MLC 1

From: Karen Smith
To: Keating, Darren
Date: 2/28/05 5:24pm
Subject: Sessions Anaesthetic Shortages

Dear Dr K
Dr Carter is unable to staff Dr Delaney's session for Wednesday am as he is getting a new anaesthetic machine commissioned.
This does not effect joint bookings so I have rescheduled the ACL Repair Dr D is going to do a MUA under GA then a Aspiration under local.
Dr Carter also informs me that not staff the list Thursday pm as the anaethetist all have to attend inservice.
I asked Dr Haines but unfortunately he is unavailable.
Regards
Muddy

Dear Dr K
Dr Carter is unable to staff Dr Delaney's session for Wednesday am as he is getting a new anaesthetic machine commissioned.
This does not effect joint bookings so I have rescheduled the ACL Repair Dr D is going to do a MUA under GA then a Aspiration under local.
Dr Carter also informs me that not staff the list Thursday pm as the anaethetist all have to attend inservice.
I asked Dr Haines but unfortunately he is unavailable.
Regards
Muddy

From: Darren Keating
To: Martin Carter
Date: 2/28/05 5:37pm
Subject: Fwd: Sessions Anaesthetic Shortages

Martin

Re: Attached email

Why does the machine need to be commissioned now with a shortage of anaesthetists ?

Surely the training can be staggered so that Thurs pm session can be done. Every little bit helps and this doesn't appear to be happening.

Darren

Martin

Re: Attached email

Why does the machine need to be commissioned now with a shortage of anaesthetists ?

Surely the training can be staggered so that Thurs pm session can be done. Every little bit helps and this doesn't appear to be happening.

Darren

MLC 2.

From: Darren Keating
To: Martin Carter
Date: 3/3/05 2:48pm
Subject: PAC Next Thurs

Hi Martin

Can you get one of your anaesthetists to do PAC next Thurs from 12.30 until 1330 (of those who need to be seen) ? They can record no lunch break.

Or do you have any other solution ?

This will ensure that gynae isn't put back and we keep up ever so slowly with their targets.

Thanks

Darren

From: Darren Keating
To: Martin Carter
Date: 3/3/05 4:45pm
Subject: Re: PAC Next Thurs

Martin

Gynaecology has an increasing long wait list. They don't need the PAC to be cancelled. All that is required is 1 anaesthetist for 1 hr or 2 for 1/2 hr.

This is a one off request. Some help and co-opeartion would be appreciated.

Darren

>>> Martin Carter Thursday, 3 March 2005 15:52:03 >>>

Darren

There are some 300 cases on file in PAC awaiting surgery. I think we can cancel one clinic.

Martin

MLC 3

From: Darren Keating
To: Martin Carter
Date: 3/4/05 8:33am
Subject: Re: PAC Next Thurs

Martin

We aren't ahead of the game with 13 LW cat2 gynae patients and elective surgery behind by 142 w/seps. There is a need to have patients on standby.

I'm no longer asking, I'm directing that an anaesthetist/s is available for the 1230-1330 time period next Thurs.

Darren

>>> Martin Carter Friday, 4 March 2005 8:23:03 >>>

Darren

We have put 30 gynae patients through PAC. Next week we will be operating on **four.** We are still well ahead of the game.

Martin

MLC4

From: Darren Keating
To: Martin Carter
Date: 3/7/05 11:55am
Subject: Fwd: Re: Pumps syringe

FYI. 2 PK pumps to be purchased by Stores under HTER, with other 4 TIVA pumps to be included in submission to DM.

Darren

FYI. 2 PK pumps to be purchased by Stores under HTER, with other 4 TIVA pumps to be included in submission to DM.

Darren

From: Peter Heath
To: Darren Keating
Date: 3/7/05 11:33am
Subject: Fwd: Re: Pumps syringe

Darren
2 pumps now approved on HTER this year. Would you please send in a copy of the brouchure for supply to order.

CC: Jennifer Duffy

Darren
2 pumps now approved on HTER this year. Would you please send in a copy of the brouchure for supply to order.

From: Jeanette Glanvill
To: Peter Heath
Date: 3/4/05 4:49pm
Subject: Re: Pumps syringe

Peter

HT2925 & 2926 are now listed as "Individual" Purchases.

