

Bundaberg Hospital Commission of Inquiry

STATEMENT OF P99

P99 makes oath and says as follows:

1. I reside in the Bundaberg district and I have provided my address to the Commission.
2. I was born on 21 August 1959. I am married and I have two sons. I have worked as an Assistant in Nursing ("AIN"), off and on, since I was 19, and I estimate that I have approximately 20 years of experience in that role.
3. In 2003, I was experiencing pain in my right side. I think I received a formal referral from my general practitioner at the Western Medical Clinic but in any case I went to see my gynaecologist at the Base Hospital, namely Dr Stumer. Dr Charles Wilson had performed a hysterectomy on me about 15 years ago, and Dr Stumer operated for endometriosis about 10 years ago. Dr Stumer said words to the effect that my problems were within the realm of a surgeon rather than a gynaecologist and he referred me to Dr Patel. To my knowledge, this occurred in about November 2003. Now shown to me marked "LAP1" is a copy of the letter of referral dated 17 November 2003.
4. In early 2004 I saw a man who identified himself as Dr Patel. He pressed my stomach and said that I had a hernia on my right side. He said that he'd remove it by day surgery and that, given that I worked as an AIN for a nursing home, it would be better that he did it as soon as possible.
5. I went to the pre-admission meeting in about February 2004. I met with a very tall anaesthetist and an administrative person and a nurse. I don't think that I met with a surgeon at that time. The meeting was routine in the sense

that similar issues were covered by the respective hospital staff as were covered in advance of my previous operations.

6. The procedure took place on 15 March 2004. I went to the ward at 7.00 am. You go to reception and they admit you and take you to your bed. From memory, there are 8 beds in the day surgery ward. I observed that staff would come to the beds one by one. They would do the pre-operative procedures (making sure that you've showered, taking your blood pressure, taking your temperature and putting you in a gown) and then they would take you to theatre. My recollection is that, with me, the pre-op. procedures were carried out in a holding area near the theatre.
7. I didn't see the tall anaesthetist on the day of the operation. I saw a woman anaesthetist instead and she administered the anaesthetic. When I woke up, I recall that I was in the recovery section. I think that Dr Patel spoke to me then and said that there was no hernia but he found some scar tissue and he clipped it back. I felt good at that time. I got up and could stand okay. I could see that there were 10 to 12 staples along my stomach.
8. The nurses gave the patients in the day surgery, including myself, a standard form which said we should come back in one week to the dressings area in the Specialist Centre so that our staples could be removed. I was a little taken aback by that direction. I knew from my experience as an AIN, and from the previous abdominal surgery I had received, that the standard practice is to take out every second staple after 7 days and for a general practitioner to take out the rest after a further 7 days. I did not, however, raise that issue with anyone.
9. On 22 March 2004 I went to the Specialist Centre at the Hospital to have the staples removed. The nurse took out my staples and then she just put one strip across the wound. It was almost comical. The wound went vertically for about 12 cm and she put a tiny strip across the wound horizontally. Although, as I mention above, I have considerable experience as an AIN, I can think of no good purpose served by such a bandage.

10. I went home with my husband. Just after I arrived home, I thought I had wet myself but it turned out that the top of the wound had opened and there was blood running down my legs. I called the Hospital and they told me to come back to the Specialist Centre. I placed a towel on the wound and my husband drove.
11. When we arrived at the Hospital, there was a wait of about 25 minutes before I could be seen. During that time, I hobbled over to the toilet and I remember that as I came back I lost another clot from the wound. The Hospital staff called my name then and then they helped me onto a table. A doctor who introduced himself as James Boyd came out to see me. He looked at the wound and said words to the effect, "*we can pack that*". I was surprised because I was expecting that the doctor would take me into theatre and treat the wound afresh. I could see that the nurse, Janice Williams (who I had worked with previously in a nursing home), raised her eyebrows when Dr Boyd made his comment.
12. Janice went and obtained the gauze for packing and the doctor went away. Whilst Janice was busy, I felt really sick. I had an awful sensation. I looked down and saw that there was now complete dehiscence around the wound. That is, it had completely re-opened. It was a horrible sight. I called out "*Hey Jan*". She came in and said, "*What, mate?*". She looked at the wound and said, "*I hope you didn't have a look*" and I said that I was afraid I had.
13. Dr Boyd came back in. He said words to the effect "*We can still pack that*" and he got Janice to do that. The result looked bizarre. The bandaging protruded way out like a belly. Janice told me to come back at 9.00am on the next day and I assumed that was so I could have further surgery. My husband and I drove home and when we arrived there was a message from the Hospital that we shouldn't return until 1.00pm on the following day.

