March 12, 2001

Dr. Brian Taylor
The College of Physicians & Surgeons of BC
1807 West 10th Avenue
Vancouver, B.C.
V6J 2A9

Dear Dr. Taylor:

RE: REQUEST FOR INVESTIGATION INTO THE DEATH OF ESTHER WINCKLER

On March 5th, 2000 my mother, Esther Winckler, **died post-operatively at Chilliwack General Hospital following elective hip replacement surgery**. The *Judgement of Inquiry* of the Fraser Valley Region Coroner, Robbie Smerchinski, has just been completed following the Medical Investigation by Kathleen Stephany, Coroner/Manager of Medical Investigations at the Office of the Chief Coroner in Burnaby.

Our family had concerns from the first day our mother entered Chilliwack General Hospital on February 20th, 2000. These concerns have now been given substance as a result of the Coroners' fact-finding and **it is our belief that, in a significant number of incidences, the definition of gross negligence is met** in that there was death resulting from a failure to provide care in conformity with standard practices or any other reasonable standards. Specifically:

- Failure to ensure the safety of the patient
- Failure to make proper diagnosis and unexplained delays in diagnosis
- Failure to use best judgement
- Failure to meet patient's 'right to know'
- Neglect and abandonment of patient
- Failure to order proper tests
- Question of informed consent and explanation of associated risks
- Failure to respond to recommendations of pre-op consultation
- Failure to obtain proper consultation throughout hospital stay
- Failure to perform proper physical examinations
- Issues of missing documentation on hospital records
- Failure to follow accepted nursing procedures
- Failure to properly inform or involve family in the decision-making

I have attached notes that I kept as a family member concerned about Esther Winckler's care from February 21st onward. I have also attached our very specific concerns following our reading of the Medical Examiner's Report.

I can not over-emphasize how devastating these findings have been to our family, and will not under-emphasize the vigour with which we intend to pursue the issue until answers are forthcoming and changes are implemented. **It is our belief that our mother would still be here today were it not for the negligence of at least two of the doctors involved, a number of the nurses, and a hospital that would allow such careless procedural practices to co-exist with its mandate to protect the public.** Our mother, as do all patients entering a hospital, depended upon the skill and vigilance of the caregivers in attendance. We believe that a number of those named in the Medical Examiner's Report clearly failed to meet even the most basic standards of their respective professions.

I would also like to note that the **results of the Hospital's own internal investigation are an insult to our family**. It is difficult to reconcile the facts found by the Coroner and Medical Examiner with the following conclusions presented to me nearly a year after my mother's death by 'Patient Advocate' Ali van Klei of the Fraser Valley Health Region. She called one month ago with the results of this Review, and I quote from my notes:

- "We will use your experience as an educational tool for nurses, particularly in the assessment of patients. When people's conditions change, nurses will know.
- We are reviewing the communication process with the physicians that clearly broke down for your family and we will be tightening that up so there will be no more 'falling between cracks.'
- In the area of post-operative confusion, we will be sure and have a specialist come and do grand rounds so that medical personnel have a better idea of what to look for."

I asked Ms. Van Klei if that was it – surely that couldn't be the sum total of nearly a year of internal investigation? I asked her when the specialist would come in and who would it be? I asked her about what form the 'tightening up' would take? She seemed completely surprised that I found the process lacking and the conclusions unacceptable. I told her that our family would follow the process, and would do nothing until I heard the results of the Medical Investigation by the Coroner's Office. However, I also told her that the Board should expect to hear back from us should the Coroner's conclusions differ from theirs.

These investigations have now been completed and I leave Esther Winckler's case with confidence in the hands of your respected Body. I understand that it is your mandate to monitor, evaluate and discipline your members. To protect the public. Maintain the standards and honour of the profession. And above all, to evaluate the competence and conduct necessary to continue to practice medicine in this Province. To these ends, I urge you to look at the facts which I feel quite clearly speak for themselves in a way that Esther Winckler clearly could not speak for herself during her 15 day residency at Chilliwack General Hospital.

I will initially be forwarding letters to the Registered Nurses Association of British Columbia; the President, Information Services Officer, Chair and Board Members of the Fraser Valley Health Region; the Operating Officer/Facilities Support of Chilliwack General Hospital; my mother's GP and the pre-op consulting anaesthetist, her MLA and MP, regional Senior's advocacy groups, among others. We also intend to post our information for Esther's many friends and family members who are understandably concerned on a web site: *www.esthersvoice.com*.

It is the family's intention to arrive at **understanding, accountability, and specific procedural and other changes as an outcome of our efforts**. I am confident that once the College familiarizes itself with this case, you will also be seeking the same.

Sincerely,

Catherine Winckler
Attach.