A SAD LOSS

Royal North Shore Hospital Shame

Donald William Mackay's cruel death cries out for justice.

On behalf of Don my husband of thirty-five years, our daughters, and myself, I request authorities begin an independent, open investigation into the surgery, treatment, care and subsequent death of Donald William Mackay.

His death was a direct result of five weeks he spent in RNSH between 11th April 2007 and 17th May 2007 (the day he died). I request that the Cardiothoracic surgeon and team, the Spinal Ward doctors and nurses who ignored my husband's worsening condition receive disciplinary action because of their negligence, which led to Don's first Respiratory Arrest and inability to come off ventilation.

ICU and Cardio Thoracic Specialists who withheld full disclosure of his condition from us should receive disciplinary action. Their non-disclosure led to Don being subjected to unnecessary torture, which lasted five long weeks. I request that the filthy practices and deplorable conditions he endured without choice in ICU be exposed. Legally, ethically, why and how are the medical practitioners protected from criminal charges?

This could happen to your loved one or yourself. I have no reason to think it has not since my husband's criminal mistreatment inside RNSH.

1. My husband, Don Mackay had been a Quadriplegic for 25 years. On 11/4/07, he arrived at RNSH at 10pm from Port Macquarie. It was not an emergency. A doctor whose English was limited signed him up for the surgery within the hour that night. He cannot recall what he told my husband about that surgery. Why?

2. The next morning as I was driving from Port Macquarie, Don was being given dangerous and unnecessary surgery (Pleurodesis).

3. How could RNSH's Cardio Thoracic surgeon just "assume" Don had been examined, by a cardiothoracic specialist in Port Macquarie? This was unprofessional.

4. There was no ECG prior to surgery although he had Pericardial Effusion. Why was that?

5. He had neither blood tests nor any pathology. How can they justify this?

6. The Admitting Cardio Thoracic Specialist who was also the surgeon saw no X-rays or Scans prior to surgery. (They were still in Port Macquarie Base Hospital.) What was going on?

7. The review by the Anaesthetist is admitted by RNSH to be "limited". He was not seen before theatre. Limited why? Don had complicated medical problems and required proper assessment.

8. The Cardio Thoracic surgeon had not seen Don before Theatre and had not done a detailed examination. The person who signed him up the night before was not part of the surgical team. No one knew anything about his multiple conditions before surgery. How irresponsible and dangerous was that?

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