14. I woke up in the morning with a migraine and I called the Hospital to make sure (assuming, as I was, that I was having surgery that day) that it was okay to take some pain relief. The nurse with whom I spoke said that was fine. When we arrived back in the day surgery ward, Dr Patel was there. He looked at the wound with Dr Boyd and said that it would just need holding stitches for ¹⁰~~14~~ days. Dr Patel went away and Dr Boyd then attended to the wound. He only used a local anaesthetic and it didn't have any effect. He started putting in stitches (there were six in all) and I could feel everything: the needle, the thread going through, and his hand. It was extremely painful, especially on top of the migraine, and I couldn't even vomit because I was worried how the upheaval might affect my wound. W.G. EP. W.G.
15. I begged Dr Boyd to stop but he wouldn't. The pain was excruciating; I was screaming and I was in tears. I could feel people holding me down. I have worked with dementia patients and I have been taught that you can place your hand on someone by way of reassurance or support but you don't restrain them. These people were holding me down by the shoulders and the ankles. I kept yelling and Dr Boyd kept saying that he was almost done. Janice kept leaving the room to get cold towels.
16. When it was over, Janice was very firm and pointed with Dr Boyd. She said, *"Do you think we could possibly get her some pain relief now?"* She is from the old school like me. You don't question a registered nurse, let alone a doctor, but she was very clear and pointed with Dr Boyd. The staff gave me pethidine after that. If they had given it to me before, I would have been on cloud nine for the operation. I don't know why they didn't do it before hand, except perhaps that, at least initially, Dr Boyd thought the local anaesthetic would work.
17. Janice and my husband helped me to leave. In the middle of the night, I woke up yelling that someone was trying to set fire to me. I realise now that the pethidine had worn off and an infection had taken hold. On the next day, I went to see my G.P., Dr Venoo Ramunnan. She prescribed an antibiotic called Keflex but she said not to fill it because I really needed an intravenous

antibiotic. My Husband took me back to Hospital but I had to wait five and a half hours. When they saw me they said that they wouldn't put me on a drip because I didn't have a temperature (which, in my view, was entirely due to the fact that it was very cold that day). As I was about to leave, the man said that he supposed he should take a swab. He did that and it revealed, subsequently, that I had staph. He told me to get the Keflex prescription filled and I did that but it made me throw up. I came back to the Hospital on the following day and was prescribed a different antibiotic but it didn't change things. I was still red raw. The area was burning up and I was in horrible pain.

18. The stitches had been put in on 23 March 2004 and by 25 March they were breaking up. I took photographs of my wound on 27 March 2004. They are now shown to me marked "LAP2".

19. The photographs depict the way my wound stayed for many months. I went to see Dr Boyd on 30 March 2004. The infection had grown steadily worse since 23 March 2004. It was accompanied by a burning sensation, an oozing discharge and swelling and smelling around the wound. Dr Boyd, however, said that the stitches were in place and that there was no infection. If you have a look at the photographs, it's patently clear that's not true. Most of the stitches were not holding. There was no tie left. They were just lying in the wound. You can also see very clearly from the photographs that the wound is infected.

20. After ^{ten} ~~fourteen~~ days had passed, I returned to the Hospital to have the stitches removed. I had to do that twice before I was treated. When the Hospital staff finally attended to the removal of the stitches, it was still gaping open, and oozing, and causing pain. I asked the nursing staff to tell me what kind of infection I had or to let me read my file but they said they did not know and they refused to let me see the file. They told me that the wound wouldn't close but it would eventually grow over.

21. A short time later, I returned for the "final" check. The wound was still oozing from the bottom and I had sores on my arms face, legs and one finger. The nurses told me simply that they were "staph" sores.
22. Now, in June 2005, there is some dead skin which has grown over the wound but otherwise it has never healed. It is very purple and very wide. Moreover, I still, to this day, get sores on my arms, legs and stomach, which leave purple scars. I was not troubled by any such ailments before Dr Patel carried out the procedure on 15 March 2004.
23. I called the Health Rights Commission on 29 August 2004. They have since told me that they record all their calls. They told me that I should take my complaint to the hospital. They have since told me that they also said that, if I got no comfort there, I should take it back to them. I don't remember the last part but maybe that's because I was distressed and sick.
24. I wrote a long letter to the Hospital which I now see produced to me marked LAP3. The contents of that letter were true, and remain true, to the best of my knowledge. It is one of the few letters I have not dated but I can say that it was sent in September 2004. In the meantime, my GP had obtained a copy of my file from the Hospital. Soon afterwards, I received a telephone call from a secretary who said I should come into the Hospital and meet with Dr Kees Nydam. It was never explained to me who he was, in the sense of why it was any of his business. I still don't know the answer to that. But I came in anyway.
25. The meeting occurred on 4 October 2004 and I brought a friend with me, namely another AIN called Vicki Hall. Dr Nydam's manner was abrasive. It was clear from his tone that he just wanted us out of his room as soon as possible. He didn't talk about solutions. He said Dr Boyd could not be held responsible because he was only on a six month training arrangement with the Hospital and it had finished and he had gone back to Brisbane. I said that, if that was the case, he should hold Dr Patel responsible. He didn't answer me there. I said I was also concerned that lots of material was

