

## Reporting Form QA2

The purpose of the Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee (QPPAMRC) is to:

- Collect and analyse clinical information regarding perioperative and periprocedural anaesthetic mortality in Queensland to identify state-wide specific trends.
- Make recommendations to the Minister for Health on standards and quality indicators of perioperative and periprocedural anaesthetic clinical care to enable health providers in Queensland to improve safety and quality.
- Assist with the adoption of such standards in both public and private sectors.

The Committee is required to provide an annual report to the Patient Safety and Quality Improvement Service (PSQ) identifying trends and issues relating to perioperative and periprocedural anaesthetic mortality and recommending quality improvement activities and methodologies for implementation to improve the safety and quality of health services. The committee is also required to provide an annual report to the Minister for Health and contribute to the national data base. The Committee functions collaboratively with the Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNET), other related clinical networks and the Private Hospitals Association of Queensland.

The Committee membership consists of:

- A medical practitioner nominated by Queensland Health who will act as Chairman of the Committee.
- A specialist anaesthetist nominated by the State Branch of the Australian and New Zealand College of Anaesthetists.
- A medical practitioner nominated by the Executive Director of Public Health.
- A specialist anaesthetist nominated by the Australian Society of Anaesthetists.
- A specialist anaesthetist nominated by the Australian Medical Association.
- Anaesthetic Support Officer nominated by SWAPNET.
- A specialist surgeon nominated by the State Branch of the Royal Australasian College of Surgeons.
- A Pathologist nominated by the Royal College of Pathologists of Australasia - Australian College of Pathology.
- An anaesthetist nominated by the Private Hospitals Association.

Additional provisional speciality group members may be called upon to assist in the review of specific cases.

### YOUR ROLE

The Committee is dependent on the goodwill of practitioners to supply information in relation to cases for consideration and the Committee's appreciation is extended to all those practitioners who submit cases for consideration. Only through such co-operation will the Committee be able to continue to function and to achieve its objective of reducing mortality associated with perioperative and periprocedural anaesthesia in Queensland.

### OUR ROLE

The Committee is gazetted as an approved Quality Assurance Committee pursuant to Part 6, Division 1 of the *Hospital and Health Boards Act 2011*. The Committee is therefore prohibited from providing a report or information that discloses the identity of an individual who is a patient or a health service provider, unless that individual has consented in writing to the disclosure.

All information held by the committee is managed in accordance with the *Hospital and Health Boards Act 2011*, Part 6, section 84 Disclosure of information and Part 7, Confidentiality. The *Hospital and Health Boards Act 2011*, Part 6 and Part 7 replace the disclosure of information and confidentiality provisions in the repealed *Health Services Act 1991*.

Names of patients, doctors or facilities are removed by the QPPAMRC Secretariat prior to being forwarded to the Committee for review. Committee members and relevant persons cannot be legally required, whether by a provision of an Act or by an order of the Court, to produce any documentation that was created during the review of perioperative and periprocedural anaesthetic mortality. This means that any information **in the possession of the Committee** including medical records furnished to the Committee are not compellable by law and cannot be used in any proceedings before a Court.

Dr James Troup  
Chair

**Important information to note before completing this reporting form:**

This form may be completed electronically or by hand. When completing the form electronically, boxes may be checked by double clicking on them and selecting 'check'.

This form has been designed to encapsulate the many variable aspects of anaesthesia related patient care. Only relevant sections need to be completed. If possible, please attach a copy of the patient's clinical record of anaesthesia / anaesthetic record.

**Please forward to:**  
 The QPPAMRC Secretariat  
 C/- Access Improvement Service  
 GPO Box 48  
 BRISBANE QLD 4001

Phone: (07) 3131 6968  
 Fax: (07) 3131 6557  
 Email: [QPPAMRC@health.qld.gov.au](mailto:QPPAMRC@health.qld.gov.au)

Additional reporting forms can be obtained from the QPPAMRC Secretariat or from the QPPAMRC website.

