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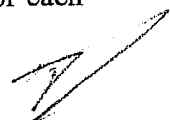
**STATEMENT OF Lynette Joy Yeoman of address known to the Queensland Nurses' Union of Employees**

**Qualifications and experience**

1. I am a Level 1 Registered Nurse employed at the Bundaberg Base Hospital in the Renal Unit. I have been employed in the Renal Unit on a full time basis since Easter 2001.

**Patient names**


2. In this statement, in the interests of protecting the privacy of patients and the feelings of patients' family and friends, I have referred to patients according to a key devised by my lawyers which I have sighted and which I understand is to be supplied by my lawyers to the Bundaberg Hospital Commission of Inquiry on a confidential basis.
3. I recall an incident which occurred in the Renal Unit involving two patients P57 and P56. I cannot now recall the date when the incident occurred. I recall that registered nurse Joanne Turner was allocated to look after these two patients. Both patients had permacaths inserted for haemodialysis purposes. A permacath is a catheter inserted into the internal jugular and sits just above the right atrium of the heart. In order to effectively haemodialyse using a permacath it is necessary to have a blood flow rate of at least 200 ml/minute.
4. It is my recollection that both these permacaths were non-functioning. An attempt had been made by Joanne Turner to remove the heparin locks unsuccessfully.
5. I cannot now recall whether Dr Patel had been paged or not but he wandered into the Renal Unit. He said that he could get the permacaths to work. The two patients were seated in chairs side by side. The haemodialysis machines were set up and ready to go. The sterile dialysis packs were opened for each



patient. Dr Patel, without washing his hands or putting on sterile gloves, proceeded to take the bungs off the end of the permacath on one of the patients. He attached a 2ml syringe to the end of the permacath and tried to withdraw blood from the line. His attempts were not successful.

6. He then moved straight over to the other patient without washing his hands. He tried also to withdraw blood from this patient's line but was unsuccessful. He then kept moving from one patient to the other trying to get the permacaths to work. I was dumbfounded by what was unfolding before my eyes. We are trained to be extremely careful when handling permacaths because of the risk of infection to the patient. For example, before accessing a permacath it is usual practise to soak the lines in an anti-septic solution of betadine for 10 minutes prior to handling them using a sterile technique. Dr Patel by not washing his hands, using sterile gloves or maintaining a sterile field demonstrated to me that he did not appreciate the serious risk that he was posing to these patients.
7. At some point, a comment was made to him about him not using gloves. He then reached up above the sink in the cubicle and as he was placing on a pair of unsterile gloves he said words to the effect that "*Doctors don't have germs*". I was bewildered by his comment and was not sure whether or not he was serious about it.
8. He continued to attend to the patients. I cannot now recall whether he was successful in getting the permacaths to function.
9. I remember discussing the incident with Robyn Pollock and Joanne Turner. Robyn told us that she would discuss it further with the Infection Control Coordinator Gail Aylmer.

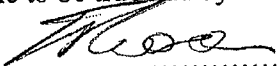


  
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Signed: Lynette Joy Yeoman

Date: 21.6.05

I, Lynette Joy Yeoman, do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the foot of the last page of the statement comprising 3 pages) is true and correct to my knowledge and belief and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

  
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*Lynette Joy Yeoman*

Declaration Taken By:

  
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Lawyer

Date: 21/6/05