missing from my file, as was in fact the case. I mentioned that there wasn't even a copy of the report showing that the swab, as I left hospital, revealed staph. Dr Nydam went outside and came back with the report, which is very odd because my GP said she had been through the records provided to her by the Hospital so many times she had a headache, and it wasn't there.

26. Dr Nydam telephoned Gail Aylmer from Infection Control within the Hospital and she came to his office. She listened to me but she subsequently wrote a letter dated 16 December 2004 in which she just twisted what we had said. I never told her, for instance, that I had a recent history of boils prior to the operation (and I had not). I never said that I was exhausted. What I told her was that I was now experiencing sores that looked like boils, and that I had been working night shifts at a nursing home. I gave her no reason to believe that my condition was related to my work as an AIN. Ms Aylmer's letter is now produced to me marked LAP4.
27. Dr Nydam asked me at the meeting what I wanted him to do. I said that an apology would be a good start. I subsequently received a letter in which Dr Nydam apologised for "*what would appear to be suboptimal care*" and hoping that "*the advice from our infection control staff will be of some use to you*". The letter is dated 8 October 2004 and it is now produced to me marked "LAP5".
28. Although I set out carefully the details set out above and explained why I believed that the standard of care was unacceptable, Dr Nydam did not offer to conduct any investigation or otherwise to ascertain the true state of affairs. I gained the impression, very clearly, that he just wanted us to leave as soon as possible.
29. As for Dr Boyd, Dr Nydam never suggested that the position he took at our meeting had changed; that is, that Dr Boyd was only at the Hospital for six months, that term had finished; he had left the Hospital and, accordingly there was no action that Dr Nydam could take.

30. I did not think that the letter of 8 October 2004 was very helpful. My condition hadn't healed. Dr Nydam didn't seem to contemplate anything that would remedy my condition, let alone anything that would change the way things had been done to me by Dr Patel and one of Patel's trainees. Nevertheless I probably would have let it go except for what happened next. My youngest son has a disability and I take him regularly to see a paediatrician at the Base called Judy Williams. We went up to see Dr Williams on 29 November 2004. Whilst I was there with my husband, I saw Dr Boyd walk by. I couldn't believe my eyes so I asked my husband to check but it was definitely him. He is a little less than 6 feet tall and he has black hair. Sometimes he wears glasses and sometimes he doesn't.
31. I subsequently wrote a letter of complaint to the local member, Nita Cunningham. Now shown to me marked LAP6 is a copy of that letter. The contents remain true to the best of my knowledge. Ms Cunningham has told me that she has no record of ever receiving the letter and I don't question that.
32. My friend, Vicki Hall, prepared a statutory declaration and that is now shown to me marked "LAP7".
33. My correspondence with the HRC is now shown to me marked LAP7.
34. I am going to see Dr Gaffield in Bundaberg and Dr Rudd in Brisbane to see if they can do anything for me.

Affidavit sworn on 30 June 2005
at Bundaberg in the presence of:

..... SPaersons

..... Wg. Zig JP (C Dec)

Signed: .. SPaersons

Taken by: .. Wg. Zig

Deponent

Solicitor/Justice of the Peace

Department of Medical Services
Bundaberg Health Service District
Bundaberg Base Hospital
PO Box 34
BUNDABERG QLD 4670

Telephone No: 41 521222
Fax No: 41 502219



Queensland
Government

6-1-04

1.30

Queensland Health

MS/sh

Gynaecology Clinic

17 November 2003

Dr J Patel
Director of Surgery
Bundaberg Base Hospital
PO Box 34
BUNDABERG QLD 4670

RECEIVED
27 NOV 2003
BY: [signature]

Dear Jay

RE: LINDA PARSONS
DOB:

UR: 057761

Could you please see Linda Parsons within the next month or two with respect to pain in the right lower quadrant associated with a previous right para-rectal incision in 1993 when I removed her right ovary.

There are multiple letters in the chart.

She had a hysterectomy done about 12 years ago. I removed an ovarian cyst from her left ovary via a transverse lower abdominal incision and then did a right salpingo-oophorectomy and later that same year 1993, I performed a left salpingo-oophorectomy.

