LOST AND DAMAGED LIVES

HOSPITAL #1 NEW SOUTH WALES

- **Equipment count-back failure**

Woman admitted to hospital for bowel polyp removal. Endures sharp, cutting pain in her stomach for 18 months. Was told it was after-effects of surgery. Had colonoscopy, which revealed nothing. No doctor suggested she have an x-ray. When patient insists on an x-ray, revealed is a pair of 15cm surgical scissors, slightly open, lodged between her lower bowel and spine. The hospital said it did not count scissors after surgery because they were considered too large to lose.

HOSPITAL #2 QUEENSLAND

- **Diagnosis failure**

Young man attended cardiology clinic for 18 months for fast heart rate, shortness of breath, lethargy. Told to lose weight, get fit and sent him to rheumatologist. Doctor deemed cause was from too much Pepsi and takes him off all medication. Week later has chest pain, sees GP, told it's indigestion, goes home and 2 hours later dies. Hospital treats his grieving family with disdain. Vehemently refused to answer family's questions or provide medical records aggravating family further. Family alerts the Coroner. Inquest finds patient had cardiac problems and hospital had not ever conducted any cardiac investigations.

HOSPITAL #3 SOUTH AUSTRALIA

- **Intern Training failure**

Young woman attends hospital Emergency Department with profuse sweating and fever symptoms. Told she has over-exerted herself playing hockey and caught a chill. Intern fails to call another doctor, let alone a specialist, for another opinion and sends patient home with Panadol. Next day patient found dead. Autopsy revealed patient had cardiomyopathy.

HOSPITAL #4 TASMANIA

- **System failure**

Man admitted to hospital for hip replacement. Surgery went OK but next day he couldn't be resuscitated and dies. Doctor said due to natural causes. A pre-operative dose of anti-coagulants had been given to patient at home, but the intra-operative dose and subsequent doses had been omitted in hospital. Surgeon blamed nurse. Medical records reveal no doctor prescribed anti-coagulants following surgery. Autopsy found patient died of post-operative clot and noted resuscitation attempts had been conducted for 20 minutes.

HOSPITAL #5 VICTORIA

- **Cross-check failure**

Two women attended same clinic and saw the same doctor, the same day. Both women had same Christian names. Both needed breast biopsies, which were done same date, same hospital by same doctor. One had breast cancer. One did not. 9 months later it was discovered the results had been muddled up. The patient with cancer is dead. The patient without cancer is alive, but had months of chemotherapy, is minus a breast and an upper arm so large it will not fit into a regular-size sleeve.

HOSPITAL #6 WESTERN AUSTRALIA

- **Infection Control failure**

Man admitted to hospital for total knee replacement. Acquires post-operative staph infection. More surgery to washout knee infection. Then more surgery to re-do knee replacement. Acquires another post-operative infection requiring more surgery to wash out knee. Drug Chart disappears from patient's medical record. Then knee replacement removed altogether and knee fused straight. 10-day hospital stay became 16 weeks. Man left a cripple with knee full of concrete.