

HPAR appeal re: Jean Reeder

I want to apologize in advance to the Board for the length of these comments. I thought I had already submitted in writing most of what I wanted to say. That was until the Board sent me a lot of documents and interviews that I had not previously seen, as part of the process of full disclosure. I have gone over them in detail, and have read so many comments that are illogical, untrue, or just plain ridiculous, that I feel compelled to add to my written correspondence. Had I seen these in advance, I would have been able to supply you with additional written explanations as to why I believe the College should reconsider its decisions. I tried hard to limit my presentation to only the things I felt were really important. I am confident that the members of this Board have read most or all of the materials for themselves and have a good grasp of the issues. I am sure you are able to see past the empty rhetoric and half-truths.

The College of Nurses issued Dr. Reeder a letter of caution and a verbal caution for failing to conduct an investigation. Reading Dr. Reeder's various letters and correspondence, she seems to have taken two mutually contradictory positions. First she says that it wasn't her job to do an investigation, and then she says that she did a satisfactory investigation and took many steps to ensure her nurses were safe practitioners.

I would like to point out that every single one of the documents submitted by Dr. Reeder and her counsel to substantiate her various arguments has been in the form of a letter from her or her counsel, or else a job description or resume. There has been nothing in writing provided to the College by any employee of the Hospital for Sick Children which documents any investigation into Lisa's death. For that matter, no such documents were ever presented by anyone at the Hospital for Sick Children or its counsel, Mr. Hawkins, to the coroner's office. There appear to be no written records about any discussions or interviews with Lisa's two nurses. There are no documents to explain how the hospital determined that Lisa's nurses were safe practitioners, and what they did about the nurses' errors to ensure these nurses could continue to care safely for other children. In short, there is nothing at all in writing to prove that any investigation took place.

The inquest occurred more than one year after Lisa died. Dr. Reeder mentions in numerous places that she was assured that an investigation was being conducted, but she never says who assured her. Dr. Reeder has also explained over and over again about the various investigations that she as well as others did, and how everyone was satisfied that Lisa's nurses were safe practitioners. I would like to say to the Board that it is very convenient that so many people talked about so many things, yet no one apparently bothered to write anything down. In a tertiary care/quaternary care hospital like Sick Kids, how believable is that?

Dr. Reeder will tell you on page 613 (page 11 of her Oct. 28, 2000 letter to the College) that she and others "identified gaps in nursing and medical practice, communication issues between all of the involved staff, problems with monitoring equipment, and gaps in computer systems." She says she submitted a document purporting to explain these issues and how the hospital attempted to address them.

I would like to point out to the Board that this undated and unsigned document (page 643-645) says nothing about any gaps or problems and identifies no issues. All it does is list some things the hospital has done, with no explanation as to why or what deficiencies the hospital was attempting to remedy. There was no direct or even indirect connection made to any of the circumstances of Lisa's death.

Dr. Reeder also asks that the College's letter of caution be rescinded because it was not her responsibility to conduct an investigation. She says in several documents that she doesn't like to "micro-manage". To that I would say that if there was ever a time that the person at the top should have been directly involved, this was that "sentinel event". Dr. Reeder says that the most senior nurse responsible for investigating nursing issues in relation to Lisa's death was an individual named Cathy Seguin. I would like to stress to the Board that no one from the Hospital for Sick Children *ever* supplied this information to the Coroner's Office. At the inquest, nurse after nurse testified, including Dr. Reeder herself, without ever once mentioning Cathy Seguin's involvement (although one nurse did say in passing that Ms. Seguin was present at a meeting she attended). Had Dr. Reeder or Mr. Hawkins or anyone else at the hospital mentioned Cathy Seguin's important role at any time, I assure you that she would have been called to testify at the inquest either by the coroner or by us. As a matter of fact, I find that the hospital's failure to mention Cathy Seguin's role until now to be highly suspect.

I would now like to go over some of the other important inconsistencies in Dr. Reeder's submissions. I believe that the complaints committee was not aware of them when it reviewed the remainder of my complaint. I believe that the committee assumed that Dr. Reeder's answers to each incident were honest and truthful, without realizing that her version of the truth varied for each answer. Had the complaints committee been aware of these inconsistencies, I am sure that it would have considered my complaints in a different light. For this reason, I would like to present some of these inconsistencies to the Board.

For incident #1, the complaints committee believed that Dr. Reeder was not clear about whether there were any nursing practice issues (page "H"). "The Committee notes that there is no information to indicate that the member knew that there were any nursing practice issues to be reported."

For incident #3 (page "J"), the Committee felt that she was aware there were *some* nursing issues. It wrote "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."

In incident #5, (page "L") Dr. Reeder's position is summarized by the comment "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 Lisa on the night in question."