I wonder whether she has a small incisional hernia or perhaps there are adhesions associated with this right para-rectal incision which are causing her symptoms.

This pain in the right lower quadrant has been present for years but has been getting much worse over the last couple of months.

Since her surgery in 1993, she has had loose bowels with frequency of defecation and some faecal incontinence at times. When she has the pain and spasm, the abdomen gets quite hard.

I don't think that her symptoms are due to a right ureteric calculus, although I suppose that needs to be considered.


In 1999, she had a CAT scan of her abdomen and a recent ultrasound scan on 11 November 2003 showed no evidence of any hydronephrosis.

I would appreciate it if you could see her and give your opinion about further management. I myself would be loath to perform the usual gynaecological laparoscopy, as I would worry about hitting bowel.

She does have omental adhesions to the anterior abdominal wall medially to her para-rectal incisions.

Thank you for reviewing her.

Yours sincerely

A handwritten signature in cursive script, appearing to read 'M Stumer'.

Dr Malcolm Stumer
FRANZCOG
Director of Obstetrics
and Gynaecology

WAP 2





UR-057761.

Pg 1

RECEIVED
04 OCT 2004

BY:.....

On March 15th this year I was a inpatient in your Day Surgery. I went in for an abdominal operation looking for a suspected hernia. I had a previous scar on my (R) side which was re-opened. No hernia was found, but I was informed that scar tissue had been removed, because I had a lot of adhesions.

I had 10-12 staples, I cannot remember exactly. I was released on the same day, I was to return 7 days later to have the staples removed.

After having the staples removed on the 21.3.04, my husband took me home to Burnett Heads, where we lived at that time. We were home only 15 mins.

I felt uneasy in the stomach, went to the B/Room & found blood running down my legs. The top of the wound had opened up. We rang BBH & was told to come straight back to the Specialist Centre. I was left sitting in the waiting room for 25 mins holding a towel on my stomach.

When I finally saw a Doctor, he informed me I only needed the wound to be packed. While laying on the bed awaiting the staff to collect what was needed, I felt a sharp pain & then a unusual sensation, I had then realised

The complete wound had re-opened. I felt frightened & a little sick, by what I saw. I called to the N/staff & she recalled the Doctor, who said it still only need to be packed. After this was completed I was informed I needed to come back the next day, at 9am as I was having the wound stapled again. My husband & I thought they meant Day Surgery again as I was told to fast from midnight.

On arrival at home again, we found a message had been left with my son saying not to come back until 1pm. At this stage I could hardly move due to all the packing.

I awoke the next morning with a migraine, assuming I was have some sort of surgery. I rang BBH asking if I could take something for my head. I was informed YES my husband took me back to the Specialist Centre as requested by 1pm. I still had a very bad headache. We were then informed that only a few holding stitches was all I needed. They would stay in for 14 days. After preparations were made I was injected with anesthetic, the doctor then proceeded. As my head was still thumping, I felt sick then I informed the Doctor that I could feel

everything he was doing. I actually told him a few times. Each time he told me not to worry it would be over soon.

The nurse who was assisting was very caring & went out for a cool cloth for my head, but I could still feel everything that was happening, by which I mean the needle & the stitching going through me.

I was in tears & very distressed & pain was unbelievable. Eventually he finally finished & I was given a pethadine injection, & sent home. That night I awoke with a burning sensation in my stomach, & found my tummy hot & red. My husband took me to my GP the next morning who directed us back to BBH to be admitted for intravenous antibiotics. We spent almost 5½ hrs in casualty to be sent home with a box of antibiotics. Just before leaving a Doctor returned saying he supposed he should do a swab. We waited for the results, but was told (not worry about it).

The Keflex started making me sick & the burning was increasing, so we went back the next day to my GP. She referred us back to BBH again. They changed the antibiotics & sent me home once again. I was very distressed & feeling a great deal of pain.

Because of the stress, my migraines returned, which my GP was administering Pethadine. On the 3rd day, the infection was worse & so was the burning. The wound was oozing a (green discharge) & I was referred again back to you by my GP. The ooze was smelly & swollen around the wound to the extent that the stitches were splitting. I was not treated with the courtesy I should have been & felt I was just being f'ked off each time.

The pain from the wound was now affecting my walking & I had to hire a toilet chair as I couldn't bend to sit on a toilet.

The antibiotics weren't working, but they were continually ordered.

After the 14 days I had 2 & a bit stitches left to be removed.

We returned to have them removed only to be informed that the Doctor hadn't documented about having them removed so we had to return to the waiting room to wait for a Doctor to give permission to have them removed.