Identifying information in this document is confidential to the Secretariat. Subsequent review by the Committee is by case number only.

Completion of this report does not exempt you from statements/reports required by the Coroner, but this report is private and not available to any court.

*Anaesthetic mortality* refers to death in association with or as a result of anaesthesia, intravenous sedation or post-operative analgesic techniques. All deaths totally or partially attributable to anaesthesia should be reported, irrespective of time interval. Failure of recovery or prolonged coma following anaesthesia should also be reported.

You are entitled to three (3) Continuing Professional Development (CPD) points for completing this form. The QPPAMRC Secretariat will provide you with a notification once the form is received.

Please ensure all appropriate sections are completed in full including the surgeons and intensivist's sections.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>Patient's name:</b>   | <b>Person reporting:</b>   |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Address:</b>  | <b>Address:</b>  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>DOB:</b>  | <b>Qualifications:</b>   |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DOD:</b>  | <b>Hospital:</b>   |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Patient's UR number:</b>  | <b>Address:</b>  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Please attach patient identification label if available:</b>  | <input type="checkbox"/> I request personal feedback <table border="1" style="width: 100%; height: 20px; border-collapse: collapse; margin-left: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table> |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |



**General Information**

**Anaesthetist**

Year of birth .....

- Specialist
- (0 – 5 years)
- (5 – 10 years)
- (> 20 years)
- Non Specialist
- Trainee    Years of Training (number) .....
- Intern / RMO
- General Practitioner
- Dentist
- Other, please specify:

.....

**Anaesthetist Supervisor** (if applicable)

- Specialist
- Non-Specialist
- General Practitioner
- Dentist
- Other, please specify:

.....

**Specialist qualifications** (including year)

.....  
 .....

Was supervisor notified    Yes     No

Was the supervisor:

- In theatre
- On the floor
- In hospital
- Available out of hospital
- Unavailable
- Other, please specify:

.....

**Operator**

- Specialist
- Non-Specialist
- Trainee

- Intern / RMO
  - General Practitioner
  - Dentist
  - Other, please specify:
- .....

Same Operator / Anaesthetist

**Operator Supervisor** (if applicable)

- Specialist
- Non-Specialist
- General Practitioner
- Dentist
- Other, please specify:

.....

**Qualifications** (including year)

.....  
 .....

Was supervisor notified    Yes     No

Was the supervisor:

- In theatre
- On the floor
- In hospital
- Available out of hospital
- Unavailable
- Other, please specify:

.....

**Administrative Information**

Number of hours of anaesthetic duty prior to incident:

Rostered ..... hrs  
 Unrostered ..... hrs  
 Emergency fill in ..... hrs  
 Number of hours since 8 hour break ..... hrs  
 Average or number of hours per week ..... hrs

**Perioperative Information**

**Patient information**

Date of birth ...../...../.....  
 Gender      Male       Female   
 Ethnic origin .....  
 Date of admission ...../...../.....  
 Time of admission ..... hrs  
 Date of procedure ...../...../.....  
 Time of procedure ..... hrs  
 Date of death ...../...../.....  
 Time of death ..... hrs  
 Weight ..... kg  
 Height ..... cm

**Pre-operative assessment**

Assessment performed    Yes     No   
 If yes, same day?        Yes     No   
 Assessment was    Adequate     Inaccurate   
 Please specify:  
 .....

Who carried out the assessment? (tick all that apply)

- Anaesthetist performing procedure
  - Other Anaesthetist
  - Trainee Anaesthetist
  - General Practitioner
  - Intern / RMO
  - Surgeon
  - Physician
  - Other, please specify
- .....

**Major disease category**

Systems involved and primary diagnosis

|   |  |
|---|--|
| <input type="checkbox"/> Cardiac          | <input type="checkbox"/> Neurological    |
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Renal           |
| <input type="checkbox"/> Hepatic          | <input type="checkbox"/> Respiratory     |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Vascular        |
| <input type="checkbox"/> Obesity          | <input type="checkbox"/> Other, specify: |

.....

