ST. GEORGE **HOSPITAL**

77

FORM A

REPORT OF DEATH OF A PATIENT TO THE CORONER

Patient's Surname: DYE Given Names: CRISPIN

Sex: M Age: 41 Marital Status: Single

Admitted: 23/12/93 at: 1205 Died: 25/12/93 at: 1830.
(Date / Time / Date / Time)

Next of Kin: Mrs Dye. Relationship: Mother.

Address: [redacted]

Telephone: (home) [redacted] (work)

BINDING MARGIN DO NOT WRITE

SYNOPSIS OF CLINICAL NOTES

(Recorded in narrative form to include)

a). History (including relevant past history): Assaulted in Taylor Square/Sydney ... → CSA - Police 23/12/93 ~0600 → SVH cas ... → Defib 200 ... /2 ... adrenaline / Na HCO3 / intubated pupils fixed / dilated but ↓ c hyperventilation + mannitol

b). Examination on admission (including evidence of injuries, alcoholic consumption or other relevant clinical findings): CT scan → multiple petechial haemorrhages ② frontoparietal hemisphere c/w shearing injury / no collectn / no midline shift / # BOS → # lat wall ② maxilla + lat wall ② orbit. arrived to SGH ~1200 pupils small - reactive / no dolls eye

c). Treatment: Ventilate
Phenytoin

d). Subsequent progress: Slowly deteriorate neurologically ↓ cough to none / no dolls eye on 24/12. 25/12 ~0600 ↓ BP / no Reflexes

e). Opinion as to cause of death: BRAIN DEATH.

f). Additonal Remarks:

I, TUAN Q LIENG, Bachelor of Medicine and Bachelor of Surgery, a registered Medical Practitioner in the State of New South Wales, hereby certify that at ______ am/pm on ______ I examined the body of the abovenamed patient and pronounced life extinct.

SIGNATURE: [signature] QUALIFICATIONS: MBBS DATE: 25/12/93

TO THE CORONER

CORONERS REPORT

FORM No. MR 39