TH26

From: Toni Hoffman
To: Linda Mulligan
Date: 3/09/2004 8:30am
Subject: Fwd: EVENTS AS RECALLED FROM 27TH JULY 2004

Dear Linda,

I am forwarding some more documentation related to the death of MR Bramich to you,

Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

From:
To: <Toni_Hoffman@health.qld.gov.au>
Date: 2/09/2004 5:30pm
Subject: EVENTS AS RECALLED FROM 27TH JULY 2004

Toni
I have actually updated this but it is on the work computer. I have added more detail and it flows better I think
See you on Monday
Karen

STATEMENT OF EVENTS ON 27TH JULY 2004

NAME: Karen Lynne Fox

Registered Nurse in the State of Queensland
Initially registered in NSW in 1985, registered in Queensland in 1996. I have a Graduate Certificate in Coronary Care, Midwifery, and an Intensive Care Certificate. I have worked in Critical Care since 1991.

Re: MR DESMOND BRAMICH DOB: 15/04/1948

On the 27th July 2004 I was called in to work an extra 12hr night shift. I commenced duty at 1900hrs. On arrival in the unit the unit was a hype of activity with a number of medical staff present, nursing staff and the NUM.

Other staff on this shift were: Vivian Tapiolas, Daniel Aitken, Sandra Sharp and a student nurse.

I began caring for Mr Bramich at the commencement of the shift. Mr Bramich's family were around the bedside and in the waiting room, including his nine year old daughter.

The busyness and need to attend procedures as required did not allow for a comprehensive nursing check of the patient or equipment.
At approximately 1930hrs we received a phone call from the RFDS flight nurse. I spoke to her regarding Mr Bramich being transferred to Brisbane. She asked if we had a confirmed bed, as I was unsure I enquired to the medical staff regarding this and was informed that we did not. I relayed this information to the flight nurse who stated that they would not come if the bed was not confirmed. I said we would follow it up and get back to them. This was discussed with Dr Boyd who said he would follow it up.

The cares for Mr Bramich were not only undertaken by myself, but a team effort from the staff on duty at the time. Mr Bramich was extremely unstable, hypotensive and ventilated. Dr Younis was present and was ordering treatment.

Times are approximate due to the busy nature of the events.

Dobutamine was commenced as I arrived on duty and then noradrenaline was commenced at approximately 2050hrs. He remained hypotensive. We commenced fluid boluses, blood transfusion and ongoing support.

Dr Patel reviewed the patient, ordered an echocardiograph at approximately 2015hrs. Whilst waiting for the echocardiograph Dr Patel, in a very loud voice, stated that they are too busy ventilating 90 year

olds and looking after cardiac patients to care for this patient. On the result of the echo Dr Patel instructed us to set up for a pericardial tap, which we did. After numerous attempts under ultra sound guidance he inserted a pericardial drain and sutured it in place.

During this procedure Dr Patel was loudly making comments that the patient will die and does not need to go to Brisbane. I asked Dr Patel to mind what he was saying as the family were in the hallway. Dr Patel commented that they need to know, I in turn commented that they need to be told face to face not over hearing what I being said behind the curtains.

During the insertion of the pericardial drain we did not have in stock all of the items that Dr Patel was requesting, when told he repeatedly said to get the Nurse Manger to get them as that was her job. I phoned and spoke to the theatre staff who also were unsure of what Dr Patel required.

Dr Patel then inserted a second chest drain, without the use of the introducer. Continuing in a loud voice he lectured the JHO as to why he did not use the introducer in a chest trauma and what he may do to the JHO if he caught him using one in a similar situation. During the insertion of the drain Dr Patel poked and prodded using his fingers through the incision. There was oozing from around the drain insertion site.

Following this Dr Patel spoke with the family, RN Tapiolas was present during the discussion. When the family came to the bedside the wife and daughter in law were extremely distressed, crying loudly and speaking to the patient. Dr Patel abruptly told them that they were not to cry at the bedside. During this time the daughter was also present.

A little later a call came from the RFDS stating that they were on their way.
They arrived at approximately 2215hrs. Dr Younis was present and handed over to the doctor. Cares were as per the retrieval doctor's instructions.

During the preparation for the flight Mr Bramich deteriorated blood was pulsating from the intercostal drain site. This was sutured by Dr Boyd. The patient continued to deteriorate and subsequently had a cardiac arrest. Resuscitation was carried out as per orders from the flight Doctor. Dr Younis was present and assisted with the attempt.

The flight Doctor spoke to the family pre, during and post the arrest. I was present when she spoke to the family during the arrest and at her request I stayed with the family. I stayed with them until after she spoke with them when resuscitation attempts were ceased. This was at approximately 0012hrs.
Dr Boyd was also present during the arrest, and a JHO.

The family were allowed time with their loved one and offered support during this time. They remained with him until the police arrived at approximately 0300hrs.

TH27

RE: DR. PATEL

I was working in ICU looking after a patient in bay seven, when Dr Patel came over and started discussing Mr. Bramich's autopsy results (that had taken place that day) with me over the top of this conscious patient. He was convinced that I had cared for the patient and was telling me about the results. I informed him that I did not know the patient. He then finished the report and moved away. The problem that I have with this is that Dr Patel was discussing confidential patient details over the top of another patient who was aware and no doubt concerned about her own problems without thinking about another patient's autopsy.

I have had found that Dr Patel is prone to be indiscreet in discussing his personal opinions of other doctors and nursing staff (very loud). I have heard Dr Patel agree with the ICU consultant with regard to NG feeding a patient who had had abdominal surgery. The next morning when he was informed that the patient had not tolerated his NG feed, he informed me that it was a "silly" idea of the consultants yesterday to even consider feeds (once again very loudly).

Karen Jenner ICU

W

TH28

Statement of account for Mr Desmond Bramich

I Patricia Gould am employed by QLD Health as a Level 1 Registered Nurse in the intensive care unit (ICU) at Bundaberg Base Hospital. My experience in the intensive care environment is approximately 4 yrs.

I was the nurse that initially looked after Mr Desmond Bramich, who received a crush injury caused by a caravan and was admitted to the ICU on the 25th of July 2004 at 2300. On arrival he was alert and orientated, complaining of pain to the chest.