Conscious                       Unconscious

**Preoperative diagnosis**

1. ....
2. ....
3. ....

Preoperative investigations:

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Biochemistry | <input type="checkbox"/> ECG                  |
| <input type="checkbox"/> Blood Gases  | <input type="checkbox"/> Haematology          |
| <input type="checkbox"/> Chest X-ray  | <input type="checkbox"/> Respiratory Function |
| <input type="checkbox"/> Coagulation  |   |

Abnormal results:

.....  
 .....

Preoperative treatment:

.....  
 .....

**Pre-operative relevant medications**

History of allergies    Yes     No

If yes, please specify:

.....

Fasting (food)                      Yes     No

Duration: ..... hours

Fasting (fluids)                      Yes     No

Duration: ..... hours

Previous anaesthetic problem    Yes     No

If yes, please specify:

.....  
 .....

**Risk Classification**

|                             | Emergency                | Elective                 |
|-----------------------------|--------------------------|--------------------------|
| 1. Healthy                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Mild systemic disease    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Severe systemic disease  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Life Threatening Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Moribund                 | <input type="checkbox"/> | <input type="checkbox"/> |

**Patient Monitoring**

Monitors used:

- Manual BP measurement
- Non-invasive automatic BP measurement
- Invasive BP measurement
- Pulse
- CVP
- ECG
- Temperature
- Inspired oxygen
- Pulse oximeter
- Capnograph
- Trans oesophageal echo
- Pulmonary artery catheter
- Peripheral nerve stimulator
- Agent monitoring
- BIS / Entropy
- Other, please specify:

.....  
 .....  
 .....

**Patient Position**

Position of patient during surgery:

- Supine                       Lateral
- Prone                         Jack knife
- Lithotomy
- Other, please specify:

.....

Was there a monitor you wished to use that was unavailable?

Yes                   No

If yes, please specify:

.....  
 .....  
 .....

**Technique**

Type of anaesthesia used:  
 (complete all sections, tick as appropriate)

- General
- Regional
- Intravenous regional
- Intravenous sedation
- Infiltration

**Drugs**

**General anaesthesia**

(time 24 hour clock – B = bolus, I = infusion)

**Pre-operative drugs**

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Induction**

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Maintenance**

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Other (i.e. steroids, insulin, antibiotics)**

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Gases and flow rates**

| Gases administered | Flow Rates |
|--------------------|------------|
| .....              | .....      |
| .....              | .....      |
| .....              | .....      |
| .....              | .....      |

**Reversal**

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Vasoactive**

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Intravenous sedation**

| Drug  | Total dose |
|-------|------------|
| ..... | .....      |
| ..... | .....      |
| ..... | .....      |
| ..... | .....      |

**Emergency and Antagonist**

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Regional / Local Anaesthesia**

Type of regional anaesthesia

- Epidural
- Spinal

Nerve blocks, please specify:                      Time of block

.....

.....

What size needle was used? ..... G

Was a catheter used?                      Yes     No

Site of epidural or spinal

- Thoracic
- Lumbar
- Caudal
- Site of anaesthesia .....

| Drugs used | Doses |
|------------|-------|
| .....      | ..... |
| .....      | ..... |
| .....      | ..... |

Was a filtration used?                      Yes     No

If yes, please specify:

.....

| Drugs used | Volume | %     |
|------------|--------|-------|
| .....      | .....  | ..... |
| .....      | .....  | ..... |
| .....      | .....  | ..... |
| .....      | .....  | ..... |

Was oxygen used?                      Yes     No

**Sedation level**

- None
- Sedation
- General anaesthesia

Was a test dose given?                      Yes     No

Effective procedure?                      Yes     No

Assistance adequate?                      Yes     No

If no, please specify:

.....

.....