Regards
Jeanette

>>> Peter Heath 7/01/2005 11:02:17 am >>>

Dear BP
Regarding HT items 2925 & 2926 our Director of Medical Services and Director of Anaesthetics are requesting Asena PK pumps in lieu of the Asnea GH pump that is on bulk purchase offer. Is it possible to purchase GH pumps?

regards
Peter

CC: HT Program CWB; Sarah Brewer

Peter

HT2925 & 2926 are now listed as "Individual" Purchases.

Regards
Jeanette

>>> Peter Heath 7/01/2005 11:02:17 am >>>

Dear BP
Regarding HT items 2925 & 2926 our Director of Medical Services and Director of Anaesthetics are requesting Asena PK pumps in lieu of the Asnea GH pump that is on bulk purchase offer. Is it possible to purchase GH pumps?

regards
Peter

"MLC 5"

Case Report – Desmond Bramich

Desmond Bramich
DOB 15/4/48
Deceased 28/7/04

This gentleman was admitted through the emergency department at 1946 following a trauma call. He had sustained a crush injury to the right side of his chest when he had been trapped under his caravan for ten minutes approximately three hours earlier. He was transferred to the hospital from the accident site by helicopter.

On arrival his observations were noted to be

Respirations	30
Saturations	96%
Pulse	107
Blood Pressure	147/93
Haemoglobin	153

His past medical history included gastritis, haemochromatosis, Hepatitis A and Left Bundle Branch Block (LBBB).

Bilateral large bore cannulae were inserted as was an intercostal drain (under ketamine and morphine.

The trauma screen radiography showed an enlarged heart, a right sided chest tube, subcutaneous emphysema, ?contusion ?inflammation to the right lung and probable fractures to the 6th and 7th ribs on the right.

The abdomino-thoracic CT showed bilateral fractured ribs, bilateral pneumothoraces with a right sided intercostal catheter. There was extensive surgical emphysema over the right hemithorax with mediastinal air extending into the neck. Pulmonary contusions were also noted. There was no intra-abdominal pathology demonstrated.

The possibility of cardiac contusion was considered and serum troponin measured. The level was 0.04 (just significant). Any other diagnostic criteria were complicated by the pre-existing LBBB.

He was admitted to the Intensive Care Unit for overnight observation.

On the following day, the 26th he was sufficiently awake and comfortable to be discharged to the surgical ward on a patient controlled analgesia regime. His chest radiograph showed collapse and consolidation on the right with multiple rib fractures.

He continued well until about 1300 on the 27th when he collapsed with a recorded blood pressure of 50 systolic. The floor anaesthetist was contacted and went to the surgical ward to assess the patient who was in acute respiratory distress and haemodynamically unstable. A haemoglobin taken during this phase showed a level of 77. The patient's conscious level was fluctuating and he was complaining of severe chest pain. The Right sided intercostal drain was noted to be non-functional at this time. The patient was, therefore, transferred to the Intensive Care unit

Upon arrival in the Intensive Care Unit a second intercostal drain was inserted at the request of the anaesthetist whilst the patient was intubated for respiratory support. The Director of Anaesthetics was called to review and advise on further management of the patient. His decision was to arrange for the patient to be transferred to a tertiary centre in Brisbane, where the capacity to provide thoracic surgery, long term ventilatory support and a blood bank with the capacity to provide products for massive transfusion were co-located. The flight coordinator was contacted at 1620 to arrange a retrieval flight.

In the interim a further abdomino-thoracic CT was performed to exclude an intra-abdominal catastrophe. The anaesthetic support for this procedure was provided by the Director of Anaesthetics. The floor(duty) anaesthetist having been diverted to deal with a less urgent case (a patient who had suffered a perforation during a colonoscopy performed by the Director of Surgery). The CT demonstrated marked change with the right hemithorax being full of blood with a mass displacement of the mediastinum to the left. There was no evidence of pericardial fluid.

Fluid resuscitation continued, the patient receiving in all:-

11 units of blood,
4 units of fresh frozen plasma,
3,000 ml crystalloid
and 2,000 ml colloid.

Despite this the patient remained hypotensive and was commenced on vasopressor agents.

The Director of Surgery reviewed the patient and decided to do an ultrasound guided pericardiocentesis despite the evidence of the CT. This produced 2-3 ml blood. He then had a discussion with the family and informed them that there were no plans to transfer the patient to Brisbane stating that the patient had a pulmonary contusion leading to massive haemothorax and was haemodynamically unstable at that time. The retrieval team had been despatched at 1930. The team arrived at 2215 and it was decided that the patient should be transferred after an aggressive bout of resuscitation. Unfortunately the patient arrested and despite all attempts at resuscitation was declared dead at 0010.