Patient was given 7.5 mg of morphine which settled the pain. Patient vomited by twice over the course of the night and was given 10mg of maxalon which settled him well.

Patient remained connected to the ICU monitors for the duration of my shift. His Heart Rate was monitored in a normal Sinus Rhythm at a rate of between 65 bpm – 81 bpm, Blood pressure (BP) also remained stable with a systolic BP recorded at between 120 – 140 and a dystolic (BP) of between 69 – 90.

Air Entry to his lungs was noisy. Underwater seal drain was insitu on the right side of patient 's chest swinging and draining. Patient had a non - rebreather mask, delivering 15 Lts of O2 per minute, O2 saturation remained consistent at 97% - 100%.

Routine bloods were taken and ECG was attended. Patient remained haemodyamically stable and requiring only the occasional dose of 7.5 mg of morphine to address his pain.

Patient's wife and sister in law was in attendance for most of the night. Patient was not reviewed by a Doctor overnight

Patricia Gould

Intensive Care Unit
Bundaberg Base Hospital
Bourbong Street,
Bundaberg

TH29

My name is Sharon Cree. I am a registered nurse in the state of Queensland and hold post graduate certificates in Cardio Thoracic and Coronary Care as well as a post graduate certificate in Intensive Care and Coronary Care. I am employed (since March 2003) at the Bundaberg Base Hospital in the intensive care and coronary care unit, Queensland.

Re: MR DESMOND BRAMICH. D.O.B: 15/04/1948

On the 27/07/2004 at approximately 1pm I received a phone call from Dr. James Boyd to alert the unit that his patient (Mr. Bramich) was haemorrhaging from the chest and would require a bed in the intensive care unit as soon as possible. I informed him that it was necessary to transfer a patient (already in the unit) to the surgical ward. Dr. Boyd stated "he would insert an intercostal catheter into his patient's chest cavity before he would escort the patient to the unit.

The patient I had been caring for was transferred by approximately 1.30pm and I immediately alerted Dr. Boyd that his patient could be transferred when he was ready to so.

Mr. Bramich was escorted (on his bed) by Dr Boyd and a registered nurse into intensive care at approximately 2.20pm. Dr Boyd gave me and updated handover alerting me to a blunt chest trauma 2 days prior to this episode of hypotension, tachycardia, diaphoresis and complaining of severe chest and back pain. The intercostal catheter wound site was heavily oozing blood from around the intercostalol catheter.

On admission the following procedures were required to safely monitor and safely manage the patient. These procedures included: administration of 90% oxygen via a face mask, connect the patient to the cardiac monitor and obtain vital sign, set up equipment for further insertion of intercostal catheter, an arterial line and central venous catheter, and attend the emergency of intubation and connection to mechanical ventilator and the emergency of the cardiac arrest.

From this time on myself and another nurse were in attendance continually all the time and the third nurse (who had other patients in her care) assisted approximately 50% of her time to the acute emergence of events that followed until I went off duty (approximately 5 hours later). Dr Boyd was also in attendance and the surgeon Dr Gaffield arrived 15 mins after admission and was also in continual attendance. Assisting were Dr Younis, Dr. Carter, Dr Patel and the intensive care unit manager T. Hoffman RN

1. Within in a very short time the patient became respiratory compromised and required intubation by the attending anaesthetist, Dr Younis, and was supported on a mechanical ventilator set with the oxygen at 100%.

2. The patient was haemodynamically compromised with a systolic blood pressure less than 90mmHg and tachycardia of 140 bpm

3. Fluid resuscitation had been commenced in the surgical ward and was continued; on my shift the patient received 4 units of packed cells and 900 mls of Haemaccel.
4. Soon after admission it became evident that further chest catheters were required to relieve the fluid and pressure in the patients right chest; both Dr Gaffield and Dr Boyd inserted intercostal catheters simultaneously into the patients right chest wall. The intercostal catheters were connected to a low suction pressure apparatus.

5. At approximately 3.45pm the patient's condition deteriorated. His heart rhythm suddenly became a ventricular standstill and his systolic blood pressure fell to 75mmHg which was reverted be administering IVI 1mg of Atropine and IVI 1mg of Aramine. By 4pm his heart was in a sinus tachycardia.

6. At some time between 4pm and 6pm the Royal Brisbane Hospital was notified of the patient's acute and severely unstable condition and had accepted the patient as an urgent transfer. Also during this time frame Dr. Patel, Director of Surgery came into the unit and overruled the transfer. At one point he and Dr Gaffield were standing behind me and the loud sound of Dr Patel's voice, discussing the relativity of the transfer, became a distraction to my concentration of care for my patient; I found it necessary to ask them to please discuss their management for the patient away from the bedside.

7. I escorted the patient with Dr M Carter, Director of Anaesthetics to the x-ray department for a CT of the chest at approximately 6pm and returned to the intensive care unit at approximately 6.50pm. The night shift had arrived and while my nursing colleagues continued to care for Mr Bramich I gave a handover to the night nurse.

8. During the course of the past four and half hours Mrs Bramich was notified and arrived with her young daughter but due to the emergence of care could only see her husband for about 15mins.

9. After my handover to the night nurse I had no further involvement in the patients care.

Sharon Cree. RN

November 1st 2004

TH30

Events 27 July 2004

I was rostered for a night shift on Tuesday 27/07/04 in Intensive Care Unit as a Registered Nurse.

That night I was allocated as a runner for the ventilated patients. On the commencement of my shift due to Mr Bramich's condition I was working very closely with RN K Fox and was assisting in the cares for him.
Whilst RN Fox received handover, I assisted with Dr Younis requests with treatment for this man. Dr Patel was in and out of intensive care unit that night as he was requesting further treatment for Mr Bramich. He was greatly concerned re the unexplained tachycardia and hypotension and was thinking this man might have a pericardial tamponade. He said that on CT scan there was a small effusion and then instructed that the radiologist be called in with the image intensifier. Dr Patel informed us that he was going to perform a pericardiocentesis and we assisted by giving him the equipment he requested, sometimes having to leave the unit to do this.
There was an incredible amount of activity for this patient, blood bank for blood, taking and making telephone calls, making up infusions, calling in personnel for the relevant doctors, commencing infusions.