My wound was gapping open, still oozing & I informed the staff that I still had pain. Once again I asked what the

infection was & was informed that the Nursing staff couldn't tell & I wasn't aloud to read my file.

I was told that the wound wouldn't close up, but it would eventually grow over. When we went back for the so called final check, the wound was still oozing from the bottom area & I had sores on my arms, face, legs & one finger.

We asked what these were & we were told that they were 'STAF' sores.

I was never informed what infection I had & should have been. I am also entitled to see my file.

I have had photo's taken of the wound from the time the staples came out & I was stitched. It took a very long time for the wound to grow over & it is also very purple & wide.

I still to this day get sores on my legs, ar is a stomach which leave purple scars.

I have informed the Health Rights Commission & at thier suggestion I am writing this letter.

The treatment I received needs an explanation.

I also have my file & alot of documentation is missing, this needs to be explained.

I also need to know what infection I have,

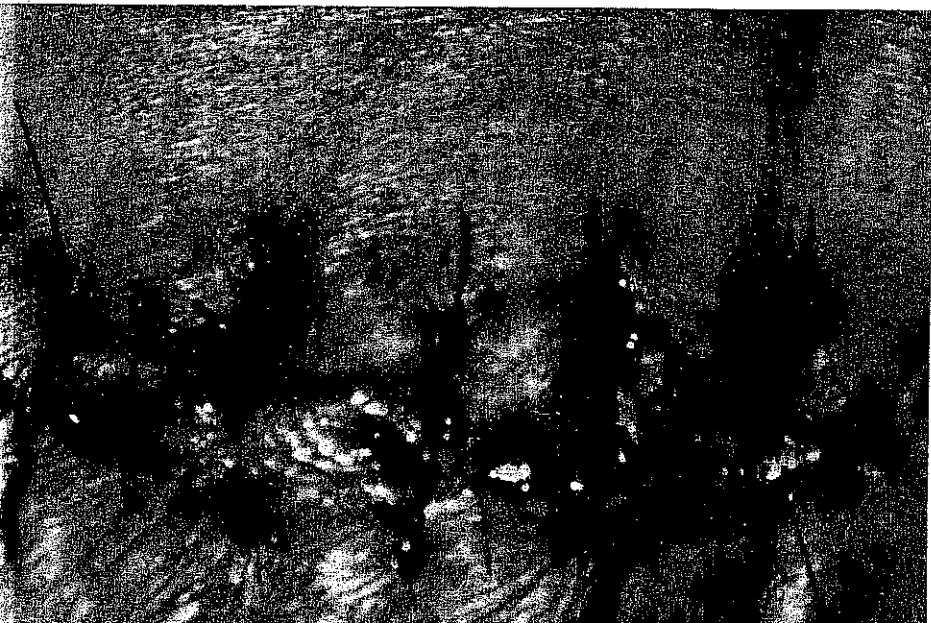
Why I still break out in sores, why I was never restapled & why the staples were removed in only 7 days, when normally abdominal ones, its usually every 2nd staple & the rest a week later.

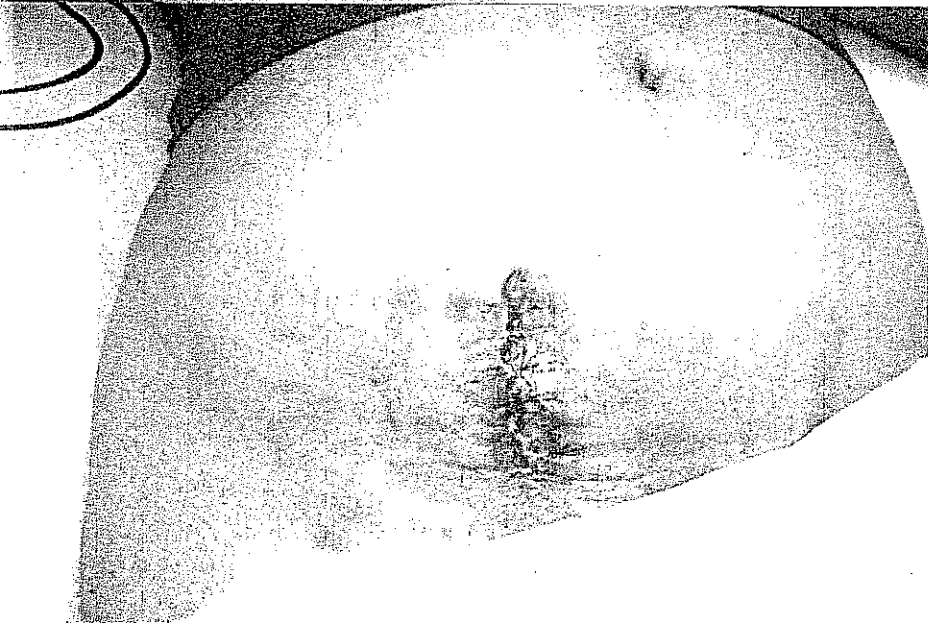
Rob messenger was informed as to what was occurring, & he had 2 ambulance officers come to our home & give a report on the wound. (At this stage on 6 large) stitches had been put in.