Vasoconstrictor combined?                      Yes     No

| Type  | Concentration |
|-------|---------------|
| ..... | .....         |
| ..... | .....         |
| ..... | .....         |
| ..... | .....         |

IV access established?

- Before block started
- After block started
- After incident

Fluid preload given?                      Yes     No

| Fluid | Volume |
|-------|--------|
| ..... | .....  |

Supplementary systemic drugs used?

Yes     No

| Drug  | Dose  | Time  | Route |
|-------|-------|-------|-------|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

Difficulties or complications

.....

.....

.....



**Airway and Equipment**

**Operative Airway Management**

**Pharyngeal airway**

- Oral
- Nasal
- Laryngeal mask      Type .....

**Endotracheal**

- Cuffed
- Uncuffed
- Nasal
- Oral
- Tracheostomy

**Type** eg. Magill, Rae, Hilo, Bronchocath etc

.....  
 .....  
 .....

**Size of tube**

..... mm

- Airway secured prior to OT?    Yes     No
- Cricoid pressure?                Yes     No
- Pre-oxygenation?                Yes     No

How was tube placement checked?

- Auscultation
- Visual
- Capnography
- X-ray
- Fibreoptically

Difficulties with the airway?    Yes     No

If yes, please specify:

.....  
 .....  
 .....

**Ventilation**

- Controlled
- Spontaneous

Brand / model of ventilator

.....  
 .....

Tidal volume ..... ml

Inspiratory rate (breaths / min) .....

What type of anaesthetic circuit system was used? Please specify:

.....  
 .....

**Resuscitation**

Resus equipment available?    Yes     No

Suction available?              Yes     No

Special intubation or resus equipment required?

Yes     No

Please specify:

.....  
 .....  
 .....

Equipment needed but unavailable?

Yes     No

Please specify:

.....  
 .....  
 .....  
 .....

**Equipment and Assistance Equipment**

Do you consider the event to have been directly or in part due to equipment malfunction?

Yes  No  please specify:  
 .....  
 .....

Anaesthetic machine checked preoperatively?

- Yes
- No
- Self
- Other anaesthetist
- Nurse
- Technician
- Other, please specify:

.....  
 .....

**Service of anaesthetic equipment**

In your opinion, was the servicing of the equipment adequate?

Yes  No  please specify:  
 .....  
 .....

**Provision of anaesthetic assistance**

Was assistance adequate? Yes  No

Please specify:  
 .....  
 .....

If inadequate, please complete:

- When was assistance provided?
- Present at induction
  - Present on extubation
  - Readily available at other times

Status of Assistant

- Registered Nurse
- Student Nurse
- Enrolled Nurse
- Technician
- Other, please specify:  
 .....

Was there adequate communication between the surgeon and the anaesthetist? Yes  No

**Fluid balance**

| Fluids given – <b>Crystalloid</b> | Total volume |
|-----------------------------------|--------------|
| 1. ....                           | .....        |
| 2. ....                           | .....        |
| 3. ....                           | .....        |
| 4. ....                           | .....        |

| Fluids given - <b>Colloid</b> | Total volume |
|-------------------------------|--------------|
| 1. ....                       | .....        |
| 2. ....                       | .....        |
| 3. ....                       | .....        |
| 4. ....                       | .....        |

| Fluids given – <b>Blood</b> | Total volume |
|-----------------------------|--------------|
| Autologous                  | .....        |
| Homologous                  | .....        |
| Other (FFP, platelets)      | .....        |

**Blood loss**

|                              |          |
|------------------------------|----------|
| Estimated                    | ..... ml |
| Measured                     | ..... ml |
| Total loss                   | ..... ml |
| Total volume of fluids given | ..... ml |

Venous access adequate? Yes  No

**Blood salvage**

Blood salvage techniques used? Yes  No

Specify technique .....  
 Volume infused .....

**Operation / Procedure Information**

Proposed operations / procedures

1. ....
2. ....
3. ....