After Dr Patel finished the procedure, RN Fox requested that I go with DRs Younis and Patel to talk with the relatives who were in the waiting room. Dr Patel informed the relatives that Mr Bramich's condition "was so critical he was going to die." He informed the relatives that "he had placed a needle around his heart and got back only three or four mls, so it was not compromising him at all." He said his injuries were so severe as his heart and lungs had been crushed from the caravan and often these injuries took 24 to 48 hours to surface. The relatives asked for him to be sent to Brisbane but Dr Patel informed them that he had been a "trauma surgeon in the United States for 10 years" and he knew that a cardio –thoracic surgeon could not operate on him in this instance. They were informed Mr Bramich would not survive the plane trip to Brisbane. The relatives were visibly upset and asked "how could this happen?" Then they asked if there was any chance of survival. Dr Patel replied "1% and it would be a miracle"

After the relatives came in to see Mr Bramich they were visibly upset, crying loudly. Dr Patel walked over to the bedside and asked them to be quiet as how would Mr Bramich feel if he could hear them. Mr Bramich's son calmed the family down.

Some minutes later RN Fox informed me that the retrieval team was on its way from Brisbane. After the arrival of the team and during stabilization Mr Bramich became bradycardiac and arrested and passed away.

? Dan Attens Statement.
Original sent to Peterleck via Linac Mulgan
& letter of the 22nd October.

L

TH31

KAY BOISEN RN
ICU Bundaberg Base Hospital.
3rd August 2004.

Dear Ms Hoffman,

I would like to bring to your attention an incident that occurred in the ICU on Sunday 1st August 2004. I was rostered and working a 0700-1930 shift with CN Byrne and RN Cree. I was assigned to nurse a ventilated patient in bedspace 5. At approximately 0900 Dr Patel entered the unit via the door connecting ICU and Theatre. Nurse Manager Ms J McClure and I were standing at the end of bed 5 having discussed the full bed status of the unit. I was handing over the patient condition to Ms McClure.
Without preamble Dr Patel launched into a tirade "Why were there two ventilated patients in the ICU?" "What about the policy of only having ventilated patients for 48 hours and then moving them to Brisbane?" "It seems only surgical patients are transferred to Brisbane from this unit." "What is needed is a separate surgical unit." Dr Patel was directing this conversation to both Ms McClure and myself, I didn't respond initially but did speak up to point out to Dr Patel that the ventilated patient in Bed 5 was only ventilated four hours previous and that the ventilated patient in Bed 8 was of much longer duration but that consultation with Brisbane doctors, more than once, had resulted in the decision by the Brisbane doctors that the patient was not to be transferred. I further stated that we were, in fact, running the unit within the management guidelines. I felt that Dr Patel was stating derogatory remarks against the unit as a whole and to the ICU management team in particular.

Yours sincerely,

Kay E. Boisen.

W

TH32

From: Toni Hoffman
To: Karen Fox
Date: 30/08/2004 8:59am
Subject: Re: pi**ed off

Oh God,
What can I say, I have a meeting with Linda this afternoon, , I will discuss all of these issues with her , It is bad enough to be so busy, let alone put up with any of their comments. I'll try and find some resolution, If you are on tonight I will call you,
Ta Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

>>> Karen Fox 30/08/2004 2:00:30 >>>

Toni
Our shift had started off bad enough with 2 pts in a mess
then.....
on the arrival of the snake bite man bed5 went into asystole, Nicole phoned Leslie who was her usual abrupt self. telling her that if we wanted staff to find someone ourselves!!
barb Taylor turned up at about 0140 with inappropriate comments when we were unable to print obs from bed 6!! then to tell us we would be moving the snake bite man and getting another cardiac pt.
AND SHE CALLED ME LUV repeatedly!!
Obviously we were in no position to take breaks.
And of course the wards were busyier than us with more confused patients than us .

Are you aware that DEM is less safe than ICU despite one pt arresting, one climbing out of bed, one pt close to needing a tube in ICU.
What a hell hole and no wonder the hospital has such bad publicity.
The nurse managers are obviously not here to assist/support ICU staff but to slander and run us into the ground.
Lucky we will still be here in the morning..but will we be back!!!!

Karen, Viv and Nicki

CC: Nicole Finger; Vivienne Tapiolas

BUNDABERG HEALTH SERVICE DISTRICT
RECORD OF MEETING

Meeting of: 3,5,6

Meeting No: 08/04

Date: 25/8/04 **Start Time:** 1335

Present: M. Mears, T. Hoffman, G. McDermid, L. Wadsworth, D. Spry, G. Aylmer, C. McMullen, T. Robinson, A. Robinson, L. Mulligan, R. Pollock, R Goodchild, S Vanderberg, C Kennedy, L Allan, D Carter,

Apologies: J Babare

Confirmation of Minutes: Lucia **Seconded:** Debra

Minute Taker: C Kennedy

Chairperson: L. Mulligan

Correspondence: Nil

Business Arising

Item No	EQuIP Function	Topic	Discussion	Agreed Action & Outcome, Person Responsible, and Time Frame	Open/Closed
02/04-2	C.C/HRM	IV Cannulation Competency	Policy has gone to C of C Committee for review. Protocol to be modified for individual area use		Closed
02/04-3	C.C	Medication Incident Management / Adverse event reporting	Still under review. L & M were in favour of the form but don't want a second form attached for staff to complete. To be trialled for use with Medication Incidents. Do as a quality activity for 12 months. Group to take form to DQDSU and then to NUMs for feedback. To be taken to the DDON/DON/A.Hrs Nr Managers meeting also.	Group-> DQDSU Linda/Carolyn to A/Hrs N Man Meeting	Open
06/04-14	L&M	Renal Services	PD still to be sent to Corp Office for consultation. Some issues re staffing in Renal. Expert Panel (Bris) will look at this.	Continue with consultation.	Open

