Catherine Winckler

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June 12, 2002

Mr. Barry Forbes
Chairman of the Board
Fraser Health Authority
260 Sherbrooke Street
New Westminster, BC
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RE: Death of Esther Winckler, March 5th 2002

Dear Mr. Forbes:

First of all, I would very much like to thank you for your phone call two weeks ago. I passed along your condolences to my father and brother, and your willingness to open up a dialogue between our family and the Hospital and Region, and it was very much appreciated. Particularly given the fact that not one in 30 letters to the Region's Executive and Board or Hospital Administration and Division Heads sent a year ago (March 2001) were even acknowledged, let alone answered. (*See attached letters dated March 12, 2001 to Mr. Marchbank and Ali van Klei of the Fraser Valley Health Authority*).

During our conversation I shared with you that our family was going to spend a week or two 'in seclusion' to sort through the past two years and three months. We were rather unprepared for the extensive coverage in *The Vancouver Sun* and the hundreds of emails we received in response, just as we were unprepared for the extent of the negligence against our mother detailed in the 22 pages of the final Coroner's Judgement of Inquiry. We have needed this past two weeks to grieve, to talk to trusted advisors, consider our options, and to ultimately become focused on what we are hoping to achieve and what we are asking of the various bodies named in the Coroner's very comprehensive and specific final recommendations.

You will forgive the length of what is to come, but I am going to take a chance and trust that unlike the situation under Mr. Marchbank, this information *will* be shared, discussed, and acted upon with your Executive and Board members who have been copied in. For this reason, I want to ensure that this letter's contents are comprehensive and perfectly clear this time around. You have 'inherited' the case and it is important to our family that you have the information that we have so that you will understand our situation and requests.

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Synopsis of Events To Date

- On February 2, 2000 Esther Winckler had a preoperative assessment at Chilliwack General Hospital for upcoming elective hip replacement surgery. At that time there is a written record by Dr. Lavin, the consulting anesthesiologist recommending that this surgery should be conducted under spinal, not general anesthetic given prior history. This was the single most compelling reason Esther Winckler decided to proceed with the surgery: a reason known by her entire 'team' including Drs. Noble (GP) and Wickham (surgeon). It is notable that family and friends know that she would not have gone ahead with the surgery if she had had to 'go under' unless it was a life or death situation – and certainly not with elective hip surgery.

- On Sunday, February 20th, 2000 Esther Winckler entered Chilliwack General and was given a quick assessment by someone new to the 'team', a Dr. Suleman who informed her that he was the anesthetist for the following morning and he was changing the gameplan by specifying a general anesthetic. Calls to her daughter indicate she was very upset by the decision, yet had no one to talk to given a Sunday evening at Chilliwack General Hospital -- none of her other care team was available and there is no evidence to show that they were ever consulted about the change of plan. She was tired and in pain and evidence shows that the Consent part of the form under 'anesthetic' was not signed.

  The horrific details of her time on the operating table (including complete overload, whereby no one kept track of intake vs output and Esther Winckler virtually drowned in excess fluid), the misdiagnosis in ICU and treatment for heart attack, the lack of charting, lack of pain management, non-reporting of falls, lack of continuity in care from floor to floor – all of these are well-documented in the Coroner's Judgement of Inquiry. Finally, on March 5, 2000, following a 15 day in-hospital recovery period post elective hip replacement surgery, Esther Winckler died with blackened and blocked bowels, brain damage, broken ribs, confused and in pain.

- In April 2000, I drove up to Chilliwack by request to meet with someone called a 'Patient Advocate' from Chilliwack General for a two hour debriefing of the events as our family had experienced them. I gave her the details of my journal (now published online on www.esthersvoice.com and in the Vancouver Sun article).