Completed operations / procedures

1. ....
2. ....
3. ....

Abandoned operations / procedures

.....  
 .....

**Timed events**

- Duration of Anaesthesia ..... hr/min
- Clamp time ..... hr/min
- Clamp sites .....
- Bypass / shunt time ..... hr/min
- Detail .....
- Tourniquet time ..... hr/min
- Site .....
- Circulatory arrest OHS time ..... hr/min
- Booked day case? Yes  No
- ICU booked pre-operatively? Yes  No

**Location of procedure**

**In hospital:**

- Induction room
- Operating room
- Procedure room
- Accident and emergency
- Medical imaging
- General ward
- Labour ward
- HDU / intensive care
- Day surgery unit
- Other, please specify: .....

**Location of procedure (NOT in hospital)**

- Private rooms
- Endoscopy suite
- Day surgery unit
- Dental surgery
- Other, please specify: .....

**Difficulties**

At what time were difficulties identified?

- Following pre-medication
- Induction
- Intubation
- Maintenance
- Reversal
- Recovery
- HDU / intensive care
- Other, please specify: .....

Time of occurrence ..... hrs

**Where (if NOT same as procedure)**

**In hospital**

- Induction room
- Procedure room
- Accident and emergency
- Medical imaging
- General ward
- PACU / Recovery ward
- Labour ward
- HDU / Intensive care unit
- Day surgery unit
- Patient's home
- Other, please specify: .....

**Not in hospital**

- Private rooms
- Endoscopy suite
- Day surgery unit
- Dental surgery
- Other, please specify: .....

**Intra-operative difficulties**

- |   |  |
|---|--|
| <input type="checkbox"/> Hypoxia                      | <input type="checkbox"/> Intubation delays |
| <input type="checkbox"/> Convulsion                   | <input type="checkbox"/> Cyanosis          |
| <input type="checkbox"/> Airway maintenance problem   |  |
| <input type="checkbox"/> Equipment problems or delays |  |
| <input type="checkbox"/> Regurgitation or vomiting    |  |
| <input type="checkbox"/> Tachycardia                  | <input type="checkbox"/> Bradycardia       |
| <input type="checkbox"/> Other arrhythmia             | <input type="checkbox"/> Cardiac arrest    |
| <input type="checkbox"/> Hypertension                 |  |

**Post-operative Information**

**Recovery transfer to:**

- PACU / recovery room
  - Intensive care unit
  - High dependency unit
  - General ward
  - Other hospital
  - Other, please specify: .....
- Duration of stay in recovery ..... hrs
- Conscious on arrival                      Yes     No

**Recovery from anaesthesia**

- Alert                       Drowsy
- Prolonged unconsciousness
- Continued muscle weakness
- Febrile
- Restless
- Hypoxia
- Cyanosis
- Airway obstruction
- Vomiting or regurgitation
- Fitting
- Shivering
- Elective post-op mechanical ventilation
- Other, please specify: .....

**Recovery position**

- |                                  |                                    |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> Lateral | <input type="checkbox"/> Supine    |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Head down |

Other, please specify: .....  
.....

Status of person responsible for the direct post-operative care during the recovery period

- |   |  |
|---|--|
| <input type="checkbox"/> Registered Nurse             | <input type="checkbox"/> Student Nurse |
| <input type="checkbox"/> Enrolled Nurse               |  |
| <input type="checkbox"/> Other, please specify: ..... |  |

Was an experienced recovery room Registered Nurse present in the area to supervise patient care?

Yes                       No

Temperature post anaesthesia ..... deg C

**Mortality Information**

Date of death                      /...../.....  
Time of death                      ..... am / pm

Location of death (if in hospital)

- Induction room
- Operating theatre
- Procedure room
- Accident and emergency
- Medical imaging
- General ward
- Recovery ward
- Labour ward
- HDU / Intensive care unit
- Day surgery unit
- Other, please specify: .....