Business Arising					
Item No	**EQuIP Function**	**Topic**	**Discussion**	**Agreed Action & Outcome, Person Responsible, and Time Frame**	**Open/Closed**
07/04-1	All	Guidelines for Application SIIPMKIII	The 3 nursing applications had been submitted and accepted. Awaiting results.		Closed
07/04-4	HRM	Training / Education Opportunities	L. Wadsworth: Ed Centre not always aware of all workshops / training being held. Causes confusion when staff contact Ed Centre for location / time of workshop.	Linda to take to L&M for ? directive that Ed Centre be notified of all planned workshops / training	Open
07/04-5	HRM	Staffing issues	Level 3 vacancies – Theatre, Informatics, Medical ICU – Toni asked if agency staff could be employed when staffing difficulties arise. Linda suggested employing another staff member during winter if required and possibly using an EN. Toni also mentioned staff stress over a medical incident – EAS were not available for counselling when approached. C0-location. Continues. Limitations on secondments being extended – need parameters for this.	Update each meeting	Open
07/04-7	All	Equipment	IVACS and other pumps, being counted this week.	Rens, Robyn and Cameron	Closed

Item No	EQuIP Function	Topic	Discussion	Agreed Action & Outcome, Person Responsible, and Time Frame	Open/Closed
07/04-9	SP&E	Computerised Maintenance Management System	To be done in the next 2 weeks.	Email Linda with details of nominated staff, training needs etc.	Closed
07/04-8	All	Communication training	Lectures to be done by Margie and will take 3 hours. A discussion arose re splitting the 3 hrs session into 2. Probably will send staff on the day and replace as required.		Closed
New Business					
08/04-1	HR	Competencies	Lucia reported some improvement in these areas. To be included in monthly report.		Closed
08/04-2		Farewell for Staff	Carol to organise farewell for Beris at Caseys and Toni to organise dinner for Jenny. ? where.		Closed
08/04-3	IT	Database NAAS versus LATTICE	A discussion arose re this issue and it was decided that staff need to tell Carol the positives with NAAS and what can be put into LATTICE. Staff generally agreed that they would prefer to keep the NAAS rather than convert to LATTICE.		Closed
08/04-4	IT	TRENDCARE Business Rules (BR)	Surgical War and ICU issues need to be reviewed. BRs soon to be released and to go into overarching Nursing Policy.	Ann Robinson and 3 other staff to review.	Open
08/04-5	IT	Information M'Ment Strategic Plan 2004-2009	This plan is now available.		Closed

Business Arising					
Item No	**EQuIP Function**	**Topic**	**Discussion**	**Agreed Action & Outcome, Person Responsible, and Time Frame**	**Open/Closed**
08/04-6	L & M	Risk Registers	Training in Integrated Risk M'Ment and Incident Analysis to commence soon. All incidents with a rating of "high" or "very high" should be sent to Executive.		Closed
08/04-7	HR	Rostering Workshop	Anyone interested in attending to let Linda know soon		Closed
08/04-8	HR	Issues from HR	Rosemary spoke about the following: EN Paypoint Progression - Under the MX 2003 Award, these staff need to be assessed before progressing to the next paypoint. This should be built into their PAD when they can be assessed. Casuals hard to capture. New IRMs - Not out on Qheps yet. There is a new website for QH but it has not been updated yet. Expert Version 3.2 – goes live on 30/8 in Payroll. Carol said that rosters cannot be exported into Trendcare. GNOR now up and running. Four positions nominated with the possibility of taking additional Post Grads at the mid-year intake. Forms for recruiting on: G\QM\Depts\HR\HRM\Rec & Sel	Small group consisting of - Liz, Rens and Rose to discuss Rose to follow up on this	Open
08/04-9		Other Issues	**Red Cross Rooms:** Debra said that rooms are not as readily available as they used to be. Linda assured her that they are available. **Linen:** Margie has trouble getting trolley sheets. Ann suggested she use Cot sheets – cheaper		Closed

Item No	EQuIP Function	Topic	Discussion	Agreed Action & Outcome, Person Responsible, and Time Frame	Open/Closed
			and more readily available. **Uniforms:** Linda reported that all ordered uniforms are in the sewing room and soon staff will be able to order Range B uniforms. Quilts: Dilys suggested they the wards recommence using quilts as they are cheaper to launder than sheets.	Peter Heath and Narelle Davy looking at costs	

Meeting Closed: 1520
Next Meeting: 9th September, 2004

TH34

From: Toni Hoffman
To: Jane Truscott
Date: 8/09/2004 11:30am
Subject: Re: Whipples

Till about 4 , can try for tomorrow or fri,
Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

>>> Jane Truscott 8/09/2004 10:52:04 >>>

I may or maynot be able to make it. How late will you be in? I have meetings early afternoon at my office at the Division.

Or, how about tomorrow or Friday??

>>> Toni Hoffman 09/08/04 10:26am >>>

yes , later today, 230 on wards I am in interviews until 2,
ta Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

>>> Jane Truscott 8/09/2004 8:34:06 >>>
Sorry, not quite sure what you're referring to. The Cancer Control project is in the process of identifying the gaps in service. In fact, I wanted to talk with you about the ICU services. Can we meet later today or this week?

>>> Toni Hoffman 09/08/04 08:21am >>>

Dear Jane.
We continue to have these ongoing issues in ICU, and have a whipples booked for tomorrow, When does this cancer op surgery thing become operational, last week we had a thorocotomy (name changed when I questioned it) and also a pericardial window done on the weeekend????
Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

TH35

From: Toni Hoffman
To: Linda Mulligan
Date: 4/10/2004 8:42am
Subject: Fwd: Re: ICU

HI Linda.
I sent up the Maternity letter so you could see it as it was a bit confusing, For Maternity leave , we have always been able to fill the vacancies with people who have been around and were never encouraged to advertise elsewhere because of the cost. I am happy for it to be advertised wherever you feel appropriate. The resignation letter was on my desk this morning, I did ask Alison to CC it to you and drop it up to you when she resigned, IN case she didn't I will send another copy by fax up to you. With Nicoles Maternity leave. I thought that was until Sept next year, So It is a full time temp position for One year,
Thanks Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

