The RNAO should carefully reflect on its mission statement "to promote excellence in nursing practice" when it discusses the nursing practice of the two nurses who "cared" for my daughter and caused her death.

Yours very truly,



Sharon Shore

cc: Ms. Sue Williams  
RNAO

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