Perceived cause of death (eg. drugs, hypoxia, haemorrhage). Please specify:

.....  
Preoperative condition, please specify:

.....  
Did organisational difficulties contribute to the problem?

Yes                       No  please specify:

.....

**Management of Cardiac Arrest**

**Cardiac Massage**

- External  
By whom (status) .....
- Open  
By whom (status) .....

**Cardiac compression**

- Adequate circulation
- Not adequate

**Ventilation**

- By mask
- Endotracheal tube
- Mouth to mouth / nose

**Endotracheal tube**

- Previous in-situ
- Inserted after arrest  
By whom (status) .....

**Inflation gas**

- 100% oxygen
- Air
- Other, please specify .....

**Type of arrest**

- Fibrillation
- Asystole
- Not known

**Defibrillator**

- Not used
- Used  
Times used .....
- Setting .....

**Defibrillator successful**

- Yes  No

**Drugs used**

|    | Drug  | Dose  |
|----|-------|-------|
| 1. | ..... | ..... |
| 2. | ..... | ..... |
| 3. | ..... | ..... |
| 4. | ..... | ..... |
| 5. | ..... | ..... |
| 6. | ..... | ..... |

**Outcome**

- Successful, died subsequently
- Unsuccessful

**Intervention**

Reason  
 .....  
 .....  
 .....  
 .....  
 .....

Was all necessary resuscitation equipment and drugs readily available?

- Yes  No

If no, please specify deficiencies  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....

**Anaesthetist's Information**

**Additional information (optional)**

This page is provided to allow you to make additional comment.

Please record descriptions, comments and recommendations regarding the sequence of events and their management which could be of importance to the Committee.

A de-identified anaesthetic record would assist review. The provision of the record or other relevant documentation is voluntary.

Please remove all identifying information (e.g. names of anaesthetist, surgeon, patient, hospital).

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**Thank you for your assistance**

## Surgeon or Proceduralist's Comments

Surgeons and Proceduralists are requested to supply additional comments under the following headings.

What was the underlying pathology?

What was the reason for the operation / procedure?

What was found at the operation / procedure and what was done?

What, in your opinion was the sequence of events that led to death?

Any additional comments?

**Send to:**

The Secretariat  
Queensland Perioperative and Periprocedural  
Anaesthetic Mortality Review Committee (QPPAMRC)  
Access Improvement Service  
Queensland Health  
GPO Box 48  
BRISBANE QLD 4001  
Email: [QPPAMRC@health.qld.gov.au](mailto:QPPAMRC@health.qld.gov.au)  
Fax: (07) 3131 6557

**Thank you for your contribution**

## ICU Physician's Comments

ICU Physician is requested to supply additional comments under the following headings.

What was the reason for the admission to intensive care?

What, in your opinion was the sequence of events that led to death?

Any additional comments?

**Send to:**

The Secretariat  
Queensland Perioperative and Periprocedural  
Anaesthetic Mortality Review Committee (QPPAMRC)  
Access Improvement Service  
Queensland Health  
GPO Box 48  
BRISBANE QLD 4001  
Email: [QPPAMRC@health.qld.gov.au](mailto:QPPAMRC@health.qld.gov.au)  
Fax: (07) 3131 6557

**Thank you for your contribution**



## Emergency Physician's Comments

Emergency Physician is requested to supply additional comments under the following headings.

What was the reason for the admission to the emergency department?

What, in your opinion was the sequence of events that led to death?

Any additional comments?

**Send to:**

The Secretariat  
Queensland Perioperative and Periprocedural  
Anaesthetic Mortality Review Committee (QPPAMRC)  
Access Improvement Service  
Queensland Health  
GPO Box 48  
BRISBANE QLD 4001  
Email: [QPPAMRC@health.qld.gov.au](mailto:QPPAMRC@health.qld.gov.au)  
Fax: (07) 3131 6557

**Thank you for your contribution**