STATEMENT OF DAMIEN PAUL GADDES of address known to Queensland Nurses' Union of Employees

1. My legal name is Damien Paul Bonderenko. I have been known from childhood by the surname Gaddes.

Qualifications and Experience

2. I was registered as a Nurse in 1992 and hold a Certificate in Nursing obtained from the Sarah Keenan School of Nursing. Since 1992 I have held clinical nursing positions in the peri-operative environment. I have worked as a theatre nurse at the Bundaberg Mater Hospital, Rockhampton Mater Hospital and the Bundaberg Base Hospital. My job entails performing roles within the theatre environment, including as a scrub nurse assisting the surgeon, a scout nurse or an anaesthetic nurse amongst other roles. Sometimes my duties involve me working in the recovery area for post-operative care of patients. I have performed all of these roles at times whilst employed at the Bundaberg Base Hospital.

Background Matters

3. I am aware that the Commission of Inquiry is interested in examining matters impacting upon the ability of nurses to report concerns as to the practice of doctors within the Queensland Health hospital environment. I myself have experienced matters which may be of relevance to such Inquiry.

4. In 1992 I was a student nurse at Bundaberg Base Hospital. Whilst on theatre rotation, I saw a surgeon, Doctor B leaving the operating suite with a full syringe with a fentanyl ampoule taped to it. I saw Doctor B go into a change room. I was aware that there was no apparent valid reason why someone would take a syringe containing dangerous drugs into a change room. A wardsman with me at the time also witnessed this. He declared he

would not be saying anything as he feared for his job. I informed my Level 2 Registered Nurse, Brett Parfitt, about what I had seen. After questioning whether or not I was certain as to this matter, he expressed the view that it might explain some behaviour he had observed on the part of that doctor (dozing off whilst on his feet, lack of coordination etc). He told me to leave the matter with him for the moment.

5. The next shift I worked, RN Parfitt grabbed me and told me that he had seen Doctor B go into the change room with ampoules. He told me to go and check the pockets of his gown after Doctor B had left the change room. He encouraged me to do so, stating that he would "stand guard" and delay Doctor B if he returned. I did search the pockets of Doctor B trousers and located 2 ampoules of pethidine. I left them there, reporting to Brett what I had observed. Brett telephoned Beris Babbidge, a Nursing Supervisor reporting directly to Glenys Goodman, the then Director of Nursing. Brett told me that it had been reported to Glenys Goodman and that I was to attend an interview with Glenys Goodman.

6. When I went to such meeting as arranged, Glenys Goodman was not present. Beris Babbidge was extremely agitated to the point of stuttering. She repeatedly questioned whether I was sure as to what I observed. Beris Babbidge said words to the following effect: "*Mrs Goodman is too busy to see you and she has said that if you speak a word of this to anyone you will lose your job, instant dismissal*". I believe that Brett told the Theatre Nursing Unit Manager, Jenny Church, about this matter subsequently. I observed from that time that Doctor B continued practising surgery. I was later informed by

the then Director of Medicine that Doctor B had been required to undergo counselling and drug rehabilitation.

7. Such an approach to the practice of a surgeon contrasted very strongly with what I know is the approach of Queensland Health and the Queensland Nursing Council to any type of allegation that a nurse may have stolen drugs or be illicitly using dangerous drugs. The response of Ms Babbidge and Mrs Goodman was one that shattered my confidence. I felt that complaints from nurses about doctors would be treated with suspicion, contempt and hostility by hospital management. I felt it an example of the unwritten policy or understanding that doctors within the hospital system are not to be challenged as to their practices.