>>> Linda Mulligan 1/10/2004 10:40:41 >>>

Dear Toni-I note receiving your advertisement for I assume this position (which I asked the questions below on), which if understanding right will be a temporary vacancy until 26 February 2005?? I am then wondering why you are only advertising internally, and not within other districts, or externally in paper?? Please advise. Also has the resignation you stated would be coming, come in yet?? ta Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone
Fax

>>> Linda Mulligan 09/28/04 04:38pm >>>

Hi Toni-I am still abit unclear-are you telling me you have had some one on maternity leave?? Can you advise for how much longer and if you have advertised the same at any stage?? Thanks Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone
Fax

>>> Toni Hoffman 09/28/04 04:06pm >>>

Hi Linda,
Havent got the resignition yet,It should be Ailsion Britton .7. level 1. Its not official yet. We have someone on Mat leave.and no-one around like we usually do. Usually we have some people around , but with the couple that have left and then using the ones that have been waiting, There will be some gaps even if we fill the posn asap. Yes, I agree with you though, even our OT budget, which

W

has always been OK is being chewed throough.
Ta Ton

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:
>>> Linda Mulligan 28/09/2004 15:25:16 >>>

Hi Toni-When is the resignation take effect, what level is it and full time or part time?? As we should be advertising ASAP if we know the date and we should be able to fill it by NOV being Sept now. As you would be aware with the current budget status of ICU paying for agency staff is something that should be avoided if we can fill it permanently first, or at least only use agency staff for a few weeks rather than a few months. Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone
Fax

>>> Toni Hoffman 09/28/04 01:50pm >>>

Hi Linda,
I hope you are better now, I have a couple of things to run by you, I have asked Martin Carter to delay(If possible) any routine surgery that may require an ICU bed until our last ventilated patient is no longer ventilated (would depend on the pt and requirements etc). I just wanted the staff to be able to have some days off, They are all exhausted from several months of high accuity, and repeatedly coming in on their days off. A lot of them have toil which they have given up to come in as well, so if there is a chance for any of them to have some toil/ be on call etc, that would be good. Also in the roster starting the 8/11 we are going to be short, due to an impending resignation and there is no-one in the wind, could we try and recruit someone form an agency for a couple of months,
Ta Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax.

TH36

From: Toni Hoffman
To: Peter Leck
Date: 22/10/2004 4:24pm
Subject: Confidential correspondence

Dear Peter,

Please find attached my conversation in Writing concerning Dr Patel. I will send up all of the documentation I have from the other staff with another copy of this to you and linda on Monday,

Thanks Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax

CC: Linda Mulligan; Paddy Martin

TH37

22nd October 2004
Peter Leck,
District Manager,
Bundaberg Base Hospital,
P.O Box 34,
Bundaberg. 4670.

Dear Peter,

I am writing to you to officially inform you, of the concerns I have for the patients in ICU in relation to the behaviour and clinical competence of one of the surgeons, Dr Patel.

Dr Patel first voiced his displeasure with the ICU around the 19th May 2003. A patient UR number 034546 came to the ICU post oesophagectomy. This patient had multiple comorbities and for the last 45 minutes of surgery, had no obtainable Blood pressure. The anaesthetist who accompanied him into the ICU, stated " It was a very expensive way to die." He required 25ug of Adrenaline and 100% O2. Dr Patel stated the patient was stable. The Nursing staff who were communicating with the patients family told the patients mother that he was extremely ill. Indeed he progressed to brain death. Dr Patel continued to say the patient was stable. The course of treatment for this patient was very difficult, he required dialysis and there was constant conflict between the anaesthetists, Dr Patel and the Physicians about his care. The Director of Anaesthetics and ICU was away and Dr Younis was left in charge, he was reluctant to question whether or not we should be doing such large operations here at BBH. Dr Jon Joiner and I went to see Dr Keating to voice our concerns. We both believed we could not offer adequate post op care for oesophagectomies. The literature stated a hospital should be doing at least 30 per year to maximise outcomes. At this time I first stated my concern that Dr Patel could describe a patient on maximum Inotropes and ventilation as stable. I voiced these concerns to Dr Keating. After this incident Dr Patel and I had a conversation where I told him that the ICU wished to have a good professional working relationship with him. I tried to tell him that we were a level one ICU and that our staffing levels and scope of practice meant that we could only keep ventilated patients for 24-48 hrs , before transferring them to Brisbane. Dr Patel stated that he would not practice medicine like this and he would go to "Peter Leck and Darren Keating and care for his own patients." This incident was repeated relatively soon after the first. Dr Patel would threaten the staff with his resignation when it was suggested it was time to transfer out a ventilated patient. He continually stated he was working in the " third world" here. He would use "Peter Lecks" and "Darren Keatings" names as a type of intimidation and threat to the staff. He stated on several occasions he would go straight to Peter Leck as he had made him " half a million dollars this year". Every time we had a ventilated patient in the ICU that required inotropes he would argue with the anaesthetists about which inotrope to use. His choice of inotropes did not reflect best practice guidelines in Australia. He refused to speak to the writer, (myself). All requests for a bed would go through either another nurse or doctor. He would yell and speak in a very loud voice, denigrating the ICU and myself and at times the anaesthetists, The nursing staff felt they were often the " meat in the sandwich" He would harass them and ask them " Whose side they were on". At times he would actively try to denigrate my ability as a NUM to the nursing staff and other doctors. (See attached documentation).

Soon after Dr Patel started operating here the nursing staff observed a high complication rate amongst the patients. Several patients had wound dehiscence and several experienced perforations. This is a list of patients I believe require formal investigation. This is taken from our ICU stats and are not a full and comprehensive review as there are no stats from OT or Surgical Ward.

UR 130224 6/6/03 post op oesophagectomy
12/6/03 wound dehiscence.
15/6/03 2nd wound dehiscence
suffered a third wound dehiscence was transferred to Brisbane on the 20/6, had a J tube leak and peritonitis. A bed had been obtained earlier for this man, but Dr Patel went up to Dr Keating who advised our anaesthetist to keep him for a few more days, in which time the bed was taken, and he stayed several more days whilst another bed was sourced. The Doctors at RBH questioned why we were doing such surgery here when we were unable to care for these patients.