I want the infection treated properly as I have had that many antibiotics & nothing is working. I am asking for answers & solutions & I am informed this is your jurisdiction. I don't want to take this any further, but I will if nothing is done & very soon.

I work in age care, & each time a sore appears I must cover it completely as you know, & its also very embarrassing having to explain why I'm always covered in dressings.

Yours Sincerely
Linda Parsons
Parsons.









LAP 4

INFECTION CONTROL
Bundaberg Health Service District
PO Box 34
BUNDABERG Q 4670



 **4150 2273**
 **4150 2309**

16 December 2004

Dear Ms Parsons

Thank you for returning the swab. I have enclosed a copy of the pathology result. Peter (the Microbiologist) and I discussed this result and we feel this persistent problem is not directly caused by the operation you had earlier this year. This organism is a common cause of skin infections because it is often present on the skin and mucous membranes of yourself, and others.

As we discussed, a person does become more susceptible to infection when they have had surgery. However you mentioned you were working night duty at the time, and that you felt physically 'exhausted'. Also, that you had a recent history of boils.

Please take this pathology result with you when you next see your GP. Your GP may be able to offer some advice in regard to these sores, and your overall health.

Please feel free to contact me if you would like any more details.

I would like to take this opportunity to wish you a Merry Christmas!! Hopefully you do not have to work!!

Kind regards



Gail Aylmer
Infection Control CNC

QUEENSLAND HEALTH PATHOLOGY AND SCIENTIFIC SERVICES

CHPS-Bundaberg Hospital
P.O. Box 34
Bundaberg, QLD, QLD 4670
ph 07-41502530
fax 07-41512539

Patient Location	Emergency Department (BNH)	UR No	BN057761	IS	4
Consultant	Keil, Naldo E (BNH)	Name	PARSONS		
Req. Officer	Dr Ammara Chaudhry	Given Name	Linda A	Sex	F
	Bundaberg Hospital	DOB		Age	
	Bourbong St	Patient Address			
	Bundaberg Qld4670				

Lab No : 18914-2679 **Micro No :**

Microbiology from Superficial Sites

Collected : 10:20 06-Dec-04

Registered: 11:26 06-Dec-04

Ward of Collection : INF-BNH

SPECIMEN : Swab Sore(s)

GRAM STAIN :

Leucocytes 1+ Gm pos cocci resemb. Staphylococci 2+

Epithelials 1+

CULTURE :

Staphylococcus aureus 3+

Penicillin G
Dicloxacillin
Cephalexin
Erythromycin
R S S S

M
I
C
R
O
B
I
O
L
O
G
Y

QUEENSLAND HEALTH PATHOLOGY AND SCIENTIFIC SERVICES

QHPSS-Bundaberg Hospital
P.O.Box 34
Bundaberg, QLD, QLD 4670
ph 07-41502530
fax 07-41512539

Patient Location	Emergency Department (BNH)	UR No	BN057761	IS	4
Consultant	Keil, Naldo E (BNH)	Name	PARSONS		
Req. Officer	Dr Ashish Gupta	Given Name	Linda A	Sex	F
	Emergency-Bundaberg	DOB		Age	
	Bourbong St	Patient Address			
	Bundaberg QLD 4670				

Lab No : 1583-8821

Micro No : BN99M2681

Collected : 18:00 25-Jun-99

Urine Microbiology

Registered: 11:43 26-Jun-99

SPECIMEN : Urine Mid stream

Ward of Collection : AE-BNH

MICROSCOPY

Leucocytes >1000x10⁶/L RR (<10)

Erythrocytes 200 x10⁶/L RR (<10)

Epithellals >100 x10⁶/L

CHEMISTRY

pH 8.0

Leuc/Est Trace

Glucose Negative

Nitrite Negative

Protein 2+

Blood 4+

CULTURE Mixed Coliforms and Skin Flora 10⁶ - 10⁷/L

Final Report: 10:15 27-Jun-99.