In her Oct. 11, 2000 interview with the College Investigator, page 507 (page 4 of the interview), Dr. Reeder says in the last paragraph that "many of the details at the inquest were heard by her for the first time. She does not recall when she first learned about the Kidcom orders not being activated by the nurses caring for Lisa that night until the

inquest.” On the next page (page 508) she says that “gaps in information regarding this case did not become apparent until the inquest occurred.”

Two weeks after the interview letter, on October 27, 2000, Dr. Reeder wrote another letter to the College. In that letter (page 607, page 5 of the letter), she wrote that she learned that the nurses had neglected to access the physician’s orders and had not strictly followed the PCA monitoring protocols at a meeting with Cathy Seguin and Anu McIntosh on February 25, 1999, four months after Lisa’s death and before any of her discussions and investigations.

Three pages further (page 610, or page 8 of the letter), she wrote that it was important for her to attend the inquest and hear the daily testimony since she still lacked many details around Lisa’s death.

I’m not sure how Dr. Reeder can say that she lacked many details but at the same time tell this Board that she conducted a satisfactory investigation. It would seem that she is trying to have her cake and eat it too. I would challenge Dr. Reeder to explain to this Board exactly what new things it was that she learned at the inquest, and if any of those were at all material. And if they were material, what did she do about them once she discovered them? What changes and improvements did she go back to the hospital and implement based on new information that she learned at the inquest? What did she document? If she learned anything significant, did this alter her decision that Lisa’s nurses were safe practitioners?

Dr. Reeder, by her own admission, knew full well about all the *significant* nursing practice issues in this case from at least Feb. 25, 1999 onwards. Between that time and the inquest, no thorough investigation was conducted by her or anyone else at the hospital. Whatever new information Dr. Reeder learned at the inquest that she did not know before was utterly inconsequential in terms of nursing practice issues. I therefore believe the complaints committee should reconsider each one of my allegations that were dismissed, bearing this in mind. The Committee should review each allegation knowing that Dr. Reeder had full knowledge of all the material facts about nursing practice issues.

Another major inconsistency I would like to bring to your attention is with Dr. Reeder’s frequent mention of her extensive discussions with Lisa’s two nurses. In her interview with the College’s investigator (page 507, page 4 of the interview), she says that in her opinion, Lisa’s nurses had admitted their mistakes and engaged in reflective practice.

In that same interview with the investigator (page 509, page 6 of the interview), Dr. Reeder says she met with the nurses and they took the situation seriously, showed remorse, and admitted their errors.

In her October 27, 2000 letter to the College (page 609, page 7 of this letter), Dr. Reeder said that from her discussions with Ruth and Anagaile, she believed that they had learned from the death and were committed to becoming safer and more conscientious practitioners.

Aside from the question I have already asked as to why Dr. Reeder didn’t bother to document any of this, I would like to draw the Board’s attention to Dr. Reeder’s

comments on page 608, or page 6 of this same October 27, 2000 letter. Here she admits that Lisa's nurses "were quite reluctant to share detailed information with me about the events of that night, having been advised by their lawyer "not to discuss this with anyone." "

Dr. Reeder was the Chief of Nursing. She had been made aware that two of her nurses did not check or follow doctor's orders, did not follow standard protocols, and did not take complete vital signs. She says elsewhere that she knew that one of the nurses had told Mary Douglas about allegedly turning off an alarm on a breathing monitor. If Dr. Reeder had reviewed Lisa's chart as she claims she did, she would have seen that Lisa was experiencing respiratory depression about the same time that the nurse said she turned off the breathing alarm. Dr. Reeder goes to have a talk to these two nurses, and they don't want to talk to her on the advice of their lawyer. Their lawyer is also the hospital's lawyer. Why didn't she call up Mr. Hawkins right then and there and tell him that this was unacceptable and that they should be talking to her? Dr. Reeder states on page 606 that she would only discipline a nurse if they commit intentional harm or show lack of trust or integrity. Personally, I think that my own employees not wanting to speak with me about very serious events that happened on the job, on the advice of our mutual lawyer would not be employees that could be considered trustworthy and to be acting with integrity.

I'd like to know how, based on that, did Dr. Reeder decide from her discussions with them that these nurse were safe practitioners who admitted their errors? Which errors were they willing to admit and which did they not want to talk about on the advice of their lawyer? Did they admit to not reading the orders? If they did, how could Dr. Reeder possibly conclude that this was the action of a safe practitioner? If they didn't tell her about it – and remember, she already knew about it from her Feb. 25 meeting – why would she conclude that nurses who refused to talk about such a significant misdeed were safe practitioners?

Dr. Reeder admitted at the inquest that no one checked the records of these nurses' other patients. How did anyone know if Lisa's nurses followed doctor's orders for those patients? More importantly, on what possible basis could anyone who gave a damn about the safety of patients decide that these nurses were safe practitioners who did not deserve to have any disciplinary action taken against them?