UR 009028 post op oesophagectomy ventilated for 302 hrs.

UR 001430 Ventilated for many days: transferred to Brisbane after many arguments in the ICU with DR Patel who refused initially to transfer this patient.

UR 880266 issue with transferring patient to Brisbane.

UR 083866 Bowel Obstruction Resection and Anastomosis on 7/2/04 T/F to Brisbane on the 11/2/04 on the 12/2/04 laparotomy showed perforation and peritoneal soiling.

UR 134442 Wound Dehiscence and complete evisceration.8/4/04. Booked for sigmoid colectomy and found to have ovarian ca. 11/4

UR 020609 27/4 Wound dehiscence. P colectomy.

UR 29/6 Insertion of Vascath perforated ® IJ. 057817 ?perf trachea. died 6.7.04

UR 086644. Delay in Transfer to Brisbane , See attached report, Pt died.

UR 017794 10/7 laparotomy for Ventral Hernia, developed haematoma in ward and attempted evacuation done without any analgesia. Drs notes consistently say patient well when Pt was experiencing large amounts of pain and wound ooze.

UR 057809 pt had Whipples , death cert stated he died of Klebsiella pneumonia and inactivity

UR 063164 death cert stated pt died of malnutrition. Had been operated on 31/7/04. died 17.8.04

several conversations were had with other doctors , Acting Directors of Nursing and NUMs. Dr Miach refused to allow Dr Patel to care for his patients as he stated he had 100% complication rate with Peritoneal Dialysis insertion. This was stated in a Medical Services forum as well as in a private conversation with myself. This data was shown to the Acting Director of Nursing Mr. Patrick Martin.

On the 27th July 2004, Pt UR number 086644 returned to ICU in Extremis with a chest injury, The events of these13 hrs is well documented. Dr Patel interfered in the arranged transfer of this patient to Brisbane and the patient died after it was thought the retrieval team were on there way to retrieve this patient. The subsequent events of this intervention and the traumatic pericardial tap (described by the nurse caring for the patient as repeated stabbing motions)resulted in the ICU staff requesting advice from the nurses union . The staff involved in this situation described it as the worst they had ever seen. They were acutely distressed. An attempt was made to seek EAS support, but they were unable to assist due to their workload. One staff member accessed Psychological support privately. I was requested to fill in a sentinal event form , by the then QI Manager Dr Jane Truscott. The events of this incident were discussed at length with the union, who offered support to the staff. They also offered me several ways I could report the long standing concerns I had with the current situation in ICU. The day after the patients death , when I thought he had safely been transferred to Brisbane , Dr Strahan came to talk to me in the office and found me very distressed. He offered to talk to some of the other doctors and get back to me as the representative of the AMA in Bundaberg. He did this stating " there is widespread concern, but at the moment no-

one is willing to stick their neck out" He urged me to keep stats on my concerns. I spoke with Dr Dieter Berens and informed him the nursing staff were going to report their concerns with Dr Patel to an official source. He stated he would support us , by telling the truth, but he was concerned he would lose his job and Dr Patel would be the one left behind. It is widely believed amongst the medical and nursing staff that Dr Patel was very powerful, that he was wholeheartedly supported by Peter Leck and Darren Keating and was untouchable. Anyone who tried to alert the authorities about their concerns would lose their jobs. This perception was indeed perpetrated by Dr Patel on a daily basis. Many of the residents and PHO's have expressed their concerns, Dr Alex Davis, and Dr David Risson, But were unsure of what to do because of the widespread belief Dr Patel was protected by executive.

The Nurses union have offered advice in that there are several ways these concerns can be reported if not dealt with internally, after my conversation with Peter Leck and Linda Mulligan on Wed, I believe they were not in receipt of the full concerns, but now that they are they will deal with them.

Dr Miach has reiterated he has dealt with the issue by not letting Dr Patel near his patients. These concerns were openly discussed at the medical services forum.

A peripheral concern is the reports the junior doctors have voiced about forms not being filled out correctly, of being told not to use certain words in discharge summaries, and various other chart irregularities.

Toni Hoffman.

Documentation from Karen Stumer,Karen Fox, Kay Boisen x2, Karen Jenner , Vivienne Tapiolas included.

TH38

ICU ISSUES WITH VENTILATED PATIENTS;
PRIVATE AND CONFIDENTIAL.

Designated level one unit, capable of ventilation for short periods of time 24-48hrs. Consistently exceed this. Can do this for short periods of time, but not longer than a few days. Level of Unit not made clear to surgeons and this has appeared to distress some of the surgeons when their patients are going to require long term ventilation and be moved to Brisbane. Usually the process works well except when Dr Patel's Patients are involved and Dr Carter does not appear to proactively pursue the transfer of these patients. When Dr Patel first came to BBH it was explained to him that we do not have the resources to ventilate long term patients. He then stated he would not practice medicine like this and would resign. He stated that he would not transfer his patients to other hospitals. He has consistently denigrated the ICU and made such comments such as:

"This would not have been missed on the wards" (Gentamycin being written up by physicians.)

He stated to one of the R.N's that he had "contacts" in Brisbane and would use them to block a patient being transferred. Dr Patel consistently vents his frustration at the current system by being insulting to the nurses and the ICU. He consistently talks loudly to his Pho and JHO about "How difficult it is to work in this ICU" How backward it is and how it is like working in the third world for him. He does not usually do ward rounds with the ICU physician and this causes problems with the ICU nursing staff when they are receiving conflicting orders about treatment.

The Director of the Unit, Dr Carter, is usually supportive and proactive about transferring patients, except when Dr Patel's patients are concerned. The louder Dr Patel screams the longer the patients stay. Dr Patel has repeatedly threatened to

A) Resign
B) Not put any elective surgery in ICU.
C) Complain to the Medical Director
D) refuse to complain to the Medical Director any more and go " straight to Peter Leck" as "I have earned him ½ million dollars this year."

