SUPPLEMENTARY STATEMENT OF GAIL MARGARET AYLMER

Gail Margaret Aylmer states as follows:-

Wound Dehiscence

1. At paragraphs 12 and 13 of my statement dated 24 May 2005, I dealt with an occasion when Dr Patel come to my office to discuss the Wound Dehiscence Report dated May 2003 to June 2003 ("the meeting"). I have since been shown a copy of an email sent by me to Dr Keating, the Director of Medical Services dated 8 July 2003. At the time I prepared my statement, I did not have a copy of the email. Having read the email, I would like to make some further comments about the meeting with Dr Patel and my subsequent email to Dr Keating.
2. Dr Patel had obviously been given a copy of my report by Dr Keating as he had a copy of it and come to my office shortly after I hand delivered it to Dr Keating. Dr Patel did not bring any patient charts with him to the meeting so we were unable to refer to any charts at the time. He stood over me and discussed each case giving a brief explanation that in my limited knowledge of surgery seemed reasonable at the time. According to Dr Patel's definition of wound dehiscence, which he did not convey to me at any time, I agreed to decrease the number of wound dehiscence from 13 to 5 (2 of the 5 relating to the one patient). I emailed Dr Keating soon after my meeting with Dr Patel to update him. In this email to Dr Keating I said I was pleased to be able to exclude many of the cases from consideration, and that I had "no further concerns" after discussing the cases with Dr Patel. It was not within my expertise to question a surgeon about surgical technique or challenge his conclusions about the wounds. Dr Patel was very confident and said he was very experienced, and I was too inexperienced and not properly qualified in surgical practices to challenge him.
3. I believed Dr Patel would have been required to explain the incidences of wound dehiscence before a qualified surgeon in an appropriately convened Morbidity and Mortality review panel. At no time did I consider that

reviewing a surgeon's surgical technique was within my scope of practice as an Infection Control CNC. I do not believe an infection control nurse would have been expected to do this anywhere else. I expected that the Director of Medical Services would review the matter and keep tabs on the issue having had the concerns brought to his attention.

P99.

4. My attention has been drawn to a paragraph of a Statement of P.99 which states as follows:

> *"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 experienced 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."*

5. I recall the conversation with P.99 I took the hospital's microbiologist, Peter Bielenberg, along with me. Dr Nydam left the room and left us to talk with P.99. P.99 was concerned about some recurrent sores on her skin that she has had since her surgery earlier in 2004. It was my understanding that P.99 felt these skins sores were directly due to the operation. I recall discussing with P.99 that surgery is one of a number of factors that can knock a person's immune system around, and as a result it is possible for things like this to occur when someone's immune system is not working well. P.99 stated that she worked a lot of night duty. P.99 looked physically exhausted and I did state this to her. It is my recollection that she conceded this at the time. I acknowledge that P.99 may have looked physically exhausted that day as she said she had worked night duty the night before our meeting. I recall saying to P.99 that from an infection control perspective, I would see no issue with her being able to practice as an Assistant in Nursing as long as she kept the sores covered at work. This was for her own and the client's protection.

6. I do not remember p.99 saying whether she had boils on her skin prior to surgery and I do not recall whether this question was asked. I did not write in my letter that p.99 experienced boils prior to her surgery in 2004. I do remember that p.99 said at our October 2004 meeting that she had a recent history of boils. This prompted Mr Bielenberg to ask p.99 whether she had a history of Diabetes. Mr Bielenberg and I discussed the importance of swabbing the sores to ascertain the causative organism. I do not recall who, but either Mr Bielenberg or I discussed the possibility that depending on the results, a referral to an Infectious Disease Consultant may be recommended.

7. I then took p.99 and the woman who accompanied her to a room in the Department of Emergency Medicine so that I could swab one of the sores. It was not possible to swab a sore at that time as the sore p.99 showed me was dry. While I do not recall exactly where this dried sore was located, I do recall that p.99 needed to lift clothing, or move clothing for me to see that site. It was my understanding from p.99 that her surgery wound was healed at the time as I would have attempted to swab that wound. I then gave p.99 a wound swab and a pathology form and asked her to swab the next sore that developed, and to return the swab to the hospital for testing. I would then contact her with the results.

8. I recall then that it took quite a period of time, approximately 8 weeks later for p.99 o return the swab to the hospital for analysis. The pathology form looks to be dated the 8 October 2004, however this is a scanned image and the date could easily be the 6 October 2004. The wound swab was documented as being collected on the 6 December 2004. After I received the swab result I discussed it with Mr Bielenberg the microbiologist and we agreed that the results appeared to indicate that the problem was not directly caused by her operation as the organism identified from the culture was an organism often found on a person's skin and was generally regarded as normal skin pathogen. The organism cultured was *Staphylococcus aureus* and not Methicillin-Resistant *Staphylococcus aureus* (MRSA).

9. I did write a letter to P.99 dated 16 December 2004 in which I referred to the discussion I had with Mr Bielenberg the microbiologist, and enclosed a copy of the pathology result. I suggested in the letter that she take the pathology result with her when she next goes to see her General Practitioner, and asked her to contact me if she would like any more details.

10. The letter I wrote to P.99 was returned to me with "NOT AT THIS ADDRESS" written on the envelope. I have kept this letter. I do not recall exactly when, but sometime in late January, February or early March this year P.99 telephoned me about her result as she had not heard from me. I explained how the letter had been returned to me and she stated that she had moved house. I spoke with P.99 on the phone about the result and then sent a copy of the original letter to her new address with another copy of her result.

11. I note that P.99 did experience a post operative wound infection following her surgery 15 March 2004. I note a wound swab was collected on 25 March 2004 that cultured *Staphylococcus aureus* and *Pseudomonas aeruginosa*. While I do not fully recollect if this was P.99 belief, it has been my experience that people in the community commonly confuse *Staphylococcus aureus* with Methicillin-Resistant *Staphylococcus aureus*. Methicillin-Resistant *Staphylococcus aureus* (MRSA) is often more commonly called Golden Staph by the general public. Neither of P.99 wound swabs cultured Methicillin-Resistant *Staphylococcus aureus*. I note that the clinical comment on the March 2004 pathology form also mentioned cellulitis. Simply stated, cellulitis is a localised inflammation of the skin. While I did not see P.99 cellulitis, the medical record does indicate that the cellulitis was in the vicinity of the surgical wound.

12. I have had the following paragraph of a statement of Vicki Narelle Hall read to me:

   1. *Dr Nydam then called a lady called Gail from infection control to the meeting. He also called a biochemist whose first name might have been Peter. Dr Nydam did not, as far as I could see, read* P.99 *file apart from the letter of complaint. He really just sat there while* P.99 *explained what had happened. He told her that everything had been*

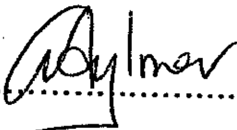
done for P.99 that could be done for her. I did notice that, at least on one occasion, Dr Nydam went outside and obtained documents relating to P.99 from a source other than her file.

2. *When Gail turned up, she took a swab. Otherwise, she just repeated what Dr Nydam had said, namely that the infection was caused by P.99 being run down and that it was due to P.99 work environment rather than the operation.*

3. *None of the officers seemed to have any interest in what we were saying. Gail did not tell P.99 to report the infection anywhere. There was never a stage when any of the Hospital staff in the room said that they would investigate, that they would see what the problem was, or that they would see if they could find some solution. The whole meeting lasted about 45 minutes.*

13. I wish to clarify some comments made by Ms Hall. I contacted Peter Bielenberg not Dr Nydam. I did not "take a swab" when I turned up at Dr Nydam's office. I have never seen a copy of the complaint made by P.99 nor was in the room to have known what Dr Nydam had said to P.99.

14. I refer to paragraph 7 above which sets out my recollection of the relevant events. It is incorrect to say that I did not offer to investigate her problem. As there were so active sores to swab at the time, I gave her a wound swab and pathology slip so that the problem could be investigated.



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Gail Margaret Aylmer 19 / 06 /2005