- One year later, in February 2001 this same Ali Van Klei, Patient Advocate, called and advised us that the hospital's internal investigation has been completed (we did not even know there was an official one!) and there were three main recommendations (outlined in the letter to Mr. Marchbank attached.) We told her that even knowing what we knew ourselves to be true of our mother's experience at Chilliwack General, this investigation

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was completely unacceptable in its lack of measurable follow-through and complete glossing over of important fact. She expressed surprise at my reaction and offered no recourse. Simply that in the hospital's mind, the investigation had been concluded.

- This was substantiated a month later (March 2001) when Kathleen Stephany from the Office of the Chief Coroner Medical Investigations completed the initial Medical Examiner's report and invited myself and our family's medical consultant (a physician) up to Abbotsford for the reading of the findings at which time we took notes as allowed. The results of this report (also shown on the website) were sufficiently upsetting for our family to write to the various bodies including the Region and Hospital for elaboration and to launch an official complaint with the College of Physicians & Surgeons against Drs. Suleman, Wickham, and Richmond of Chilliwack General Hospital. We also filed a complaint with the RNABC. There was no meaningful response by any parties (and, as we said, no response whatsoever from the Region), and we were told by the College that we would have to wait for the release of the official Coroner's Judgement of Inquiry before their own investigations would start. The College has since (May 22nd, 2002 in a letter by Deputy Registrar Brian Taylor) acknowledged the complaint will now be investigated over the summer by the College for review by the Quality of Medical Performance Committee at the September meeting. We understand that they are receiving dozens of letters from Esther Winckler's many friends across Canada urging them to give this case priority given the length of time it has been 'on hold' and to involve the Disciplinary Committee in this investigation. We have written a letter to the College outlining our concerns about process; as yet, we have not received a response to our questions.

- With great patience our family waited another year and two months for the release of this final Coroner's Judgement of Inquiry on May 15, 2002 (now two years and two plus months later!) We still do not know why there was this long delay between the March 2001 Medical Examiner's findings … and the final public report. There had been talk of an outside consultant giving expert anesthesiology evidence – this never materialized. However, we were very pleased with the comprehensiveness of the Report by Coroner Margaret Turner and considered ourselves fortunate that she had completed it with the degree of detail shown.

- A reporter, Glenn Bohn from *The Vancouver Sun*, had been following the progress of our family's journey on our website, www.esthersvoice.com. He asked to be kept apprised of when the official JOI was to be published. We called him and the result was a very thorough and completely accurate account of the last 15 days of our mother's life in the May 22nd issue of the paper. Following this, we have received over 200 emails and

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> letters from media, doctors/nurses, and the general public – all of them asking to be kept informed of what happens in what one doctor describes in his email as "an important case to see how the various regulatory bodies respond to the current situation of seniors care in our system."

This then is a summary of what has transpired. I think that it is crystal-clear that at every level – doctors, nursing, hospital administration, and the Fraser Valley Health Region – our mother was completely abandoned by the system. She was misdiagnosed, mistreated, unmonitored, and shunted from wards prematurely. There was a compete lack of continuity in her care, and indeed, outside consultants have advised us that this is negligence, malpractice, system breakdown, and even 'elder abuse' at its most insidious.

On a personal note (because, in the end this is all personal), my last memory of my mother is a woman who had gone into the hospital a lively, articulate 77 year old looking forward to her summer garden and a pain-free cruise in the fall for she and her husband's 50th wedding anniversary. This is the same woman whom I saw on her last day of life, stuck into the corner of a general ward, naked with head injuries, and misdiagnosed as a senile geriatric patient. No wonder. By that point, 15 days post surgery, no one had read the surgical chart to see what had transpired in the operating room; no one had challenged the internist's diagnosis of heart attack; no one had noticed she hadn't had a bowel movement in 15 days; no one had examined her to find that she had brain damage and broken ribs following two unreported falls; no one had followed an effective pain management protocol; and no one questioned that a lively senior had come into the hospital, only to become agitated and non-responsive over her stay as her body systems shut down (choosing instead to either ignore her or administer psychotropic drugs and a strait-jacket *without* informing the family of any of these developments!)