Post mortem confirmed that there was ~3,000ml of blood in the right hemithorax and the right lung was collapsed. There were fractures of the 6th and 7th ribs on the right as well as the sternum. The right ventricle had been abraded and the visceral pericardium perforated, blood within the pericardial cavity is attributable to this. Cause of death is attributed to internal haemorrhage.

Areas of concern

1. The delay in the arrival of the retrieval team. Request logged at 1620, despatched at 1930 and arrived at 2215. A six hour delay is excessive.
2. Lack of coordination of care – two surgical teams involved. Mixed messages being conveyed to the family over the advisability of transferring the patient.
3. Poor triaging with a patient with a perforation of a prepped large bowel being prioritised ahead of a patient with catastrophic intra-thoracic bleeding.
4. Pericardial paracentesis being performed without any indication (see CT and PM report).
5. Lack of radiology support – CTs not reported until 30/8/04

MLC 6

MANAGEMENT SUMMERY

REGARDING BRAMICH DESMOND. UR NO 086644.
D·O·B 15/4/1948.

As directed by DR MARTIN CARTER.
DIRECTOR ANAESTHESIA & ICU.
BUNDABERG BASE HOSPITAL.

I was consultant on call for FLOOR & ICU on 27/7/04. I received a telephonic call from DR JAMES BOND surgical PHO (at about mid day) regarding above mentioned pt in surgical ward. I immediately attended the pt.

MR BRAMICH DESMOND was in acute respiratory distress & Haemodynamic stability, pale, & desaturating. His conscious level was fluctuating GCS 10 – 13 And was c/o severe chest pain when he was responsive (Sitting at 75° on his bed.

As a team work & other surgical doctors and paramedical staff we commenced fluid resuscitation. His chest tube (Rt lung) was not functioning properly. I requested to review the drainage system. DR garfield also joined us from O.T.

I planned to shift the pt to O.T. Meanwhile (in the ward pt,s did respond to our prompt resuscitation.) on arrival in I.C.U pt again deteriorates (respiratory distress + Haemodynamic instability)

(2)

I requested the surgeon to [redacted] insert another big sized intercostal drainage tube as I was not satisfied with the L/C catheter already in place.

In view of impending cardiorespiratory collapse I decided to intubate & ventilate & available invasive monitoring.

Surgeon managed to insert another L/C drainage tube and there was a big gush of blood in the drainage tube.

At about 2.30 PM I requested My director to review and give me a hand and advise for further pt management.

Dr Carter immediately accompanied me to I.C.U. He discussed with the surgeon about option of shifting the pt to Brisbain in a cardiothoracic unit for better pt management in case he requires immediate surgical interference and better I.C.U & blood bank back up services.

Surgical PHO communicated Brisbain hospitals and had a positive response from P.A hospital.

I personally talked to DR Gajild in O.T about this development. He was almost finishing his surgery in O.T but he said that he will review the pt after just finishing the case but it would be better to arrange a CT scan (Thoracoabdominal) before a final decision is made.

Meanwhile pt was given blood Transfusion Hb/ raised from about 6 gm/ to 10 gm/. Oxygenation satisfactory. and BP was reasonable ē ont any vasopressor support

DR CARTER very kindly accompanied the pt to C.T scan room as I was busy in an emergency laparotomy.

At about 7.00 PM after finishing my anaesthesia I reviewed the pt in I.C.U and found that his BP again was very low. started ē vasopressor as per protocol.

Dr Patil (Director of surgery) also

)

reviewed the pt. He decided to do a ultrasound guided pericardiocentesis in suspision of a cardiac temponade. Results of the procedure ??? (There was 2-3 ml of blood on one syring aspiration which immediatily clotted later on.)

He had a detailed discussion with the family and explained pt's condition and answered there relevent concerns about the pt. He explained them that we have no plan to shift the pt to BRISBAIN (No good reason to move him - Diagonosis after CT. pulmonary contusion → Haemothorax maynot and the pt is also haemodynamically very unstable by that time (about 9.00PM) After about 20 minutes of that detailed discussion surgical R/O DR JAMES BOYD told me that he has recieved the telephonic message that air retrieval team from Royal Brisbain hospital is on the way to BUNDABERG.

