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August 10, 2000

Ms Anne Coghlan
Executive Director
College of Nurses of Ontario
101 Davenport Road
Toronto, Ontario
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Dear Ms Coghlan:

Please consider this to be a revised letter of complaint against **Ruth Doerksen, RN**. This letter is to replace my original letter of complaint which was dated March 3, 2000.

A portion of the original complaint made reference to testimony given at the Coroner's inquest investigating my daughter, Lisa Shore's, death. I have been advised that under section 42 of the Coroner's Act, the testimony of a witness cannot be used as a basis for disciplinary proceedings.

Accordingly, I am restating the complaint to exclude the testimony given in coroner's court by Doerksen. The allegations contained herein are therefore based exclusively on the medical records and other documents. This is more than sufficient to encompass the grossly substandard care that Doerksen provided to Lisa Shore, the lies she told and charted, and the deceitful actions in which she engaged in an attempt to cover up the evidence of her negligence.

It is apparent that had Lisa Shore been cared for on October 22, 1998 by a nurse who was even minimally competent, she would still be alive today. Ruth Doerksen's actions, her omissions, her gross negligence, and her blatant disregard for protocols, procedures, and basic nursing resulted in Lisa's death.

The specific complaints are as follows:

Quality of nursing care grossly substandard:

- 1) She failed to check the computerized doctor's orders entered for Lisa's admission to Unit 5A, when all patients admitted to the units from the Emergency Department have computer orders.
- 2) The doctor specifically wrote by hand in the Emergency Department records to refer to his computer (Kidcom) orders, by writing "see kidcom orders". Since Doerksen did not check the Kidcom orders, either she failed to read the Emergency Department records, or else she read them and deliberately chose to ignore them.

- 3) Doerksen failed to read Lisa's chart that was handed to her when Lisa arrived on the unit from the Emergency Department. This chart was only a few pages long and contained information about the preceding few hours only, including admission documents, vital signs, nursing notes, and doctor's handwritten orders.
- 4) She accepted responsibility for Lisa's care when she knew nothing about Lisa's situation and health status, and did not take any steps to obtain information subsequently.
- 5) She failed to follow the doctor's orders in that she did not:
 - Put Lisa on oximetry;
 - Put Lisa on an apnea monitor;
 - Take Lisa's vital signs as directed;
 - Assess Lisa's pain scale and sedation scale as ordered;
 - Contact the physician as ordered regarding Lisa's deteriorating condition;
 - Take appropriate measures when Lisa showed signs of respiratory depression;
 - Take appropriate measures when Lisa showed signs of tachycardia
 - Set the IV flow rate as ordered
- 6) Failed to follow the standard written protocols and usual practice for patients on a PCA morphine pump in that she did not:
 - Put Lisa on oximetry (the written protocols state that it may be ordered at the doctor's discretion, and it was the usual practice at the hospital for patients on PCA morphine pumps to be on oximetry)
 - Put Lisa on an apnea monitor (the written protocols state that it may be ordered at the doctor's discretion)
 - Take Lisa's vital signs as directed;
 - Assess Lisa's pain scale and sedation scale as directed;
 - Contact the physician regarding Lisa's deteriorating condition;
 - Take appropriate measures when Lisa demonstrated signs of respiratory depression.
 - Take appropriate measures when Lisa demonstrated signs of tachycardia
- 7) Regardless of orders and protocols, Doerksen failed to follow minimal and basic nursing standards in that she did not:
 - Take appropriate vital signs when a patient on a high level of morphine was demonstrating signs of respiratory depression
 - Attempt to arouse a patient on a high level of morphine who was demonstrating signs of respiratory distress
 - Conduct a thorough respiratory assessment of a patient on a high level of morphine who was demonstrating signs of respiratory distress
 - Take appropriate measures regarding a patient demonstrating signs of tachycardia
 - Contact a physician regarding a patient's deteriorating condition

- Attempt to determine the oxygen saturation levels of a patient in respiratory distress
 - Check into the medications that the patient was taking concurrently, to learn about potential interactions
 - Make adequate or sufficient nursing notes or flowsheet observations
- 8) Doerksen says (as per the letter from the hospital) that she turned off an apnea alarm on a patient who had received a large amount of morphine. Respiratory depression is the most dangerous side effect of morphine, and disabling the alarm designed to warn of respiratory distress is an act of gross recklessness bordering on criminality.
- 9) Doerksen failed to ensure that she had the knowledge, skill and judgement required to evaluate the contraindications and interactions of the morphine Lisa received in the Emergency Department with the other medications that she was on.
- 10) She failed to ensure that she had the knowledge, skill, and judgement required to evaluate the side-effects of morphine and to recognize when intervention was required.
- 11) Doerksen failed to have the resources available to intervene when Lisa's condition deteriorated.
- 12) Doerksen failed to do a complete assessment of Lisa's vital signs when it was apparent that the vital signs had fluctuated beyond an acceptable level.
- 13) When Doerksen returned from duty after having been away from her patients for several hours (on break or in the Constant Care Room), she
- did not review the care provided and/or charted by the relieving nurse; if she had done so she would have seen serious deficiencies in nursing care and charting, and evidence of Lisa's deteriorating condition, OR
 - she did review the care provided and/or charted and did notice the serious deficiencies in nursing care and the evidence of Lisa's declining condition, and wilfully failed to take action.

Nursing documentation

- 14) Doerksen failed to write nursing notes while responsible for Lisa's care for a period of time during which Lisa's vital signs indicated a deterioration in her condition.
- 15) Notes that were made at 01:50 were inaccurate - she wrote "vital signs stable" without any frame of reference, when Lisa's vital signs were *not* stable compared to what they had been in the Emergency Department (of which she was wilfully ignorant).
- 16) Failed to document such a significant event as turning off the alarm on an apnea monitor, an action she alleges she did.
- 17) With assistance from at least one other nurse, falsified the nursing flowsheet by destroying the original and making a new one.
- 18) Entered false information in the 09:00 post-mortem nursing notes

- "Child settled to sleep and was asleep all night *except when woken by nurse for vital signs*".
- The two statements, "Corometric monitor applied since arrival to unit and in situ throughout the night" and "...monitor ~~in situ~~^{error RD} on and functioning."
- "vital signs stable"

19) Doerksen did not voluntarily report her failure to follow nursing practices and protocols to Mary Douglas, the nursing-educator for ward 5A, or to Dr. Jean Reeder, Chief of Nursing, or to any other nurse superiors. She did not report that she:

- neglected to access the Kidcom system and activate the doctors orders
- shut off the apnea alarm on the monitor she alleges she attached to Lisa
- failed to put Lisa on oximetry
- neglected to take Lisa's blood pressure (other than the one time when she was admitted to the unit)
- did not read the Emergency Department chart
- did not contact a physician when Lisa's vital signs were clearly deteriorating

Lied about what she did and did not do

20) Provided false information to her superiors, by lying about her actions. She told them:

- she placed Lisa on a Corometric monitor on arrival to 5A
- she settled Lisa for sleep after she arrived on 5A
- that the apnea alarm on the Corometric monitor sounded several false alarms
- Lisa was unable to get to sleep because of these false alarms
- she turned the apnea alarm of the Corometric monitor off
- she woke Lisa up at 05:00 and took an oral temperature, for which Lisa responded by opening her mouth. Shortly after, Lisa fell asleep.

Please contact me if you require any additional information.

Yours truly,

Sharon Shore

Back-up to the complaint regarding Ruth Doerksen

History

Lisa suffered from reflex sympathetic dystrophy (also known as RSD, CRPS, or complex regional pain syndrome), which developed as a result of a broken leg she had sustained eight months earlier, in February 1998. RSD is a chronic pain condition thought to result from nerve damage from a fracture, sprain, or other trauma. Its primary symptom is pain, but it is in no way life-threatening or dangerous. In every other respect Lisa was a completely healthy and active 10-year-old.

As a result of the pain she was suffering, Lisa had two admissions at Sick Kids in February and March 1998, totalling about three weeks. Approximately 1/2 of this period was spent on Ward 5A/5B, so Lisa was known to most of the staff on the ward. Ruth Doerksen, although she was working on 5A/5B at that time, did not provide direct nursing care to Lisa, but would certainly have known of her.

One of the treatments that was tried in an effort to reduce Lisa's pain was a short trial of morphine, orally and via PCA pump. This did not ameliorate her pain and was quickly discontinued. (Lisa had no further experience with opioids until October 21, 1998, several hours before she died.)

Hospital staff then diagnosed Lisa's pain as psychogenic and made no attempts at further treatment. She was subsequently diagnosed with RSD by Children's Hospital in Boston, and given medications which helped control her pain - gabapentin, amitryptiline, and carbamazepine.

In October 1998, Lisa experienced a severe flare-up of pain and was brought to the Emergency Department of the Hospital for Sick Children on the evening of October 21st. There she received 14.5mg of morphine in one and one quarter hours (via IV bolus and PCA pump), after which she fell asleep and was brought up to ward 5A.

Ward 5A (and its counterpart 5B) is a general surgery/orthopedics/ear nose & throat unit. Nurses rotate interchangeably through 5A and 5B, and may do one shift on the first ward and the next shift on the other.

The doctor who treated Lisa in Emergency, the one who administered the morphine and set up the PCA pump, entered detailed monitoring orders for her care into the computer system and put a handwritten note into the chart that said to refer to the computer orders. Lisa was admitted to ward 5A - under the care of nurse Doerksen - at approximately 01:40am. She was found vital signs absent at 07:15 the next morning by doctors on rounds.

Excluding a Constant Care Room which had a full-time attending nurse (and who was not allowed to leave it), ward 5A had nine patients including Lisa that night. Care for these nine patients was assumed by two nurses, Ruth Doerksen and Anagaile Soriano. It was a

relatively quiet night with no medical emergencies (other than Lisa Shore). This is my personal observation, as no monitor alarms went off nearby during the remainder of the night, the intercom was never used (no one calling for assistance, for keys to the locked medication storage, etc.), and I have spoken with two of the other eight patient's mothers and they both stated that it was quiet on the ward that evening. The hospital has not suggested otherwise or offered this as a reason to excuse the nurses' actions.

Just before Lisa was transferred from Emergency to ward 5A, a call was made from an Emergency Department nurse up to the nurse who was assigned to Lisa. Although the assigned nurse was Doerksen, the call was taken instead by Soriano.

When Lisa arrived on the unit, both nurses Doerksen and Soriano remained in Lisa's room while Lisa was transferred from the stretcher to the bed and vital signs taken. The two of them checked the PCA morphine pump together. Although I was present and attempting to be helpful (asking, for instance, if they needed my help in transferring Lisa from the stretcher), neither spoke to me other than to respond curtly to my direct questions. I thought to myself that in comparison to the other 5A nurses I had met on Lisa's prior two admissions, these nurses were quite rude. I deliberately attempted some casual conversation in the hope that they would take notice of me and "lighten up".

Doerksen *never* spoke to me, not a single word. The only nurse who spoke to me was the one who I now know to be Soriano. As both nurses appeared equally involved in Lisa's 01:45 assessment, I assumed - incorrectly - that the one nurse who spoke to me was Lisa's assigned nurse.

Several minutes after Lisa's admission to the unit, both nurses left. One of them returned shortly after with linens for me (there is a couch in the room which doubles as a bed). No monitor was brought into the room at any time. Lisa was not attached to any equipment other than the IV and the PCA pump, which had both been set up in Emergency. No nurse returned to the room in the next fifteen minutes or so, at which time I closed the light and went to sleep, and Doerksen entered the Constant Care Room.

I am a light sleeper, and would have awakened had there been any noises in the room such as alarms, conversations, or attempts to wake up Lisa up.

Additional information, item #1

She failed to check the computerized doctor's orders entered for Lisa's admission to Unit 5A, when all patients admitted to the units from the Emergency Department have computer orders.

- Doerksen has been employed at the Hospital for Sick Children, on the same unit, for fourteen consecutive years (excluding maternity leaves)
- The Kidcom system has been in use at the Hospital for Sick Children since 1993

- Children arriving on a ward from Emergency always have Kidcom computer orders placed in the system; if for some reason orders failed to arrive, it would be incumbent upon the nurse to phone the doctor to question him or her about them.
- All doctors orders for the wards are placed in the Kidcom computer system
- The written policy for the Kidcom system states that the doctor in Emergency should call up to the ward when a patient is being admitted. The current practice, in existence for several years, is for the nurse to call up. The reason for this change is that doctors frequently move around the hospital, go to sleep, go into surgery, etc., and it is far more consistent and reliable to have a nurse who is on a regular shift make this phone call.
- In Lisa's case, two different doctors - an Orthopedics resident and the Pain Service physician - entered orders into Kidcom relating to her care. Neither of these doctors contacted the ward nurses.
- Two phone calls were made by Emergency Department nurses regarding Lisa - one taken by Doerksen and one by Soriano (although only one call is noted in the Emergency records, this fact is not in dispute).
- The Pain Service doctor who saw Lisa in Emergency, Dr. Schily, had been working at the hospital for approximately seventeen hours when he left for home around midnight, and he was due to return only a few hours later, early the next morning. He was not in the hospital when the Emergency Department nurse contacted the nurse on ward 5A. This is a perfect example of why the practice was changed, notwithstanding the written policies.
- Wards 5A/5B are general surgery wards that have regular admissions from Emergency and are experienced with the required routines.
- Ward 5A/5B is the destination of choice for patients on PCA morphine pumps due to their expertise in this area.
- The CEO of the hospital, Michael Strofolino, personally advised me that he is not aware of any other instances where a nurse neglected to check the doctor's orders.

Additional information, item #2

The doctor specifically wrote by hand in the Emergency Department records to refer to his computer (Kidcom) orders, by writing "see kidcom orders". Since Doerksen did not check the Kidcom orders, either she failed to read the Emergency Department records, or else she read them and deliberately chose to ignore them.

- The hospital's Emergency Department is not fully integrated into the Kidcom computer system
- Emergency Department orders are hand-written and are for use in Emergency only, a fact well-known by all ward nurses who deal with Emergency and emergency admissions.

- Emergency Department nurses have no access to the Kidcom system, so a notation in the Emergency Department orders to refer to Kidcom was specifically directed to the ward nurses, and was an additional reminder or prompt over and above the standard requirements.
- The page containing the doctor's hand-written orders consisted of nine lines only. In the middle of these lines was the sentence, "see Kidcom Orders"

Additional information, item #3

Doerksen failed to read Lisa's chart that was handed to her when Lisa arrived on the unit from the emergency department. This chart was only a few pages long and contained information about the preceding few hours only, including admission documents, vital signs, nursing notes, and doctor's handwritten orders.

- If Doerksen did not follow the order to refer to the Kidcom orders because she failed to read the doctor's orders, she obviously did not read anything else in the chart, given that it was only a few pages long.
- Lisa's respiration on admission to the unit was 16 breaths per minute. One hour later it was down to 8-10 breaths per minute. When Lisa came into the hospital, her respiratory rate was charted as 20. Lisa's blood pressure in Emergency was last charted as 106/84, and on admission to the unit it was 90/60. A diligent nurse who had read the emergency chart would have become concerned about the decline in vital signs and increased the level of monitoring.
- Doerksen's nursing notes, written just after Lisa was admitted to the unit, contain the comment "vital signs stable". Since Lisa's vital signs were clearly not stable, and Doerksen had no reference to compare them to, this note is indicative of either incompetence or intentional deception.

Additional information, item #4

She accepted responsibility for Lisa's care when she knew nothing about Lisa's situation and health status, and did not take any steps to obtain information subsequently.

Doerksen took over responsibility for Lisa's care without:

- having read the Emergency chart,
- checking the doctor's orders,
- knowing whether or not the administration of any medications had been ordered,
- knowing or learning any information on the medications Lisa was concurrently on or their interaction with morphine
- attempting to obtain any information on Lisa by questioning Lisa's mother (the complainant).

She made no attempt to obtain this information subsequently.

Items #5-7

Failed to follow the doctor's orders...

Failed to follow the standard written protocols and usual practice...
Failed to follow minimal and basic nursing standards...
Self-explanatory

Additional information, item #8

Doerksen says (as per the letter from the hospital) that she turned off an apnea alarm on a patient who had received a large amount of morphine. Respiratory depression is the most dangerous side effect of morphine, and disabling the alarm designed to warn of respiratory distress is an act of gross recklessness bordering on criminality.

This is what she told her superiors she did, as per the hospital's letter of March 3, 1999 to the Coroner's office. I know beyond a shadow of a doubt that there were no alarms in Lisa's room that night. This statement is part of the elaborate lies she concocted about the night and what she did. However, in her effort to tell big lies, little inconsistencies such as this one creep in. If she insists she turned off an apnea alarm on a patient for whom respiratory distress is a potentially disastrous side-effect of the medication she was on, then Doerksen should account to the College for the sheer recklessness of that action.

Additional information, item #9

Doerksen failed to ensure that she had the knowledge, skill and judgement required to evaluate the contraindications and interactions of the morphine Lisa received in the Emergency Department with the other medications that she was on.

- Lisa was taking three medications other than morphine - amitriptyline (a tricyclic antidepressant), gabapentin, and carbamazepine. According to the CPS,
*"Morphine should be used with caution and in reduced dosage in patients who are concurrently receiving other opioid analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, **tricyclic antidepressants** and other CNS depressants (including alcohol). **Respiratory depression, hypotension and profound sedation or coma may result.**"*
- Amitriptyline is a highly sedating medication, and it is relatively commonly prescribed. Even without checking, Doerksen should have been aware of its sedating properties and its potential interaction with morphine. A competent nurse using her own clinical judgement would have increased the monitoring levels over and above what the doctor had ordered, instead of decreasing monitoring to significantly less than what was ordered.
- Gabapentin and carbamazepine, Lisa's other medications, are both used in the treatment of epilepsy, and less commonly for neuropathic pain. It would be unlikely for a nurse on a general surgery ward to have much if any knowledge of these medications. A competent nurse would have checked into these medications, their actions and interactions with morphine, and increased her monitoring of the patient. A competent nurse who did not check into these medications, aware that her patient

was on medications that she did not know much about, would likewise in the default have increased, not decreased, her vigilance.

Additional information, item #10

She failed to ensure that she had the knowledge, skill, and judgement required to evaluate the side-effects of morphine and to recognize when intervention was required.

The most dangerous side effect of morphine is respiratory depression, which untreated can lead to death. All nurses should know this, but the nurses on ward 5A, where Doerksen had worked for fourteen years, were supposed to be the most experienced in the hospital with morphine and patients receiving morphine via PCA pumps.

Where respiratory depression occurs in a sleeping patient who has received a very high amount of morphine, as Lisa had, the most important thing to do initially is to attempt to arouse the patient and assess her level of consciousness. This was not done, and the failure to do so demonstrated gross incompetence and/or extreme negligence.

Additional information, item #11

Doerksen failed to have the resources available to intervene when Lisa's condition deteriorated.

- respiratory depression in a patient on a high dosage of opioids calls for immediate medical attention, e.g. measurement of oxygen saturation levels, stat call for a physician, and possible administration of nalaxone. As Doerksen was not sufficiently competent to assess her patient and determine that she was deteriorating, none of these resources or opportunities for intervention were available to Lisa.

Additional information, item #12

Doerksen failed to do a complete assessment of Lisa's vital signs when it was apparent that the vital signs had fluctuated beyond an acceptable level.

- Over the course of the evening, Lisa's heart rate - while sleeping - went from 90 in Emergency, to 72 on admission to the ward, to (as charted) 120, 130, 134, 126, 126. Blood pressure was taken on arrival to the unit at 01:45 and never again.
- Doerksen's failure to take Lisa's vital signs in accordance with what had been ordered by the physician and equally by written protocol has been discussed above. However, regardless of that deficiency, once Lisa's vitals - the ones that *were* taken - were abnormal, any minimally competent nurse would at least then have taken a blood pressure, done a detailed respiratory assessment, attempted to awaken Lisa, and contacted the doctor. The Coroner's Pediatric Death Review Committee stated in its report that:

"...Even though the monitoring was insufficient, that which was done demonstrated cause for clinical concern. The response to this monitoring by

nursing staff was insufficient in the opinion of the committee - the tachycardia and the falling respiratory rate required timely medical attention."

- According to the flowsheet, Doerksen returned from break and entered Lisa's room at 05:00. She noted that she took Lisa's heart rate, respiratory rate, and temperature. Temperature was not one of the vital signs required by doctor's orders or PCA protocols. There was no reason whatsoever to take Lisa's temperature and every reason to take her blood pressure.

Additional information, item #13

When Doerksen returned from duty after having been away from her patients for several hours (on break or in the Constant Care Room), she

- *did not review the care provided and/or charted by the relieving nurse; if she had done so she would have seen serious deficiencies in nursing care and charting, and evidence of Lisa's deteriorating condition, OR*
- *she did review the care provided and/or charted and did notice the serious deficiencies in nursing care and the evidence of Lisa's declining condition, and wilfully failed to take action.*

A diligent, responsible nurse, after returning from break, would review the status of her patients and the care given in her absence, knowing that she was ultimately responsible for her patients. Since the relieving nurse was a new graduate of only a few months experience, it was all the more critical that such a review be conducted. A competent nurse, returning from break between 04:30 and 05:00, would have seen from the chart alone that Lisa's condition was deteriorating, and a competent nurse would have taken immediate action. Doerksen did not care to check, or else she checked and didn't care.

Additional information, item #14

Doerksen failed to write nursing notes while responsible for Lisa's care for a period of time during which Lisa's vital signs indicated a deterioration in her condition.

- the only nursing notes written while Lisa was alive were done within minutes after Lisa arrived onto the ward at about 01:45am
- A second nursing note was done, post-mortem, at 09:00, almost two hours after Lisa was found vital signs absent
- When Doerksen returned from break somewhere between 04:30 and 05:00, the relieving nurse had contacted the physician, Lisa had been experiencing respiratory depression, fluctuations in respiratory rate, and tachycardia, yet Doerksen made no nursing notes or notations on the flowchart.
- It was a quiet night and no one was unusually pressed for time; no alarms sounded and there were no emergencies (other than Lisa).

Additional information, item #15

Notes that were made at 01:50 were inaccurate - she wrote "vital signs stable" without any frame of reference, and when Lisa's vital signs were not stable.

- Doerksen's nursing note, written shortly after Lisa's admission to the ward, said "vital signs stable". Lisa's last blood pressure, charted in Emergency approximately one hour before she was admitted to the floor, was 106/84. On admission to 5A one hour later, after receiving a large dose of morphine, it was 90/60. It is my allegation that she wrote "vital signs stable" without having any indication whether or not Lisa's vital signs were stable.
- It is possible that these words "vital signs stable" were added in after the fact, in order to make it seem as if Doerksen had done a thorough evaluation. A forensic document examiner will be analysing this document to see if this can be confirmed.

Item #16

Failed to document such a significant event as turning off the alarm on an apnea monitor, an action she alleges she did.

Since there was no monitor ever used, there were no alarms to turn off. Doerksen devised this lie to help explain why no alarms sounded on the monitor she surreptitiously attached to Lisa (most probably after Lisa was already dead) but did not turn on.

In order to turn off the respiratory rate alarm, the monitor has to be opened up with a tool (scissors, knife, etc.). Unless documented, there is no way for other nurses and doctors to know that this has been done. The act of turning off a respiratory alarm on a patient who had received a high dosage of morphine (had it been true) was negligent. Failing to document such a significant and dangerous act so that the relieving and other nurses could know about it is criminally negligent.

Additional information, item #17

With assistance from at least one other nurse, falsified the nursing flowsheet by destroying the original and making a new one.

I believe that

- The major change in the rewritten chart was the removal of blood pressures (minor changes included among others the addition of 'os', and changing the time that the temperature was taken from 04:05 to 05:00). The nurses were pressed for time, and they were afraid that if they made too many alterations they might be detected.
- Lisa's blood pressure was taken one or more times in the night after 01:45 and was seen to be dangerously low, although no blood pressures are shown on the chart except for the one taken at 01:45 on admission to the unit.
- Doerksen and Soriano, knowing that their care had been negligent, decided that the sin of omission would be less serious than the sin of commission. The most obvious indication on the flowchart that Lisa was in medical distress would have been her

falling blood pressure. Fluctuations in heart and respiratory rates could be explained away as still falling within normal ranges (they thought), but not so with a dropping blood pressure. Therefore, if they rewrote the chart and removed the blood pressures, they might get in trouble for failing to take all the vital signs, but could not be accused of charting and ignoring obvious signs of medical crisis. Their actions would be seen as stupid, but not negligent, which is by far the lesser “crime”.

- I further believe that analysis of the other patient charts would show that all of them except Lisa Shore had their blood pressures taken at or around 04:05 by Soriano.
- The temperature charted by Doerksen as taken os (by mouth) at 05:00 was not taken at that time, and was added in the revised version. Lisa was such a sound sleeper, even without any medications, that she would sleep through alarm clocks. The amitriptyline that she took was prescribed largely for its sedative abilities, so she could sleep at night even though she was in pain. It would have been impossible to awaken Lisa that night - assuming that she was not already near death - without screaming in her ear and shaking her vigorously. And had she been successfully awakened, Lisa would have opened her eyes and then gone right back to sleep, unable to hold a thermometer in her mouth.
- I believe that this temperature was taken at 04:05 (by ear, and not by mouth) by Soriano – along with blood pressure – when Soriano did her rounds on all the patients. I believe that the 04:05 temperature was moved to 05:00 in the revised chart in order to make it look as if Doerksen was doing an adequate assessment at 05:00. The hospital, in response to our question as to why Lisa did not have her blood pressure taken, said that perhaps the nurses did not want to wake her up. How could Doerksen have awakened Lisa to take an oral temperature, yet “not want to wake her up” to take her blood pressure?
- I believe that Doerksen was dishonest and deceitful, and that the chart was falsified in an attempt to hide or minimize the evidence of her negligence.
- A forensic document examination will be conducted at the Centre for Forensic Science at the end of August 2000.

Additional information, item #18

Entered false information in the 09:00 post-mortem nursing notes

- *"Child settled to sleep and was asleep all night except when woken by nurse for vital signs".*

As noted in item 17, Lisa was such a sound sleeper - even without any medication - that it would have been impossible to awaken her without shouting in her ear and shaking her vigorously. Had Lisa really been awakened, the entire floor would have heard the efforts of the nurses. I would have been awake in an instant. In the throes of respiratory depression and tachycardia, Lisa was simply not rousable. There was only silence in Lisa's room all night - no one *ever* tried to awaken her.

- *The two statements, "Corometric monitor applied since arrival to unit and in situ throughout the night" and "...moniter ~~in situ~~^{error RD} on and functioning."*

This is a complete fabrication. Doerksen charted that Lisa arrived on the unit at 01:45. No monitor was applied on arrival to unit. No monitor was brought in over the next fifteen minutes, after which time I went to sleep and Ruth Doerksen entered the Constant Care Room to relieve another nurse. Computer entries made into Lisa's file can place Doerksen in the Constant Care Room at 02:05, and she had to have given a report to the nurse she was relieving, and then taken a report from the nurse she relieved, before entering any data at the computer. Doerksen did not return to floor duty until approximately 05:00 (Doerksen's next entry in the flowchart after 01:45 is at 05:00), the earliest time she could possibly have brought a monitor into the room.

A monitor was found in the room when Lisa died, but all parties concur that the machine was not turned on. The hospital cannot (or will not) provide an explanation.

Lisa was not on any monitors prior to 05:00. Sometime afterwards, Doerksen brought a corometric monitor into the room and attached it to Lisa, but could not turn it on. If Lisa was still alive when she brought the monitor in and turned it on, it would cycle through a startup self-test which includes a short but loud alarm. This would have awakened me instantly, and I would have started asking many questions. The more likely reason that Doerksen did not turn on the alarm was that Lisa was already dead. Why else would a nurse who has already failed to follow even the most basic nursing practices suddenly decide to bring an apnea monitor in the room, to a child about whom she wrote "vital signs stable"?

If a corometric apnea monitor is "on and functioning" and does not read any heartbeat or respiration, it will alarm very loudly. Since the monitor did not alarm when Lisa died, it would be expected that this was a matter significant enough to have been addressed by the nurse in her post-mortem nursing notes. Instead of distress, anger, and questioning why a piece of equipment that was supposedly attached to a patient did not work, and the child had died, Doerksen merely wrote that the monitor was there. No unusual problems were noted or felt to be worth mentioning.

Doerksen also crossed off "in situ", which she used several lines earlier in the same note, about the same monitor. Instead, she wrote "on and functioning". Although nothing was charted about a monitor while Lisa was alive, she now addressed the subject twice, near the beginning and again near the end of her notes. Since the hospital subsequently agreed that the monitor was not on when Lisa died, why would Doerksen write "on and functioning", unless she was anticipating some questions that might be asked of her down the road?

- *"vital signs stable"*

See comments above on item#15. Lisa's vitals were anything but stable.

Additional information, item #19

Self-explanatory

Additional information, item #20

Provided false information to her superiors, by lying about her actions. She told them:

- *she placed Lisa on a Corometric monitor on arrival to 5A*
- *she settled Lisa for sleep after she arrived on 5A*
- *that the apnea alarm on the Corometric monitor sounded several false alarms*
- *Lisa was unable to get to sleep because of these false alarms*
- *she turned the apnea alarm of the Corometric monitor off*
- *she woke Lisa up at 05:00 to take her oral temperature, and Lisa responded by opening her mouth and holding the thermometer in her mouth for the required thirty seconds or so. Shortly after, Lisa fell asleep.*

The above information is taken entirely from the Hospital for Sick Children's letter of March 3, 1999 to the coroner's office, in response to questions that the Shore family asked. The details contained in the letter regarding the nurses' actions are clearly what was relayed by Doerksen and the other nurse on duty that evening, Anagaile Soriano. A number of sentences in the letter start with "she states..." or "The nurse states..."

The real truth is that

- no monitor was attached to Lisa on admission to the unit.
- if a monitor was attached sometime after 04:30, it was never turned on.
- If a monitor was brought into the room while I was sleeping, sometime after 04:30, it was never turned on. The monitor emits a short burst of alarm when turned on as it cycles through a "self-test". Such a noise would have woken me instantly.
- Lisa was not "settled for sleep" because she fell asleep in the Emergency Department and never woke up again.
- no alarms ever went off in Lisa's room - false alarms or otherwise. There was silence in the room the entire night.
- no one entered the room between 1:45, when the nurses assessed Lisa, and 2:00, when Doerksen entered the Constant Care Room, for any purpose whatsoever (except to hand me linens). Since Doerksen wrote her nursing note on Lisa at 01:50, and presumably had to give a report to Soriano so that Soriano could take over the care of Doerksen's patients, that leaves very little time for Doerksen to have entered the room to turn off multiple false alarms. And where was I when this was supposed to be happening?
- Lisa was not "unable to get to sleep", she was always asleep and never woke up. Ever. It is noteworthy that Doerksen's statement to her superiors was that she turned off the alarm because Lisa was unable to get to sleep, but she wrote in her post-mortem nursing note at 09:00 that Lisa was asleep all night.

- Lisa was not awakened at 05:00, and no oral temperature was taken. (I believe that no temperature was taken at all, and that this was one of the things added when the nursing note was redone. Why would a nurse who didn't bother to take blood pressure, a mandatory requirement, take the patient's temperature when that was not part of the orders or protocols?)
- There are 11 lines of data on the nursing flowchart, representing 11 times one or the other nurse was in the room. On five of those occasions, only respiration was noted. If there was a functioning monitor, why wouldn't the heart rate have been noted as well (particularly when it was rapidly increasing to dangerous levels)?
- There are 20 separate entries noted on the flowsheet for heart rate and respiratory rate. Every one of them is an even number, which is exactly what you would get when taking these measurements manually. If you were taking them off a monitor, it is statistically almost impossible that every one of those 20 measurements would be an even number.

I believe that Ruth Doerksen brought a corometric monitor into the room and attached it to Lisa when Lisa was already dead, at approximately 07:00 when Doerksen was doing her regular nursing checks. I believe that she conspired with Soriano to fabricate the story about the corometric monitor being used throughout the night. I believe that since neither Doerksen nor Soriano voluntarily notified their superiors that they had not read the doctor's orders or followed the mandatory PCA protocols, their actions were dishonest and deceitful, and the falsehoods about the monitor were concocted in an attempt to hide or minimize the evidence of their negligence.