Lab No : 16132-8880

Micro No : BN04M1925

Collected : 10:30 25-Mar-04

Microbiology from Operative/Invasive Specimens

Registered: 11:34 25-Mar-04

SPECIMEN : Swab Wound, Post-operative Abdomen

Ward of Collection : AE-BNH

GRAM STAIN :

Leucocytes Nil Gm pos cocci resemb. Staphylococci 1+

Epithellals Scant

CULTURE : Mixed skin flora 2+

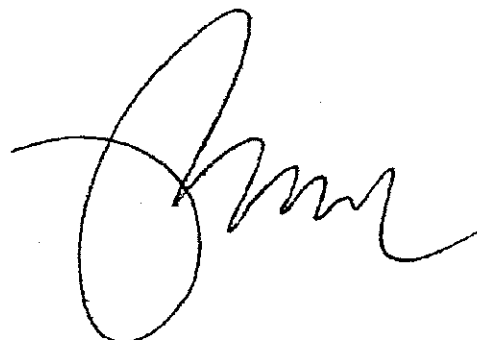
Pseudomonas aeruginosa 3+

Staphylococcus aureus 2+

	Penicillin G	Dx(Flu)cloxacillin	Cephalexin/NaOHin	Erythromycin	Gentamicin	Trimethin
R	S	S	S	S	S	

Final Report: 10:53 29-Mar-04.

Chart ph.





**BUNDABERG HEALTH SERVICE DISTRICT
MEDICAL SERVICES**

Enquiries to: Darren Keating
Telephone: 41502210
Facsimile: 41502029
File Ref: DKjaw

8th October 2004

Mrs L Parsons

Dear Mrs Parsons

Thank you for attending the meeting today where discussion took place regarding the concerns raised in your letter of 4th October 2004.

As discussed, I am happy to give you a personal apology for what would appear to be sub-optimal care and I hope that the advice from our infection control staff will be of some use to you.

Yours sincerely



Dr Kees Nydam
A/ Director of Medical Services

LAPB

Mrs. Linda Parsons

To whom it may concern,

I and a friend attended a meeting with the acting "Director of Medical Services" Dr. Kees Nydam on the 4th October 2004, regarding concerns I had about an operation I had at the Bundaberg Base Hospital on the 15th March 2004.

During this discussion Dr. Nydam was very condescending, treating myself and my friend patronizingly, with one objective in mind, to say what he thought we wanted to hear and get us out of there quickly. He informed us that the Doctor who was treating me was a trainee from Brisbane working under their surgeon Dr. Pattel, and since he was no longer with the hospital he could not be held accountable.

He asked what I wanted, I explained that an apology would not go astray, and how the extra time off work had cost my family and myself extra expense.

Well I received what Dr. Nydam feels is an apology letter that { it would appear the care received was.....
..SUB - OPTIMAL}, meaning less than optimal, not of the best quality, type, etc!!!!!!!!!!.

I recently had an appointment at the hospital on the 29th November 2004 for my son to see his specialist and found that the Doctor in question who apparently no longer works there was at the Specialist Center practicing and treating clients.

I believe Dr. Nydam was being DISHONEST and made a FRAUDULENT and INSINCERE statement.

He showed affability towards us, treating us as inferiors. I was not happy with the way the apology letter was written, but was willing to accept it, and chalk it up to experience, until I found out he lied to us. It was a contemptible thing to do, lie this way when I was looking for answers as to why I had been treated so badly.

I contracted Staf from this hospital and it is still causing me problems. I believe something should be done about treating clients this way, because they attend a public hospital. This matter needs to be addressed otherwise I will be going to the media and a lawyer to see what can be done.

Yours sincerely

SPRINGS.

Statutory Declaration

I, Licki Hart
(FULL NAME OF DECLARANT / PERSON MAKING THE DECLARATION)

of 3 Dawson Avenue
(ADDRESS OF DECLARANT / PERSON MAKING THE DECLARATION)

Thirubeen Bundaberg Postcode 4670

in the State/Territory of Queensland

Insert your occupation(s) Nurse

do solemnly and sincerely declare that on the ⁴14/10/04 a meeting of Dr. Kevin Needham was arranged with Linda & myself. Regarding concerns about my friend's operation at the B.B.H. on the 15/3/04. Dr. Needham was considering & treated me & my friend & then kept dismissing her complaints & stating the treating doctor was no longer working at the hospital & therefore I could not be held responsible. He told her the case she heard was a bit of a flimsy & what did she want done about it. My friend suggested in letter of apology might be a start. Gail Olympe from infectious control was called as was the Biochemist Peter. They stated she had a history of Bacteremia which was incorrect & they said being sure. Gail Olympe does not have anything to do with it. Dr. Needham wanted to end his affair & couldn't tell her about this. Kevin's fear of discomfort.

Place your initials in the box beside the State or Territory in which your Statutory Declaration is being made.

☐

N.S.W. – And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1900*.

☐

VIC. – And I acknowledge that this declaration is true and correct, and I make it in the belief that a person making a false declaration is liable to the penalties of perjury.

☒

QLD. – And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

☐

S.A. – And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1936*.

☐

W.A. – And I make this solemn declaration by virtue of section 106 of the *Evidence Act 1906*.

☐

TAS. – I make this solemn declaration under the *Oaths Act 2001*.

☐

N.T. – And I make this solemn declaration by virtue of the *Oaths Act* and conscientiously believing the statements contained in this declaration to be true in every particular.
NOTE: A person wilfully making a false statement in a declaration is liable to a penalty of \$2,000 or imprisonment for 12 months, or both.

☐

CTH/
ACT – And I make this solemn declaration by virtue of the *Statutory Declarations Act 1959* statutory declarations, conscientiously believing the statements contained in this declaration to be true in every particular.

Declared at BUNDABERG in the State/Territory of QLD

this TENTH day of MAY 2005.

[Signature]
(SIGNATURE OF DECLARANT / PERSON MAKING THE DECLARATION)

before me

[Signature]
(SIGNATURE OF WITNESS / PERSON BEFORE WHOM THE DECLARATION IS MADE)

JAMES HENRY THORNE
(NAME OF WITNESS / PERSON BEFORE WHOM THE DECLARATION IS MADE)

FREWINS ROAD
(ADDRESS OF WITNESS / PERSON BEFORE WHOM THE DECLARATION IS MADE)

ROSEDALE Postcode 4674

JUSTICE OF THE PEACE
(TITLE OR QUALIFICATION OF WITNESS / PERSON BEFORE WHOM THE DECLARATION IS MADE)

5 May 2005

Private & Confidential

Ms Linda Parsons

Dear Ms Parsons

I refer to our telephone call today regarding your complaint about a health service provider. I have noted that you have agreed to forward details of the complaint in writing.

There may be ways I can help if you have a problem forwarding the complaint to us. I am happy to discuss your complaint in more detail over the telephone. Please let me know if I can help.

Because we need as much detail as possible, I have also enclosed a "*Guide to Writing a Complaint*" which covers the types of issues you need to mention. Please complete the details about yourself and the provider(s) on the form called "*My Health Service Complaint*". If your complaint involves more than one health service provider, it would be helpful if you separated the different issues by writing individual complaints for each provider.

If you have any questions about your complaint or require further information, please call me on 3234 0272 or Qld toll free 1800 077 308 (excl. Brisbane Metro). I look forward to hearing from you.

Yours sincerely



Maree Wilson
Intake Officer

Enc.



**Health Rights
Commission**

Our Ref: 049251/mew
Your Ref:

5 May 2005

Private & Confidential

Ms Linda Parsons

Dear Ms Parsons

Following our telephone conversation today, please find enclosed an *Authority for Release of Information* form. Could you please sign this form and return it to me.

I will be in contact with you when I have additional information.

Thank you for your assistance in this matter.

Yours sincerely

Marce Wilson
Intake Officer



HEALTH RIGHTS COMMISSION

AUTHORITY FOR RELEASE OF INFORMATION

I, Ms Linda Parsons of _____, authorise officers
of the Health Rights Commission to contact my doctor/s and hospital about my medical treatment
and to have access to my medical notes.

(Signature)

(Date)

(Date of Birth)

MY HEALTH SERVICE COMPLAINT

An Optional Complaint Form: Please write your own if preferred

I wish to lodge a complaint, and my name is:

Name

Linda Anne Parsons

Address

Phone H)

W)

Date of Birth

Aboriginal or Torres Strait Islander? ☐ Yes ☒ No

Non-English Speaking Background? ☐ Yes ☒ No

I am complaining on behalf of (if relevant):

Name

Address

Phone H)

W)

Date of Birth

Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Non-English Speaking Background? ☐ Yes ☐ No

The person (or place) I want to complain about is: Doctor/Hospital/Other Health Care Provider

Name

Dr Patel / Dr Boyd / Dr Kevin Neelkumar

Address

C/- Bundaberg Base Hospital

Phone

WHEN IT HAPPENED (Date) Problems started 21.3.2004

On Separate sheets please outline your complaint with reference to the attached "Guide to Writing a Complaint"

SIGNED: _____

DATE: _____

Any further queries, contact the *Health Rights Commission* on (07) 3234 0272 or Toll Free 1800 077 308

For people outside the Brisbane area ...

◆ It is an offence to threaten, punish, harass, discriminate or intimidate a person who has made a complaint to the *Health Rights Commission*

Please return this completed form to the *Health Rights Commission, GPO Box 3089, BRISBANE Q 4001*