As one medical consultant to our family said: "There were at very least four or five significant occasions over the 15-day stay that we believe the outcome for Mrs. Winckler could have been very different. But this case is one that shows a complete lack of continuity of care, serious disregard for accepted medical practice such as surgical procedure, documentation, and reporting, poor medical judgement, and a culture at the hospital that clearly works against geriatric patients."

As a family we have decided to not pursue the legal route (pending, of course, positive reinforcement that we are, indeed, making the right choice) and have also pledged to keep a journal of events following the release of the Report and the reaction and follow-through of the various bodies involved. We are prevailing upon existing systems such as the College, the RNABC, and the Health Authority to do their job. And we will hold all of these institutions accountable. Our mother would have expected no less.

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What Our Family and Friends of Esther Winckler Are Seeking

The fact that we aren't taking legal action should not be taken to mean we aren't taking *any* action. I'm sure you can appreciate that all my resources and contacts are behind our search to have our mother's life mean something. We want to know that because of her death, systems in the Fraser Valley did, and will, continue to change and improve. That my father, or any other senior in the Region, can go into the Chilliwack General Hospital and expect a certain level of care. Care that is not associated with new acquisitions of equipment or even personnel. But care that lives up to the promise that each of the individuals involved made when they made the choice to become Doctor, Nurse, Hospital or Regional Administrator.

Now that we know WHAT happened to Esther Winckler in Chilliwack General Hospital, it is long past time for a few critical things to take place:

1. First of all, my father deserves some kind of apology or acknowledgement of the complete lack of response there has been to our family over the past two years, and for the regret the Hospital and Region must surely feel when faced with the facts behind my mother's death. I do not think it enough for the new Chief of Staff to be quoted publicly as calling this an 'unfortunate experience.' Or the Region's Communications officer to say they are 'concerned with the family's reaction.' What about the family's ordeal?

I do not know what form this acknowledgement takes; I'm sure that the Region, the lawyers, and powers-that-be might have some ideas. Suffice to say, it is long overdue and will be a meaningful gesture to an 84 year old man surviving the death of his wife.

2. I would like to sit down with yourself and/or relevant members of the new Health Authority and key 'change agents' at Chilliwack General Hospital for a candid discussion of what happened and more important, what has happened as a result of Esther Winckler's death, and what will happen in response to the Coroner's very specific recommendations. I understand that Coroner's recommendations are not enforceable and are voluntary by nature. However, I do not think that it will be acceptable to our mother's wide network of family and friends to find out that no pain management protocols, documentation review, falls prevention activities, or geriatric education has been introduced to this hospital in the two years plus since her death.

I am sure you will understand when I say that I do not want to meet with 'spokespersons', Patient Service "Advocates", or other individuals from the various 'Communications' departments. I think our family deserves to meet with those who are in a position to answer our questions and talk about what they envision for this important community hospital. I like the quote that Dr. John Gray, head of the Canadian Medical Protective Association (certainly one of

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the doctor's 'own') said in the *Medical Post, Vol. 37, No. 10, March 13, 2001)*: "We favour open discussion of adverse events, but it must be done in a non-punitive way. We all know that the litigation system now is very much one of naming, blaming and shaming, but that's not the approach we should be taking any longer, and most people would agree that's not the approach to risk management that will likely achieve any lasting changes."

Well, our family is on board. So let the Hospital, the Region and the professional bodies show that when things don't go right (and indeed, go very very wrong) they will step up to the plate and try and do things a different way. I think that all the lawyers involved (the Coroner intimated to us that there were already a number in place, in anticipation of … what??) would agree that our family probably has a solid case of 'Actionable Malpractice' on any number of fronts in this case. And yet this defeats the whole purpose of what we are trying to do in our mother's name. Patients and families must be recognized as members of the decisionmaking team. They must also be part of any post-mortem.

I look forward to your invitation to be part of the process.

Sincerely,

Catherine Winckler

cc. Board and Executive
Fraser Health Authority

Attach.