8. During 2004 I was assisting Dr Stumer, Director of Gynaecology & Obstetrics at the Bundaberg Base Hospital, whilst he performed a diagnostic laparoscopy on a female patient whose identity I do not now recall. Dr Stumer had apparent difficulty in inserting a Verres needle which is used to inflate the abdominal cavity. It was apparent that the needle had not penetrated the abdominal wall so as to be able to inflate the abdominal cavity but was in fact inflating the tissues of the abdominal wall itself. After Dr Stumer had eventually succeeded in inserting the Verres needle inflating the abdominal cavity I observed him plunge the 30 centimetres length of a laparoscope into the abdomen of the slightly built patient. I was so alarmed that I immediately grabbed his hand and pulled it back, concerned as to the potentially fatal consequences of such an action. Indeed, as the laparoscope was withdrawn, it was possible to observe the intestinal content of the patient which indicated that the laparoscope had been thrust into the intestinal contents of the patient.

Soon after, I spoke to Jenny White, my Nursing Unit Manager, and reported to her what I had observed. Jenny White replied with words to the effect of: "*What can I do about it? I'm just a nurse*".

Dr Patel

9. Prior to myself being involved in surgical procedures with Dr Patel which caused me great concern and led me to voice such concerns to my superiors, I had become aware that other persons including an anaesthetist, Dr Joiner, had apparently voiced concerns about Dr Patel's clinical practice with no response from management. Subsequently, it was always in the back of my mind that if doctors could not be heard as to such matters, nurses were unlikely to succeed in such.

10. After Dr Patel commenced as Director of Surgery at the hospital, I was not initially directly involved in any of the major surgical procedures that were undertaken by Dr Patel and have no direct knowledge as to his clinical practice in major surgery generally. My impression was that he appeared to have appropriate clinical skills in relation to routine surgery. It was his ability to perform major surgery which became a matter of concern to me. I became aware from discussions amongst clinical staff at the hospital of post-operative complications such as wound dehiscence.

11. The things I heard led me to be vigilant as to Dr Patel's clinical techniques in surgery in which I was involved as a theatre nurse. I did observe that Dr Patel appeared to be considerably more casual in maintaining aseptic techniques during bowel resection than I had generally observed on the part of surgeons. I do recall raising this on one occasion with Jenny White, my Nurse Unit Manager. She said words to the effect of: "*What do you expect me to do? You*

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can't expect me to tell a surgeon what to do". I found this frustrating because it did not in any way address the concerns I had for the clinical outcomes of patients. I believe such comments are reflective of a culture whereby doctors are not seen to be subject to the same type of peer review, accountability and discipline which applies to nursing practitioners. It reflects a culture whereby nurses cannot complain about poor technique or clinical procedures on the part of doctors without fearing adverse consequences for their own careers.

12. I wish to address particularly my knowledge as to the clinical outcomes in relation to 2 patients who underwent surgery by Dr Patel.

Patient P21

13. On 20 December 2004 I commenced a shift at about 0730 hours. I started half an hour early to accommodate organisation of all the necessary anaesthetic equipment and stock for planned surgery upon a patient, P21 who was scheduled for a gastro oesophagectomy via an abdominal and thoracotomy approach (Ivor-Lewis oesophagectomy). Whilst collecting the dangerous drug keys from the Intensive Care Unit ("the ICU"), I conversed with the ICU staff as to their readiness for P21 post-operatively. Registered Nurse Martin Brennan informed me that the ICU did not have the staff for another ventilated patient as they already had 2 patients on ventilators. I telephoned Dr Berens regarding the situation and raised the possibility of postponing or cancelling P21's surgery. Dr Berens agreed that we should postpone the case. I told Dr Berens I would notify Dr Patel.

14. I spoke to Dr Patel by mobile phone and informed him of the bed situation in the ICU. His tone of voice became very angry. He stated that the "brain dead" patient should have had their ventilator turned off and that the other

patient had private cover and could be transferred to Brisbane. Dr Patel said that the ICU staff and Dr Joiner were interfering with his planned case that day and that he would clear the ICU for his patient. I interrupted Dr Patel and explained that I was passing on pertinent information and that I would not be preparing expensive equipment and waste it until I knew definitely whether the case would be going ahead. Dr Patel said "*I know, thank you*", and then hung up.

