44

From: Martin Carter
To: Darren Keating
Date: 25/10/2004 10:23am
Subject: Report to the coroner

Darren

This is my report. Can you get it typed in the correct format for me to sign.

Martin

Report to the coroner

Re: Desmond Bramich

DOB 15/4/48

Deceased 28/7/04

This gentleman was admitted through the emergency department at 1946 on 25/7/04 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. He was admitted to the Intensive Care Unit for overnight observation.

When I first encountered him 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 that I instituted.

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 blood sample for 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. I was called to review and advise on the further management of the patient. My 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 therefore 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 me. The floor(duty) anaesthetist having been diverted to deal with another case (a patient who had suffered a perforation during a colonoscopy). 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.

Following this I left to give a lecture to some of the local General Practitioners. I returned in the morning to discover that he had died prior to being transferred.