Another example of where the complaints committee erred is in its response to incident #3 (page "J"). The committee wrote that there was no information to indicate that the member had the power to dismiss the named nurses from their employment.

However, in Dr. Reeder's interview with the College investigator, page 507, she says that she did not have hiring and firing responsibility for staff nurses, but then goes on to say that she could influence people's decisions. She says that the Director of surgical specialties agreed that there was insufficient cause for terminating these nurses. I would suggest to the Board that the College's interpretation that there was no information that Dr. Reeder had the power to dismiss the nurses is an incorrect interpretation.

In Dr. Reeder's recent letter to this Board, dated June 28, 2001, page 4, she requests that all the allegations against her be dismissed. She says she dealt with the nursing errors

appropriately, and states that she has acknowledged to us publicly and privately that serious errors did occur. She says she has explained to us the steps that the hospital has taken to help the nurses improve their practice and ensure that they are safe practitioners.

I would like to tell the Board that not a word of this is true. Dr. Reeder told us that her nurses made innocent mistakes. She said they made errors in judgement. She said they accidentally forgot to check for doctor's orders. Every single thing she told us implied that they made a few mistakes, but they were all minor and of no consequence.

Dr. Reeder never said a word about what steps the hospital took to specifically help the nurses improve their practice and ensure that they were safe practitioners. She talked about all sorts of general things like buying new monitors and doing more auditing on charting, but she said nothing specifically about Lisa's nurses until I asked. Then all she said was that the nurses had learned from their mistakes.

Michael Strofolino, the chief executive officer of the hospital, said in his interview with the College of Nurses (page 113) that "the hospital has no explanation as to why the orders were not opened and not followed. Jean Reeder believed that the nurses used professional judgment and found no fault with the care provided by the nurses to Lisa." Mr. Strofolino was positive enough about how Jean Reeder felt about the nurses' actions that he was willing to have it form part of his statement on the record. It's very strange, isn't it, how she could tell her Chief Executive Officer one thing – that the nurses used their professional judgment and did nothing wrong, yet she can tell the College of Nurses something completely different?

As further evidence that Dr. Reeder did not believe that her nurses did anything terribly wrong, I draw your attention to page 612 (page 10 of her October 27, 2000 letter to the College). She says, "I recognize that there were serious gaps in nursing practice. The monitoring did not comply with the doctor's orders or the protocols. The nurses told me and everybody else that this was because they forgot to check the orders. This was not challenged. This was clearly a mistake, *one that we all can and have made*, but a mistake nevertheless."

I know this is a formal presentation, but I have to say that I have never heard a more ridiculous statement coming from someone with a PhD in nursing. Forgetting to check the doctor's orders or complying with standard protocols is a mistake that all nurses can and do make? If this is not proof that Dr. Reeder believes that her nurses didn't do anything wrong, then what is?

I believe that the Complaints Committee should consider these contradictions when assessing the sincerity and credibility of Dr. Reeder. It is easy to understand why no corrective or disciplinary action is undertaken when one believes that not checking doctors orders or following standard protocols is a common mistake that anyone can make.

I'd like to give you another example where Dr. Reeder's credibility appears to be suspect. In her October 27 letter to the College, page 608, she writes that over the few months after she learned there were nursing issues, she met with staff to provide support and help them deal with the impact of this case. She cites a problem with their collective morale.

This is all very interesting given that seven nurses from the ward on which Lisa died, ward 5AB, testified at my daughter's inquest, and virtually every one of them swore under oath that they had never, ever discussed the case or Lisa's death amongst themselves or with anyone else after the day she died. Dr. Reeder was present for all of this testimony, of course. How does she reconcile problems with morale and dealing with the impact of the case when none of them ever, ever talked about it?

In conclusion, I would like to add one last thing. I am sure Mr. Hawkins and Dr. Reeder will stress how she believes in having a blame-free culture so people can learn from their mistakes. I agree with that. But Dr. Reeder does not appear to understand that there is a very big difference between human error and reckless, grossly negligent conduct. There is a very big difference between making an incorrect decision and breaking the fundamental existing rules of the organization (like not reading the doctor's orders or following hospital protocols). There should be no organization in the world, even those professing a "blame-free" culture, that will not discipline an individual who has been reckless toward the safety of others.

The inquest jury felt that the actions of Lisa's nurses were responsible for her death. The College of Nurses has charged them with professional misconduct. Yet Dr. Reeder did not investigate them and still feels that these nurses are safe practitioners. I ask that the Board reconsider my original complaints and my appeal, along with my written and oral arguments, and ask the complaints committee of the College of Nurses to re-evaluate its decisions.