15. I continued to prepare the theatre suite and anaesthetic equipment to a point where the equipment was ready but no items had yet been wasted. We were subsequently advised that the "brain dead" patient's ventilator had been switched off and that a bed in ICU was therefore available. I assumed that this meant that the appropriate brain death testing had been performed by the appropriate physicians before the ventilator was switched off but I have no personal knowledge as to whether in fact such procedure was followed. Given Dr Patel's earlier comments that he would clear the ICU so that a bed would be available, I also assumed that Dr Patel may have taken steps which had led to such a ventilator being turned off; I assumed after the appropriate certification had been carried out.

16. I was the anaesthetic nurse during the surgical procedure for P21. Anaesthetic commenced at approximately 9.00 am. P21 received a central venous catheter, arterial line, thoracic epidural, left and right peripheral lines. Such lines allow the infusion of anaesthetic for the surgery and also allow our surgical staff to monitor in real time the patient's blood pressure and central venous pressure.

17. The surgical procedure commenced at 0952 and concluded at 1312 hours. The procedure began with the laparotomy which is a surgical opening of the abdominal cavity. After the laparotomy, P21's position was changed to lateral and the thoracotomy commenced. A thoracotomy is an opening of the chest cavity.

18. Approximately half an hour into the surgery I noticed that the bellovac drain was half full without vacuum and that blood was freely draining into the bellovac. By this time we had given the patient at least 3 units of packed cell blood products. The pre-operative arterial blood gas haemoglobin had dropped from 75 grams per litre pre-operatively to 70 grams per litre at that point. The patient's heart rate was climbing steadily during the surgery and his systolic was consistently less than 100 millimetres of mercury. All these matters were indicative of a potential problem with the haemostasis of the patient.

19. I said to Dr Patel "*Dr Patel, the bellovac drain is over half full with no vacuum and is still draining freely*". Dr Patel stated "*That's what drains are for Damien*". Dr Berens continued intravenous fluids as per the fluid balance and anaesthetic record sheets. Dr Berens ordered another arterial blood gas after additional units of packed cell blood products. The patient's haemoglobin had remained at 70 grams per litre. Dr Berens relayed this information to Dr Patel and his impression that the patient was haemorrhaging. Dr Patel gave no response to Dr Berens. Dr Patel continued with the thoracotomy. The bellovac drain was emptied twice before the surgery was complete and continued to drain blood throughout. Dr Patel left the theatre leaving junior medical staff to close the incision.

20. Dr Kariyawasam was asked by the clinical staff present to obtain Dr Patel to review the flow from the bellovac drain as the blood pressure was low and pulse elevated. Dr Kariyawasam returned and informed us that Dr Patel's orders were to admit the patient to ICU. All the staff present including myself expressed disbelief as to this response from Dr Patel. It was clear that all present believed that the patient was haemorrhaging. Dr Berens stated "*This patient will be back to theatre tonight*". I was then instructed to go to my break and the patient was transferred to the ICU.

21. When I began my shift the following day (21 December 2004) I was told that P21 had died at approximately 1000 hours that day due to loss of blood. I decided that I must voice my concerns as to his treatment. I spoke to David Levings the Acting Theatre Nurse Unit Manager. He informed me within about an hour that he had spoken to Linda Mulligan, Director of Nursing, and that there would be a meeting arranged with Linda Mulligan and myself and two other theatre nurses, Katrina Zwolak and Janelle Law.

22. A day or two later myself and the other two theatre nurses met with Linda Mulligan in her office. I outlined to Linda Mulligan the details of the surgery as I have outlined in this statement and my concerns as to such. I recall both Katrina and Jenelle outlining their own experiences in relation to the clinical care of P21 in surgery that was subsequently performed upon by Dr Patel. I asked Linda Mulligan how matters would proceed from thereon and expressed concern on behalf of the female nurses as to the possibility of retaliation in the way of bullying from Dr Patel if we were to make formal complaints. Linda Mulligan asked us to make written statements about the matter which would remain confidential and would go to the Director of Medicine for further

investigation. I told Linda Mulligan that I would be making a written statement and also forwarding a copy to the QNU. She agreed that I had every right to do so.