He in my presence conveyed this latest development to the family.
At about 11.00 PM the retired team doctor had a detailed discussion with the family about pros & cons of shifting the pt in that critical and unstable condition. Any way it was decided to shift the pt after another aggressive resuscitative effort (as per their protocol.)
Just before final move pt arrested. Standard CPR (advance) done for about 20 – 25 minutes. Another intercostal 16 G cannula → R/c drain inserted on left side (Gush of blood stained fluid from left side of Thorax) by DR James Boyd surgical PITO.
Resuscitation terminated at 02.10 AM as there was response to CPR. and death declared to the family by retired Team doctor.

This is YOUNIS mastitis

MLC 7

Report to the coroner

Transcription of Dr Iftikhar Younis's hand written note by Dr M L Carter

Management Summary
Regarding Bramich Desmond UR No 086644
DOB 15/4/1948

As directed by Dr Martin Carter
Director Anaesthesia & ICU
Bundaberg Base Hospital

I was consultant on call for floor and ICU on 27/7/04. I received a telephone call from Dr James Boyd surgical PHO at about midday regarding above mentioned pt in surgical ward. I immediately attended the pt.

Mr Bramich Desmond was in acute respiratory distress with haemodynamic stability, pale, sweaty and desaturating. His conscious level was fluctuating GCS 10 – 13 and was c/o severe chest pain when he was responsive (sitting at 75° on his bed).

As a team work with other surgical doctors and paramedical staff we commenced fluid resuscitation. His chest tube (Rt lung) was not functioning properly. I requested to review the drainage system. Dr Gaffield also joined us from O.T.

I planned to shift the pt ICU. Meanwhile (in the ward pt did respond to our prompt resuscitation.) on arrival in ICU pt again deteriorated (respiratory distress and haemodynamic instability). I requested the surgeon to insert another big sized drainage tube as I was not satisfied with the i/c catheter already in place.

In view of the impending cardiovascular collapse I decided to intubate and ventilate with available invasive monitoring. Surgeon managed to insert another i/c drainage tube and there was a big gush of blood in the drainage tube. At about 2.30 pm I requested my director to review and give me a hand and advise for further pt management.

Dr Carter immediately accompanied me to ICU. He discussed with the surgeon about option of shifting the pt to Brisbane in a cardiothoracic unit for better pt management in case he requires immediate surgical interference and better ICU and blood back up services.

Surgical PHO communicated Brisbane hospitals and had a positive response from PA hospital.

I personally talked to Dr Gaffield in OT about this development. He was almost finishing his surgery in OT but he said that he will review the pt after just finishing the

case but it would be better to arrange a CT scan (thoracoabdominal) before a final decision is made.

Meanwhile pt was given blood transfusions Hb% raised from about 6gm% to 10gm%. Oxygenation satisfactory. And BP was reasonable without any vasopressor support. DR CARTER very kindly accompanied the pt to CT scan room as I was busy in an emergency laparotomy. At about 7.00 PM after finishing my anaesthesia I reviewed the pt in ICU and found that his BP again was very low. Started with vasopressor as per protocol.

Dr Patel (Director of Surgery) also reviewed the pt. He decided to do a ultrasound guided pericardiocentesis in suspicion of cardiac tamponade. Results of the procedure ??? (there was 2-3 ml of blood on one syringe aspiration which immediately clotted later on.)

He had a detailed discussion with the family and explained pt's condition and answered their relevant concerns about the pt. he explained to them that we have no plan to shift the pt to BRISBANE (No good reason to move him – diagnosis after CT pulmonary contusion → haemothorax massive) and the pt is also haemodynamically very unstable by that time (about 9.00 PM). After about 20 minutes of that detailed discussion surgical PHO Dr JAMES BOYD told me that he had received the telephonic message that air retrieval team from Royal Brisbane hospital is on the way to BUNDABERG.

He, in my presence, conveyed this latest development to the family.

At about 11.00PM the retrieval team doctor had a detailed discussion with the family about pros and cons of shifting the patient in that critical and unstable condition. Any way it was decided to shift the pt after another aggressive resuscitation effort (as per their protocol). Just before final move pt arrested. Standard CPR (advance) done for about 20 – 25 minutes. Another inserted 16G cannula → i/c drain inserted on left side (gush of blood stained fluid from left side of thorax) by Dr James Boyd surgical PHO.

Resuscitation terminated at 00.10 AM as there was no response to CPR. And death declared to the family by retrieval team doctor.

Dr I YOUNIS
SMO Anaesthesia
28/7/04
1245PM