Dr Carter has approached the NUM several times about increasing the Nursing FTEs so that we can " care for Dr Patel's patients properly" when it was explained to him that It is a complicated process that requires much more than an increase in FTE's he stated the NUM has Blinkers on. He handed her a piece of paper that had the name of a person who gives grants to train ICU nurses in Brisbane. He also stated that as an incentive we need to offer a week's holiday on Lady Musgrave Island to bring nurses to Bundaberg. It was explained to him we do not need more nurses when we are acting in our designated capacity. It is when we consistently act outside of this role for extended periods of time that these issues arise.

It needs to be reiterated with the Director of Anaesthesia that he needs to direct, and explain to DR Patel what our resources are capable of. Whether we agree with this or not is irrelevant. There should not be one rule for Dr Patel's Patients and one for others. There is such a feeling of disunity in the ICU at present, it is upsetting to the nurses and they literally refuse to care for Dr Patel's patients because of the disunity that exists. With Dr Patel's ventilated Patients it needs to be again reiterated that they will need to be retrieved to Brisbane after 24-48 hrs , or sooner if there are two ventilators in ICU. The admission and discharge policy of ICU must be adhered to.

On several occasions when Dr Patel's Patients have been in the ICU, he has refused to transfer his patient to Brisbane, even when the patients have deteriorated and have been in ICU for much longer than 24-48 hrs.

I have voiced my concern regarding the level of care required for some of Dr Patel's patients several times. I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit.

This week we had a critically ill patient transferred back to ICU in extremis. He was shocked, in pain, tachycardic and hypotensive. The Anaesthetist in charge attempted to place an arterial line and a central line as well as transfuse the patient. At one point the patient went

into ventricular standstill. Dr Patel was seen to make a comment to another surgeon and laugh. Dr Patel repeatedly stated in a loud voice the comments that this patient did not need to be transferred to Brisbane. He stated the patient did not need a thoracic surgeon. He asked the PHO " how much trauma had he done". He went on to say "no more trauma should be done at this hospital, if we cannot handle it" All of these comments were said in front of staff and other patients. A bed was arranged at PAH, and booked at around 1430 hrs. The clinical coordinator only needed to be notified to organise the retrieval. It was decided, before the clinical coordinator would be called a CT needed to be done. There was a delay in obtaining an anaesthetist due to one being required for a perforated bowel. Dr Patel insisted the surgery for the perforated bowel be performed prior to the CT, despite the patient requiring ongoing resuscitation. I called Dr Carter and he agreed to transport the pt to CT. On return from CT it was agreed the patient would be transferred to Brisbane. I had previously voiced my concerns to Dr Gaffield that although I had heard Dr Patel say the patient did not need transfer as he did not need a thoracic surgeon, there were other issues such as a lack of pathology and blood bank support and the fact we did not have an intensivist or other equipment such as Bypass should the pt require surgery. I voiced my concern about the delay in transfer and my concern the patient would die before he could be transferred.. After it was decided that the patient be transferred to Brisbane there was a delay of about half an hour whilst the clinical coordinator was located. I called several numbers including using switch through RBH and the 1-800 number before I was told the Clinical coordinator would ring back. The Clinical coordinator called back about 15 minutes later and spoke with Dr James Boyd. The retrieval team was then organised and arrived at 2215. Before the patient could be transferred he further deteriorated and died. Once I knew the retrieval team were on there way I left the unit, expecting the patient to be retrieved. When I returned the next day, I was informed the patient had died. I was also informed that the staff on the night shift were extremely alarmed at Dr Patel's behaviour and care. I was informed Dr Patel was "rude to the patients wife, telling her to " be quiet" when she was distressed at the outcome.

7H39

From: Toni Hoffman
To: Peter Leck
Date: 26/10/2004 8:20am
Subject: Re: Complaint

HI Peter,
I have just sent them up now, sorry, I forgot to sign them
Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

>>> Peter Leck 25/10/2004 16:26:58 >>>

Hi Toni,

I have received the additional information you have forwarded today.

You indicated in Friday's email that you would forward another copy of your letter today - I had assumed that a hardcopy with signature would be sent. This doesn't appear to have arrived. I would be grateful if you could arrange to sign a copy of this correspondence and forward to me.

One of the documents provided today - " ICU Issues with Ventilated Patients" is also unsigned. I would be grateful if you could arrange for a signed copy to be sent to me.

Thanks

Peter

W

TH40

From: Toni Hoffman
To: Darren Keating
Date: 1/11/2004 2:18pm
Subject: ICU stats

Dear Darren,

I broke up all of the ventililated pts into diagnosis. age and co-morbities. Nothing stood out. The main issue was the length of stay; the patients diagnoses seems pretty much the same, although there has been an increase in the ratio of ICU patients to CCU patients, in fact in some months there were more ICU patients than CCU (IT usually ran around 6o % CCU to 40% ICU. The other issue is the number of vents at any one time. Up until about 18 mths ago we were very strict about transferring ventilated patients out after 24 -48 hrs. It has become more the norm to wait until we have 2 or even 3 vents before trying to transfer them. Several issues have impacted upon this decision, from individual physician /surgeon preference, to no beds availble in Brisabane, to Brisbane not wanting the type of patients we have. I shall enclose the breakdown of figures that I have done, If there is anything else I can help with please ask

Thanks Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

CC: Linda Mulligan

TH 41

From: Vivienne Tapiolas
To: Toni Hoffman
Date: 20/01/2005 11:05am
Subject: Concerns

Good morning Toni,

I have written a report regarding the concerns I had and discussed with you with Mr Kemps. I realise this is late but as explained to you I was on nights and you were away. I wished to discuss this case with you before a report was written.
Thank you Vivian

W

20/12/2004 At approximately 0800hrs I was caring for a patient, P44 who had suffered a Sub Dural Haematoma. She was intubated and ventilated and her condition was that she was most probably brain dead with no spontaneous respirations and fixed dilated pupils. Her relatives were in attendance but had left to sit in the relative waiting room to await an interview with the morning doctor re where their mothers care was proceeding.