23. On 22 December 2004 I spoke to Vicky Smyth of the Bundaberg Branch of the QNU and detailed my concerns as to Dr Patel's treatment of P21. I subsequently supplied her with a copy of the same statement that I supplied to Linda Mulligan. A true copy of the facsimile copy of the statement faxed to the QNU is attached and marked "DG1". I also approached the ICU Nurse Unit Manager, Toni Hoffman, at this time and she encouraged myself and the other nurses to speak to Linda Mulligan about the matter.

24. The next week I was advised by my Nurse Unit Manager that they had been told that Dr Patel was not going to be permitted in the future to perform surgery of the type performed upon P21. I did not receive any further response directly from Linda Mulligan or the Director of Medicine Dr Keating.

Patient P26

25. On 23 December 2004 the hospital received a phone call stating that a 15 year old boy had been involved in a motor vehicle accident and had a possible femoral artery injury, was losing a massive amount of blood and would be transferred straight to theatre upon arrival of the helicopter. Staff made ready the theatre for the patient's arrival.

26. The surgical procedure began at approximately 1213 hours on 23 December 2004. The surgical team led by Dr Patel explored the left groin laceration and discovered that the left femoral vein was transacted. The vein was repaired and haemostasis was obtained. The wound was debrided and washed, a

suction drain inserted and closed with sutures and staples to the skin. The procedure ended at approximately 1310 hours. Staff involved with the first procedure were myself, Katrina Zwolak RN, M Gotham RN, E Newton EN, Dr Patel, Dr Risson, Dr Athananasiouv and anaesthetists, Dr Berens and Dr Zia.

27. Later that shift at about 1600 hours we were informed that the patient would be returning to theatre to receive necessary fasciotomies for compartment syndrome of the patient's left leg. The procedure began at 1631 hours. Staff involved were myself, Katrina Zwolak RN, E Newton EN, Dr Patel, Dr Berens, Dr Zia and Dr Athananasiouv. The patient received incisions on the lateral left thigh, lateral and medial lower leg and muscle protruded from these incisions.

28. I asked Dr Patel what would cause the compartment syndrome and he replied "*Bleeding into the muscle or a clot*". I then asked if the patient was bleeding and Dr Patel said words to the effect of "*No he isn't bleeding. We had haemostasis in the initial operation*". I asked whether it was possible that the patient's femur could be broken. Dr Patel asked Dr Athananasiouv if x-rays had verified this and his response was negative. I suggested that we do an on table angiogram or a portable x-ray. Dr Patel's response was to the effect of "*No it is not necessary to do it now. I am happy with my anatomy and we have haemostasis*". I then suggested that the x-rays or the angiogram would not take long to set up. The reason I did so was to be certain that the femur was not fractured and to establish whether any blood flow to the leg was disrupted. Dr Patel would not agree that such investigations occur.

29. Dr Patel attempted to palpate for a pulse in the foot and appeared to be having trouble locating one. I suggested we set up the Doppler and Dr Patel agreed. No pulses could be heard with the Doppler. I noticed that the leg was very mottled and extremely stiff (ie that it would not bend through the usual range of motion) in appearance and again suggested angiogram and/or on table x-ray. Dr Patel informed me that the patient's circulation would return after the swelling went down. He said that such investigations were not necessary. He informed Dr Athananasiouv to order an ultrasound at some stage.

30. Once Dr Patel left the room I tried myself to palpate a pulse in the patient's foot and found no discernible pulse. The patient was then discharged to the ICU at approximately 1700 hours.

31. I spoke to Dr Risson who entered the theatre at the end of surgery. I expressed to him my concerns about the lack of pulse in the left leg. He agreed that this was of concern and that he would contact Dr Robinson, a Consultant Orthopaedic Surgeon, about the patient. I then resumed my duties in cleaning up theatre as I would usually do. I completed my duties and instructed the other two nursing staff to shut down the theatre and complete the usual paperwork. I then went through to the ICU to ascertain the patient's condition and see for myself if the pulses of the left leg were returning.

32. Upon entering into the ward I saw Dr Patel, Dr Robinson, Dr Risson and Dr Athananasiouv standing about the patient's bed. Dr Robinson was writing in a chart which I assume to be the patient's chart. The patient's leg was still mottled in appearance and the wounds were oozing through the dressings.

33. I spoke to Dr Risson out of hearing of Dr Patel. I asked Dr Risson if the pulses had returned and he replied in the negative. Dr Athananasiouv, also out

of hearing of Dr Patel, told me words to the effect of: "*We will get him to Brisbane*".

34. I returned home where I received a phone call at about 2020 hours in relation to the patient needing to return to theatre. I recall being surprised that he had not in the meantime been transferred to Brisbane. I returned to the hospital and was present for the patient's return to theatre at approximately 2030 hours to explore the wound and investigate the lack of pulses in his left leg. The wound was open and it was noted that the femoral artery was damaged. The surgical team repaired the artery with a goretex bypass and removed a clot with an embolectomy catheter. The patient's pulses were checked by Dr Patel who said that the patient had a good palpable post-tibial pulse and that his swelling and left leg stiffness would settle down now that blood flow had been restored. The wound was closed and dressed. I noted the left leg to be still mottled and could not feel a post-tibial or pedal pulse. The case ended at about 2300 hours and the patient was again transferred back to the ICU. I cleaned up after this procedure before heading home.

35. The following day, Christmas Eve, I came on shift and enquired of Dr Risson about the patient. He told me that the patient still had no pulse in his leg. I expressed my concern to Dr Risson as to how Dr Patel was handling the case. He agreed that it was in the patient's best interests that he be transferred to Brisbane. I asked Dr Risson to keep me informed as to the patient's progress in Brisbane. At that time, I felt that I had done all I could to voice my concerns to the appropriate persons as to the treatment of the patient.

36. I had days off on Christmas Day and Boxing Day and the following 2 days. When I came back to work on 29 December 2004, the patient had already been

transferred to Brisbane. I was told that the patient's leg had been amputated through or above the knee. I said to Dr Risson words to the effect of "*Would you be prepared to stand up to Patel and make a statement about this*?". I recall him replying "*My oath*". I asked Dr Risson: "*You're not scared of him damaging your career?*". Dr Risson replied "*No*".

37. I spoke to Dave Levings about the case at around the same time and voiced my concerns. Dave Levings told me that there would be an inquiry about the matter and that I would get a chance to speak of it at that time.

38. At this time I had already taken those steps outlined in this statement to voice my concerns about the treatment of P21 by Dr Patel. In light of the feedback given to me regarding P26, I felt that I had taken all steps reasonably open to me to voice my concerns about the treatment of that patient and that I should await the further inquiry mentioned by Dave Levings.

39. After this time Dr Patel started making comments to me, always when we were alone, to the effect of "*Don't you know how much this community relies upon me; you're lucky to have me; I have done a lot for this hospital; I increased its money, its activity; are you aware of that Damien?*". He would speak of the lack of knowledge of the department which I took to be an implicit criticism of myself and other staff and hint that that might be the reason for complaints against him. I did feel intimidated somewhat by these comments. I knew that Dr Patel had threatened other nurses previously with them losing their jobs or being transferred from theatre. I had heard him being belittling to staff. His bullying and inappropriate behaviour was widely known and yet I observed that no steps were taken by management to curb such behaviour.

40. I felt that I could not take any further than what I already had, without suffering damage to my career by way of loss of job or transfer of position, bad reports from Dr Patel as to my clinical performance, and/or bullying by Dr Patel in carrying out my duties.

Other Concerns

41. I understand from what I have been told that there was a very high post-operative infection rate from Dr Patel's surgery. I cannot remember any occasion when theatre staff received feedback alerting them to a high rate of infection regarding Dr Patel's patients. My understanding is that there is a process whereby we should be informed of such a matter. It is obviously of real importance that theatre staff be advised as to apparent problems with infection control during surgery. I am now concerned that such information was somehow being blocked.

42. During the occasion of my meeting with Linda Mulligan regarding P21, I mentioned that Dr Patel had had five patients die after oesophagectomies. Linda Mulligan told me that she hadn't been aware of that because the reporting of such matter did not fall within certain set criteria so as to be flagged to her attention. I am concerned that the clinical feedback systems could somehow not flag and highlight a 100% failure rate on the part of a surgeon in performing oesophagectomies. I would have thought that such circumstances would ring very loud warnings bells for the hospital administration.

43. I wish to state that I have no axe to grind with doctors generally. I am not in the habit of cutting down "tall poppies". Almost all of the doctors whom I deal with, including overseas trained doctors, demonstrate clinical competence

and compassion for their patients and real concern for their outcomes. I do hope that the process currently underway results eventually in systems whereby persons, including nursing staff, can voice concerns about the clinical care of patients, whether it be by doctors or anyone else, without feeling inhibited by fears of reprisal and with confidence that such concerns will be acted upon in the interests of patients.

Patient names

44. 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.

....

Signed: Damien Paul Gaddes
Date: 18/5/05

I Damien Paul Gaddes 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 15 pages) is true and correct to the best of 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.*

....
(Damien Paul Gaddes)

Declaration Taken By:

....
Lawyer

Date: 18/5/05.

DG1

COVER NOTE

DAMIEN PAUL GADDES
REGISTERED NURSE (SINCE 1992)
BUNDABERG BASE HOSPITAL

QUALIFICATIONS

CERTIFICATE IN NURSING 1992
SARAH KEENAN SCHOOL OF NURSING
SINCE 1992 I HAVE HELD CLINICAL POSITIONS IN THE PERI OPERATIVE ENVIRONMENT.

I AM WRITING THIS STATEMENT TO VOICE MY CONCERNS IN MY OPINION OF DANGEROUS PRACTICE WITH DOCTOR J. PATEL (DIRECTOR OF SURGERY OF THE BUNDABERG BASE HOSPITAL.)

I ALSO REQUEST THAT I HAVE PROTECTION UNDER THE WHISTLE BLOWER'S ACT 1994. MY REQUEST IS FOR THE PURPOSE OF AVOIDING BULLYING (FROM DR PATEL) AND STAFF SPECULATION.

BED WAS NOW AVAILABLE.

MR KEMP RECEIVED A C.V.C, ARTERIAL LINE, THORACIC EPIDURAL, LEFT AND RIGHT PERIPHERAL LINES. THE SURGICAL CASE BEGAN AT 0952 TO 1312 HRS. THE PROCEDURE BEGAN WITH THE LAPAROTOMY; NOTHING I RECALL DURING THIS PART OF THE OPERATION WAS A

I BEGAN MY SHIFT AT0730 HRS ON THE 20/12/04> THE HALF HOUR EARLY START WAS TO ACCOMMODATE ORGANIZATION OF ALL NECESSARY ANAESTHETIC EQUIPMENT AND STOCK FOR MR G.KEMP UR NO.007900 SCHEDULED FOR A "GASTRO-ESOPHAGECTOMY" VIA A ABDOMINAL AND THORACOTOMY APPROACH. (IVOR-LEWIS ESOPHAGECTOMY).

I COLLECTED THE DANGEROUS DRUG KEYS FROM ICU AND CONVERSED WITH THE STAFF RE THEIR READINESS FOR MR KEMP POST OP. MARTIN BRENNAN (RN) INFORMED ME THAT THEY DO NOT HAVE THE STAFF FOR ANOTHER VENTILATED PATIENT; AS THEY ALREADY HAD TWO PATIENTS ON VENTILATORS. I THEN DECIDED TO RING DR BERENS RE THE SITUATION AND THE POSSIBILITY OF POSTPONING OR CANCELLING THE CASE DR BERENS CONCURRED WITH AND STATED WE WOULD POSTPONE THE CASE; I TOLD DR BERENS THAT I WOULD NOTIFY DR PATEL.

I ASKED SWITCH TO CONNECT ME TO DR PATEL'S MOBILE PHONE. I INFORMED DR PATEL OF THE BED SITUATION IN ICU. HIS TONE OF VOICE BECAME ANGRY. HE THEN STATED THAT THE *BRAIN-DEAD* PATIENT SHOULD HAVE HAD THE

VENTILATOR TURNED OFF AND THAT THE OTHER PATIENT HAD PRIVATE COVER AND COULD HAVE BEEN TRANSFERRED TO BRISBANE. DR PATEL BEGAN TO SAY HOW THE ICU STAFF AND DR JOINER WERE INTERFERING WITH HIS PLANNED CASE THAT DAY; ALSO THAT HE WOULD CLEAR THE ICU FOR HIS PATIENT. I INTERRUPTED DR PATEL AND EXPLAINED THAT I WAS PASSING ON PERTINATE INFORMATION AND THAT I WOULD NOT BE PREPARING EXPENSIVE EQUIPMENT AND WASTE IT UNTIL I KNEW DEFINITELY WHETHER THE CASE WOULD BE GOING AHEAD. DR PATEL SAID, " I KNOW THANK YOU" AND THEN HUNG UP.

I CONTINUED TO PREPARE THE THEATRE SUITE AND ANAESTHETIC EQUIPMENT TO WHERE NO ITEMS WERE WASTED YET, WERE AT THE READY. WE BEGAN THE ANAESTHETIC AT APPROXIMATELY 0900 HRS POST HEARING THE *BRAIN-DEAD* VENTILATOR WAS SWITCHED OFF AND A

PROBLEM. WE CHANGED MR KEMP'S POSITION TO LATERAL AND PROCEEDED WITH THE THORACOTOMY.
APPROXIMATELY HALF AN HOUR ON I NOTICED THE BELLOVAC DRAIN WAS HALF FULL WITH NO VACUUM AND THE BLOOD WAS STILL DRAINING INTO THE BELLOVAC. BY THAT TIME WE HAD GIVEN THE PATIENT AT LEAST THREE UNITS OF PACKED CELLS. DR BERENS REQUESTED AN ARTERIAL BLOOD GAS THE HB WAS 70 G/L. PREOPERATIVELY IT WAS 75 G/L. I OBSERVED HIS HEART RATE WAS CLIMBING STEADILY DURING THE CASE AND HIS SYSTOLIC WAS CONSISTENTLY LESS THAN 100 MMHG.
I STATED,"DR PATEL THE BELLOVAC DRAIN IS OVER HALF FULL WITH NO VACUUM AND WAS STILL DRAINING FREELY". DR PATEL STATED, "THAT'S WHAT DRAINS ARE FOR DAMIEN!" DR BERENS CONTINUED INTRAVENOUS FLUIDS AS PER THE FLUID BALANCE AND ANAESTHETIC RECORD SHEETS. DR BERENS ORDERED ANOTHER ARTERIAL BLOOD GAS POST ADDITIONAL UNITS OF PACKED CELLS; THE PATIENT'S HB REMAINED AT 70 G/L.

DR BERENS RELAYED THIS INFORMATION TO DR PATEL AND HIS IMPRESSION THAT THE PATIENT IS HAEMORRHAGING. DR PATEL GAVE NO RESPONSE TO DR

Berens. The operation was complete bar closure and the bellovac was emptied twice before the operations end and was continuing to drain blood. Dr Patel had left the theatre and left the junior staff to close the incision. Dr Kariyawasam was asked after applying the dressing to obtain Dr Patel to review the flow from the bellovac drain (laparotomy) and the blood pressure was low and his pulse was elevated. Dr Kkariyawasam returned and informed us Dr Patel's orders were to admit the patient to ICU. All present staff looked at each other and statements carried the theme that the patient was bleeding. DrBerens stated," This patient will be back to theatre tonight" I was then instructed to go to my break, by then the patient was transferred to ICU.

I began my shift the next day (21/12/04) and heard at approximately 1000 hrs that Mr Kemp had died due to loss of blood. It was then I felt I needed to let my superiors know my concerns.

Damien P Gaddes