Dr Patel came into Intensive Care Unit and entered a discussion with Dr Carter re P44 condition and next step with her care. Dr Carter stated he wanted to read P44 chart before any decision was made. Dr Patel continued to speak within the Intensive Care Unit with Dr Carter about P44's condition stating she was brain dead and turning her off and the relatives wishes re withdrawing support and treatment. He then went on to discuss that he wished to perform an Oesophagectomy for today. Dr Patel was told there was insufficient nursing staff to care for his case. He persisted with withdrawing treatment of P44 so he could operate. Dr Patel was asked could he not perform the operation tomorrow or next week? Dr Patel said he could not operate tomorrow. Dr Patel continued the discussion about an Oesophagectomy he wished to perform that day. Lengthy discussion continued regarding this. Dr Carter, Dr Patel and myself went and spoke with P44's relatives in the unit waiting room about treatment being withdrawn. As we walked back up the corridor Dr Patel said "now I can perform the oesophagectomy".
Treatment was withdrawn from P44 and she consequently passed away.

Later during the day, at approximately 1430hrs I received Mr Gerald Kemp, UR: 006700 post operatively following a Oesophagectomy /gastrectomy for distal oesophageal cancer.
Dr Berens and OT staff escorted him into Intensive Care. He was intubated and hand ventilated. Mr Kemp had bright bleeding, moderate to large amount flowing into the bellovac drain. This was pointed out to the theatre staff who acknowledged this. He also had a chest drain. I was informed that he was bleeding internally and would need to return to Theatre at a later stage.
His initial observations was hypothermic, and hypotensive. Parameters were written so as to maintain Mean Blood Pressure with Fliud and Blood management and inotropes.

His initial post operative in Intensive Care was intense. He remained hypotensive most of the time with a Hb around 70-80. Dr Anthaniasiov was informed and requested to review the patient. He continued to haemorrhage. Permission was sought and given to compare a blood sample from the bellovac with an arterial sample. Dr Anthaniasiov was informed that these samples in fact had the same results via the Blood Gas Machine. He returned to review Mr Kemp and said he would speak to Dr Patel. Dr Patel was continuing to operate. Dr Berens was present throughout this time and as Mr Kemp's haemorrhaging worsened so did his acuity. The next four hours was a period of intense acuity, requiring 3 staff members at the bedside for fluid management, in order to maintain a BP 80 and Hb 70. Mr Kemps' abdomen was now distended with bright blood flowing into his bellovac. Numerous telephone calls were made regarding his condition. Orders were followed for crossmatching blood and FFP. A staff member was constantly running to Blood Bank for blood products as well as constantly on the telephone ordering further blood products and paging the relevant Doctor.
The relatives were extremely distressed regarding his deteriorating condition. The relatives kept asking when would he be going back to Theatre.
Dr Anthaniasiov was informed several more times, Mr Kemp had received 13 units of blood, 6 units of Gelofusin, 4 litres of normal saline, 4 units of FFP.

W

Dr Anthaniasiov reported back that Dr Patel had agreed that Mr Kemp would return to theatre later.

1700hrs Dr Anthaniasiov returned to the Intensive Care Unit to inform that Mr Kemp would return to OT at 1800hrs. My concerns were expressed again about his blood loss and how much blood and fluids were being infused to maintain his blood pressure and Hb. I expressed my concerns as to if Mr Kemp would survive to return to theatre and how much blood and products were necessary to maintain a mean blood pressure of 70.

At 1730 hrs I observed a flow of bright blood flowing from the chest drain. I conveyed my concerns to Dr Patel through the OT staff. Dr Patel came to ICU and spoke with the relatives (wife and son and other relatives who were present). He entered the relatives waiting room and spoke with the relatives. Mr Kemp returned to theatre at 1830hrs.

My concerns are as follows:

1. The urgency to withdraw treatment of one patient so an elective surgery could take place
2. Why was a patient transferred into the Intensive Care Unit from the Operating Theatre haemorrhaging immediately post operatively?
3. The delay in time to return this man to the operating theatre. I understand that an operation was in progress but this was deemed urgent/life threatening.

TH42

From: Linda Mulligan
To: Toni Hoffman
Date: 20/01/2005 1:25pm
Subject: Re: Fwd: Concerns

** Confidential **

Hi Toni-Thank you for the same, I will be forwarding this documentation on to Mr P Leck DM. Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone
Fax

>>> Toni Hoffman 01/20/05 11:42am >>>

Hi Linda,
Vivienne Tapiolas has sent me this complaint which i am just forwarding on to you.
Thanks Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

From: Vivienne Tapiolas
To: Toni Hoffman
Date: 20/01/2005 11:05am
Subject: Concerns

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TH43

From: Linda Mulligan
To: Toni Hoffman-NUM ICU/CCU
Date: 4/01/2005 5:32pm
Subject: Issues raised Today

** Confidential **

Hi Toni-I have followed up the issues you have discussed with me today re medical matter with NUMs of the relevant area. From ICU perspective if any further issues do occur, please ensure that they are documented and sent immediately to me and I will forward to the DM. Thanks Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone
Fax

TH44

From: Toni Hoffman
To: Linda Mulligan
Date: 4/03/2005 3:22pm
Subject: Re: ICU pt

Hi Linda,
Yes I had already reclarified that and have filled in an incident form ,even though at the time it looked like it was heading for a " sentinel" event. Yes lets hope it all turns out Ok,
Thanks Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax:

>>> Linda Mulligan 4/03/2005 15:12:11 >>>

Hi Toni-Thanks for this information appreciate you informing of the same, and I have informed Dr Keating- I hope all progresses with a favorable outcome.

In our early conversation you stated this incident was a "sentinel event", however it appears you may unfamiliar with the current QH definitions for the same, as this is not the case at the moment with the information you have provided. However it is very important the incident be documented, just not as a "sentinel event" at this stage. Please call if you need any clarification. Thanks Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone
Fax

>>> Toni Hoffman 03/04/05 03:04pm >>>

Hi Linda and darren,
Just to keep you informed. We have just receieved notification that the RFDS are coming to take P33 to Brisbane. I am completeing the incident report and shall forward same. complicating issues were High INR and fact pt is JW. He was ustable for quite a long period of time but has stabilised out now. Ministers are with his wife, family have been contacted, and help given for accomadation/ flights etc. Social worker has been offered,
ETA RFDS 1600
Ta Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph:
Fax: