COLLEGE OF PHYSICIANS & SURGEONS OF BRITISH COLUMBIA

January 9, 2003

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**Personal & Confidential**

Ms. Catherine Winckler
c/o 1237 Howe Street
Vancouver, BC
V6Z 1R3

Dear Ms. Winckler:

**Re: Mrs. Esther Elsa Winckler, mother, deceased**
**Drs. A.A. Suleman, D.M. Wickham and A.R. Richmond**

Further to your letter of concern with regard to the care provided to your late mother, Mrs. Esther Elsa Winckler, by Drs. A.A. Suleman, D.M. Wickham and A.R. Richmond, the College has received responses from Drs. Suleman, Wickham and Richmond, together with comment from Drs. V.K. Noble and E.A. Quinn. In addition, the College received a copy of the Judgement of Inquiry, the Medical Investigator's Report and the Autopsy Report from the Office of the Chief Coroner. As well, the College obtained the clinical records from the Chilliwack General Hospital. Your letter of concern, and all of the material listed above was reviewed by the members of the Quality of Medical Performance Committee of the College at the September 2002 and November 2002 meetings of the committee. The committee consists of a number of physicians from various disciplines, including cardiology and orthopaedic surgery, and two members of the general public appointed by the Minister of Health. It is a peer review committee, not a disciplinary committee of the College.

In reviewing this matter, the members of the committee noted that the Coroner's Service had performed a thorough review of the care provided to Mrs. Winckler and the committee was concerned to note that the Medical Investigator's Report and the Judgement of Inquiry appeared to reach some conclusions which were based upon a false premise. The committee felt that this should be brought to your attention and would emphasize that it does not detract from your overall concerns. The committee noted that you have presented a very clear and detailed letter of concern, together with further detailed correspondence, but would further note that some of your criticisms are based at least in part upon the opinions expressed by the Coroner's Service.

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If I may summarize, On the 5th of March 2000, Mrs. Esther Winckler died in the Chilliwack Hospital following elective hip replacement surgery. The family members have questioned whether or not the preoperative assessments of Mrs. Winckler were adequate and whether or not she should indeed have been submitted to hip replacement surgery. The family members also questioned the standard of anaesthetic care that was provided to her, and especially make reference to the issue of fluid replacement during the surgery. Within the body of the Judgement of Inquiry it indicates that the patient received an intraoperative fluid overload. The committee noted your detailed comment and questions. The committee members would emphasize that your complaint has received careful review.

It is noted that Mrs. Winckler had a significant past surgical and medical history. In 1986 she had a right pneumonectomy for carcinoma of the lung and was treated with radiotherapy following that surgery. She suffered a fracture of the right hip in November 1995, which was surgically pinned. Mrs. Winckler had also had two back surgeries.

During the first surgery that was performed on the 2nd of June 1994, Mrs. Winckler suffered from bleeding, hypotension and hypoxemia, and the procedure was abandoned. Surgery was rescheduled on the 23rd of June 1994 and was successful on that occasion.

It is noted that Mrs. Winckler stopped smoking in 1986, but that she was a smoker for some 40 years prior to that and had a history of asthma, chronic bronchitis and hypertension. In the period before her surgery Mrs. Winckler suffered from severe pain in the left hip and left knee, which interfered with the quality of her life. Assessment by Dr. Wickham revealed the presence of severe osteoarthritis in both the knee and the hip and Dr. Wickham felt that both joints were troublesome to her and that in the first instance hip surgery should be performed. Mrs. Winckler was therefore scheduled for a left total hip arthroplasty, which was to be followed by a total knee replacement some time later.

It is apparent from Dr. Wickham's letter of consultation that Mrs. Winckler fully understood the risks, and anticipated results of her surgery. The benefits and options of either continuing with the medical management of her arthritis or proceeding with surgical treatment were discussed with her and Mrs. Winckler chose to proceed with the surgery, with the hip arthroplasty being the first surgery to be performed.

Dr. Wickham advised the College that he arranged for the surgery to be performed at the Chilliwack General Hospital and also arranged for Mrs. Winckler to be assessed in the Pre-admission Clinic, and in particular to receive an anaesthetic consultation. She was seen once again in Dr. Wickham's office prior to the surgery, the procedure was re-explained to her,

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together with the risks and complications. Dr. Wickham indicates he discussed the issue of possible blood transfusions, and spent some time discussing the fact that Mrs. Winckler had a previous pneumonectomy, advising her that although this did increase her risk for pulmonary and cardiac complications, the consultant anaesthetist would order any further assessments and investigations that would be necessary in that regard.

Mrs. Winckler was admitted to the Chilliwack General Hospital on the 20th of February 2000 and Dr. Wickham saw her that evening, discussed the surgery further with her and wrote the preoperative orders. On the 21st of February 2000 Mrs. Winckler underwent a total hip replacement and the OR report records that she received a combined epidural and general anaesthetic. From the orthopaedic point of view the procedure was straightforward and uneventful and the blood loss was recorded at 650 ml.

Dr. Wickham records that Mrs. Winckler developed atrial fibrillation following her surgery, and that Dr. Richmond was asked to see her in consultation and that she was transferred to the Intensive Care Unit where she received treatment for her atrial fibrillation.

Dr. Wickham records that he visited Mrs. Winckler daily, except when other orthopaedic surgeons were covering his patients on weekends, but was absent from the 3rd to the 5th of March 2000, at which time he was out of town and during which time another orthopaedic surgeon was available to provide emergency orthopaedic care. Dr. Wickham returned to Chilliwack on the 6th of March, at which time he learned that Mrs. Winckler had unfortunately died the day before. He states that the orthopaedic surgeon on-call was not asked to see the patient with regard to her deteriorating medical condition, and the committee members felt that this was appropriate, as there was not a need for further orthopaedic assessment and intervention at that time.

Dr. Wickham advises the College that he was fully available to the members of the family and that following Mrs. Winckler's death he spoke to members of the family to express his surprise and sadness at her sudden death and the family's tragic loss. Dr. Wickham also assured the family members that the Fraser Valley Regional Patient Advocate would investigate Mrs. Winckler's death and report to them. Although Dr. Wickham moved to the Persian Gulf in May of 2000, he has been fully cooperative in this investigation by the College and has provided the committee members with full and appropriate documentation when it was requested.

The committee members had no criticism of the orthopaedic care provided to Mrs. Winckler by Dr. Wickham and would comment that the surgery planned was appropriate and that Mrs. Winckler would appear to have been fully informed of the various treatment choices that were available to her and would note also that Dr. Wickham ensured that Mrs. Winckler received a pre-anaesthetic consultation from the anaesthetist.

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On the 2nd of February 2000 a full preoperative assessment was performed on Mrs. Winckler at the Chilliwack General Hospital, which included x-rays of the left hip and chest, a preoperative physical assessment, appropriate laboratory studies which included a CBC, electrolytes and renal function tests, and a coagulation profile. Mrs. Winckler was noted to have a low serum potassium at 2.9, and an anaesthetic consultation by Dr. Patrick Lavin, an anaesthetist, was performed.

The committee members noted that the Coroner's Service stated that a preoperative ECG was not performed, but it would appear that that was not so. An ECG was performed on Mrs. Winckler on the 2nd of February 2000 and that tracing was included in the material forwarded to the College by the hospital. Dr. Lavin's concluding comments in his consultation indicated that although Mrs. Winckler was optimized for the planned surgery, he would be hesitant to utilize a general anaesthetic for this elective procedure. He indicated that Mrs. Winckler was happy to proceed with a spinal technique. It is understood by the committee members that these opinions were an issue for the family as Mrs. Winckler subsequently received a combination of a general and epidural anaesthetic.

Mrs. Winckler's actual anaesthetic care was provided by Dr. A.A. Suleman and as this care was the focus of significant criticism from the family members, and also the focus of significant comment in the Judgement of Inquiry, the College elected to obtain an expert opinion on this facet of the case. The Coroner noted that, although the previous anaesthetist had felt that this patient should not receive a general anaesthetic, Dr. Suleman, who conducted a careful assessment of the patient on the evening of the 20th of February 2000, advised the Coroner that after reviewing all of the documentation that was available, and considering Mrs. Winckler's history and the operation to be conducted, made a decision to use a general anaesthetic, as he felt it was the best means of protecting the patient's airway and monitoring the patient's oxygenation and respiratory status. He advised the Coroner that due to the positioning of the patient during hip surgery, an emergency intubation would be difficult to perform and therefore the felt that the patient should be intubated prior to the surgery being undertaken. Dr. Suleman also advised the Coroner that Mrs. Winckler requested that she be asleep for her surgery.

In his letter to the College, Dr. Suleman emphasizes that he did in fact review the ECG that was performed on the 2nd of February 2000 on the night before surgery and noted that it showed her to be in sinus rhythm with non-specific ST changes in the anterolateral leads. The expert member of the committee commented that the ECG's appearance may well be a reflection of the previous pneumonectomy and the secondary emphysema that would have developed subsequently. Dr. Suleman emphasized that on rechecking the serum potassium it was found to be 3.1 on the 20th of February 2000 and that as a result he ordered supplemental potassium to be administered preoperatively, together with dietary supplemental potassium.

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With regard to the anaesthetic, the committee members noted that the Coroner's investigator and the family raised questions on the following issues:

1. Consent for anaesthesia
2. Preoperative investigations including electrolytes, ECG and pulmonary function tests
3. Appropriate choice of anaesthesia
4. Fluid replacement in the operating room
5. Volume replacement in the PACU and the treatment of the interstitial edema

These main concerns will be addressed sequentially:

**1. Consent for anaesthesia**

It was noted that the consent for anaesthesia appears as part of the hospital consent. There is no specific anaesthetic consent form utilized in any other hospital in BC, except the BC Women's Hospital. It is clear that Dr. Lavin discussed all the various anaesthetic options with Mrs. Winckler and that she agreed to have a spinal anaesthetic at that time. It is noted that Dr. Suleman did not document his discussions with Mrs. Winckler on the 20th of February 2000 and in the absence of any documentation by Dr. Suleman it is not possible to confidently state that Mrs. Winckler was satisfied with the anaesthetic choice that Dr. Suleman made. This lack of documentation has led to a discrepancy in the family's understanding of why the anaesthetic technique was changed from spinal to general/epidural.

The committee was advised that patient's often change their mind as to the type of anaesthetic that they wish to be utilized between the preoperative visit and the discussion with the consultant anaesthetist immediately prior to the surgery. All forms of anaesthesia are attended by some degree of risk and the committee was advised that there are very few circumstances where one form of anaesthesia is demonstrably safer for a given patient than another, and therefore patient preference plays a large part in the decision on what anaesthetic to use. The committee was advised that it is not surprising that there was a difference in anaesthetic preference expressed by Drs. Lavin and Suleman, however the committee members would be critical of Dr. Suleman for not documenting the reasons for his choice of anaesthetic and clearly recording also that Mrs. Winckler was compliant with that choice.

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## 2. Preoperative investigation

The committee noted that there is conflict as to the existence of a preoperative ECG and this has been referred to above. An ECG was performed as part of the preoperative assessment on the 2nd of February 2000, but no ECG was performed at the time of the admission of the patient to hospital on the 20th of February 2000. The committee was advised that the ECG performed on the 2nd of February 2000, which showed the elements described earlier, was in fact very similar to the first postoperative ECG which would suggest that no acute ischemic injury occurred during Mrs. Winckler's surgery.

With regard to the serum electrolytes the College received the following expert comment:

> "The electrolytes done on February 2 reveal a potassium level of 2.9 mmol/L which is lower then the standard for the lab at Chilliwack General Hospital. Should this potassium have been aggressively increased during the time prior to Mrs. Winckler's surgery? Should the surgery have been cancelled until the potassium was within normal limits? The answer to both questions is No. There is excellent evidence that chronic low potassium in patients being treated with diuretics does not increase perioperative morbidity. When there has been chronic loss of potassium, there are biologic mechanisms that come into play that minimize the risk of morbidity. The rapid correction of chronic hypokalemia is associated with many risks which cannot be justified in an otherwise healthy patient. Risks of surgery and anesthesia are not increased by chronic hypokalemia. I think, however, that there is evidence that hypokalemia in the postoperative patient in the presence of evidence of hypoxemia does require more aggressive therapy. Mrs. Winckler may have benefited from a more rapid attempt to correct hypokalemia in the PACU."

The committee accepted your mother's potassium level was not at issue prior to and during the surgery, but that it became an issue in the recovery period and was critical that this did receive urgent attention in that setting.

With regard to the respiratory function the committee was advised:

> "The pulmonary function tests and blood gases done preoperatively appear to show only moderate on-going respiratory impairment despite her previous pneumonectomy. There is no evidence of an improvement in pulmonary function with bronchodilators so more aggressive therapy of her respiratory disease was not necessary."

The committee members accepted this expert opinion.

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### 3. Appropriate choice of anaesthetic technique.

It was accepted that the patient had a right to make her choice of anaesthetic and it was accepted also that there was a need for full discussion, with documentation, of the risks and benefits of various anaesthetic techniques. The committee was advised that there are few circumstances where there is a definite safety advantage of one form of anaesthesia over another. The expert opinion stated:

> "...In Mrs. Winckler's case, I am unable to find any safety issue that would lead me to pick one form of anesthesia over another. Her previous surgical bleeding leading to aborting back surgery was not due to the type of anesthesia that she received but due to surgical positioning and surgical bleeding. Mrs. Winckler had received a number of general and regional (spinal) anesthetics in the past without apparent anesthetic morbidity. The choice of anesthetic becomes one based upon anesthesiologists experience and preference and patient's experience and preference."

The committee was advised that the spinal anaesthetic proposed by Dr. Lavin was an appropriate choice, as was the general and epidural anaesthetic which was actually provided by Dr. Suleman. The committee was advised that the combination of general and epidural anaesthesia had the advantage of providing general anaesthesia with lower levels of anaesthetic agent than with general anaesthesia alone. It also allows for continuous pain relief with small doses of narcotics and local anaesthetics. This technique often allows earlier ambulation of elderly patients who have undergone major orthopaedic procedures. The committee was advised that the reasons given by Dr. Suleman for using this technique are valid, with the exception that both techniques allow adequate monitoring of respiratory function. On this matter the expert opinion concluded:

> "I, therefore, do not believe that the type of anesthesia chosen by Dr. Suleman had any bearing on Mrs. Winckler's outcome."

### 4. Fluid replacement in the operating room

The committee members recognized that this was a significant issue for the family members, possibly as a result of the comments recorded in the Report of the Medical Investigator and the Judgement of Inquiry. In addressing this issue, the College was advised:

> "There are several statements in the coroner's documents that suggest that the volume of intravenous fluid given during the surgery was excessive and led to "fluid overload". This belief is based upon a surprising lack of knowledge of the distribution of added fluids to the body's fluid compartments."

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It would appear from the Coroner's Report that it has been assumed that 650 ml of blood loss equates to 650 ml of intravenous crystalloid so that 2000 ml of intraoperative fluids as replacement would be excessive. The committee was advised that the 650 ml of blood loss is entirely from the intravascular space. The 2000 ml of intravenous fluid is distributed to both the intravascular space and the extracellular space. The recognized ratio of crystalloid replacement to blood loss is 3:1. Therefore, 650 ml of blood loss can only be replaced with 1950 ml of crystalloid to adequately replace intravascular losses.

The committee noted that on this basis, Dr. Suleman exactly replaced Mrs. Winckler's blood loss. This does not take into account the volume deficit created by fasting, the fluid loss through evaporation during surgery, and "third space" losses during and after surgery. The committee would comment that fluid replacement during surgery is a balance of several factors and would have no criticism of the intraoperative fluid replacement that was provided to Mrs. Winckler by Dr. Suleman during the operative procedure.

The committee noted that within the Coroner's Investigative Report and the Judgement of Inquiry, it is suggested that the fluid overload in the Operating Room was a factor in the morbidity suffered by Mrs. Winckler. The committee stated that the suggested approach to fluid replacement within those reports, grossly underestimates replacement requirements and may have caused unnecessary concern on this issue for the family.

## 5. Fluid replacement in the PACU

While in the PACU Mrs. Winckler initially appeared to be doing well with adequate BP and O2 levels. When she showed signs of a drop in her blood pressure, Dr. Suleman chose to treat her with additional volume replacement. In view of the issues described above, the committee questioned this decision. The committee was advised that the causes of postoperative hypotension include blood loss, fluid loss to the third space and urine, and in addition, spinal or epidural anaesthesia can cause a drop in blood pressure. It is unclear from the clinical record whether the fluid ordered by Dr. Suleman was actually administered to Mrs. Winckler and certainly the decision to give her the fluid should have been based on a complete assessment of her status. The committee was advised that a careful examination of Mrs. Winckler by the anaesthetist might have suggested fluid overload and the development of desaturation should have been a warning sign that something other than the simple loss of fluid volume was the cause of the hypotension. The committee was advised that there is little doubt that Mrs. Winckler developed heart failure in the PACU and this should have been diagnosed and treated before she was sent to the Ward. No documentation was found that showed that Dr. Suleman was notified of the desaturation, examined the patient or considered a diagnosis of congestive heart failure before allowing Mrs. Winckler to be sent from the PACU to the Ward.

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The committee was advised that the postoperative chest x-rays showed evidence of interstitial edema in the one lung that the patient had and that this alone should have led to reassessment of the situation and further volume replacement should have been withheld, pending a careful assessment of the patient for other causes of the hypotension and hypoxia.

In summary on these anaesthetic issues, the committee was advised that there was inadequate documentation to determine whether Mrs. Winckler was an informed participant in the choice of her anaesthetic. Despite this, the anaesthetic technique chosen was perfectly appropriate and the fluid replacement in the OR was appropriate. The care of Mrs. Winckler in the PACU was poorly documented, however, initial use of fluid to increase the blood pressure would be an appropriate choice of therapy. Nevertheless, the subsequent treatment and investigation of the ongoing drop in blood pressure and oxygen level would appear to be suboptimal.

The committee members noted that at 1455 hours Mrs. Winckler's oxygen saturation was low at 87%. Despite that, she was transferred at 1500 hours to the Ward. At 1530 hours the oxygen saturation remained at 88% and there was no indication on the record that a physician was aware of these findings.

At 1715 hours Mrs. Winckler was noted to be in atrial fibrillation and at 1745 hours the potassium level was recorded at 3.1 mmol/L. It is noted that at 1955 hours her oxygen saturation remained low at 87%.

The committee members noted that Dr. Suleman felt that his responsibilities for Mrs. Winckler, once she was discharged from the PACU, were limited to the care of her epidural catheter. However, the committee members expressed concern with regard to the fact that Mrs. Winckler was transferred from the PACU with a low oxygen saturation and in undetected congestive failure. It was noted that the PACU score criteria on discharge from that unit was recorded as 10/10. This would appear to be based upon a nursing assessment. The committee members felt that Dr. Suleman should have carefully assessed Mrs. Winckler himself prior to her discharge from the PACU and it is not clear that such an assessment occurred. It would appear that the decision to transfer her to the Ward was based upon a nursing assessment.

The committee was critical of Dr. Suleman for the care provided to Mrs. Winckler in the PACU.

Following transfer to the Ward, Mrs. Winckler had ongoing low blood pressure and low oxygen tensions. At 1955 hours the oxygen saturation had dropped to 87% even though she was receiving oxygen. She had some signs of pulmonary edema and the atrial fibrillation was evident on the ECG with an apex of 155 BPM. She was sweating, she was short of breath, but had no chest pain. She was assessed at this juncture by Dr. A.R. Richmond, a consultant in

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internal medicine. She was given appropriate treatment but continued in atrial fibrillation with an oxygen saturation of 88%. At 2130 hours a decision was made to transfer her to the ICU. At 2230 hours Mrs. Winckler remained markedly short of breath with an oxygen saturation of 84% and Dr. Richmond was informed of her status. By 2305 hours Mrs. Winckler was markedly hypotensive and Dr. Richmond was called again, and at that juncture he ordered that some more fluid should be given intravenously, together with a cardiac drug called Digoxin.

The committee members were advised that with the onset of atrial fibrillation there would be a further decrease in the cardiac output and there was an urgency to slow the heart rate and to correct the atrial fibrillation. It was noted that Mrs. Winckler's blood pressure was already low, requiring a drug called Dopamine to maintain the blood pressure, and the committee was advised that at least some of her postoperative confusional state could have been related to the low oxygen status.

In one of your letters to the College you state:

> "Mrs. Winckler was in atrial fibrillation for a long period of time and severely compromised due to pulmonary edema and was not initially coagulated (sic). Would it not appear more reasonable that her infarctions were due to emboli secondary to her atrial fibrillation and her fractured ribs and the subdural more likely related to at least two documented falls?"

The committee members felt that these were reasonable questions. Mrs. Winckler became extremely confused in her postoperative, post ICU period of recovery having required ventilation in the ICU and it is noted that her period of confusion continued on and she required physical restraint for a period of time. She was transferred from the ICU to the Ward on the 28th of February 2000 and at that time remained in restraint and an ultrasound of her legs did not reveal any evidence of deep vein thrombosis as a source for her stroke condition. As has been previously noted, Mrs. Winckler had persistent atrial fibrillation but an echocardiogram was not performed. The committee felt that a likely source for her stroke lay in her heart and this would have been a useful examination. Mrs. Winckler suffered multiple emboli causing multiple cerebral infarctions, bowel ischemia and pulmonary edema. The bowel ischemia itself led to the release of endotoxins, bacteremia, marked hypotension and renal failure. The committee noted that Mrs. Winckler's white blood count was 34,900 just prior to her death.

It should be stated, however, that no evidence of any intracardiac clot is recorded in the Autopsy Report.

The committee focused on the issue of atrial fibrillation and noted that Mrs. Winckler was first discovered to be fibrillating late on the evening of the 21st of February 2000, on transfer to the Ward from the PACU. She may well have been fibrillating in the PACU.

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Dr. Richmond performed cardioversion at 0327 hours on the 22nd of February, and it is assumed that normal rhythm ensued, although it was difficult to understand clearly from the record that it did. The committee noted that a tracing within the nurses' notes at 2121 hours on the 22nd of February 2000 would seem to indicate that Mrs. Winckler may well have been fibrillating again. However, at 0710 hours on the 23rd of February, Mrs. Winckler was noted to be in normal rhythm. Dr. Richmond has indicated to the College that Mrs. Winckler began to fibrillate again when she was weaned off her procainamide and he states in his response to the College:

> "... She had been on prophylactic doses of Tinzaparin 75 mcg per kg per 24 hours from the 22nd as per the orthopedic orders. However when she went back into atrial fibrillation on the 27th and I didn't know whether she would be going in and out of this rhythm I fully anticoagulated her with a full dose of Tinzaparin."

The committee noted that Mrs. Winckler had paroxysms of atrial fibrillation and whether or not to anticoagulate her was a difficult decision. It is recognized that the physicians were concerned with the possibility of a postoperative bleed, given the extensive orthopaedic surgery that had been performed. The committee was advised that in an orthopaedic patient who has undergone hip surgery, there is no orthopaedic contraindication to full anticoagulation being commenced 24 hours after the surgery in the normal course of events. It is noted that Mrs. Winckler was only receiving DVT prophylaxis initially and after much discussion on this point, the committee members felt that Mrs. Winckler could have been fully anticoagulated earlier than she was. This may have had a preventive effect upon the subsequent embolic occurrences.

On the issue of Mrs. Winckler's postoperative confusional state and possible stroke, the committee members felt that these symptoms and signs should have been more fully investigated before she was transferred from the ICU to the regular ward. Certainly, the fact that Mrs. Winckler had a subdural haemorrhage with a history of falling on the Ward would be compatible with her having suffered a closed head injury. Similarly, the rib fractures that were described at autopsy were almost certainly sustained in the described fall. It would seem from a review of the clinical record that when Mrs. Winckler initially became confused, it may well be that she suffered some cerebral emboli, which contributed to the confusional state. The subsequent subdural haemorrhage, however, was due to the direct trauma of a closed head injury.

With regard to missing the presence of an acute abdomen in a confused patient, the committee members would comment that this can present a difficult diagnostic task and would have no distinct criticism of the care of Mrs. Winckler in this regard. The committee would state that her abdominal pain was due to the mesenteric emboli and bowel infarction, and would emphasize to you that the presence or absence of a bowel movement was not an issue or relevant to the presence of the mesenteric embolus/bowel infarction. While acknowledging that the presence of

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an acute abdomen secondary to the mesenteric infarction was not appreciated by her attending physicians, given Mrs. Winckler's clinical status at that time, the committee was not critical that this uncommon diagnosis was missed.

With regard to Mrs. Winckler's pain control, Dr. Richmond advised the College that once she was extubated in the ICU, she did not have adequate control of her surgical pain. The epidural was not working adequately and morphine was not an option for her, as she became confused on that drug. Finally, pain control was achieved using a low dose Fentanyl patch. Dr. Richmond held the opinion that Mrs. Winckler's periods of confusion and agitation in the ICU were likely in part related to her analgesia needs. The committee felt that Mrs. Winckler's hypoxia and poor cardiac output were also significant factors, together with the deposition of cerebral emboli.

In bringing this complex review to closure, the committee members were critical of the postoperative care that Mrs. Winckler received and felt that she should have been anticoagulated earlier and that her confusional state should have been more thoroughly assessed before she was transferred from the ICU to the regular ward. A thorough assessment of Mrs. Winckler's condition following her fall in the ward should have led to the discovery of her head and rib injuries. It is recognized by the committee that the degree of supervision provided in the hospital was probably less than Mrs. Winckler required.

Drs. Suleman, Wickham and Richmond will be made aware of the committee's opinions in this matter and will receive a copy of this correspondence, as will the Office of the Chief Coroner. The committee would like to thank you for the patience that you have shown with the processes of the College.

Yours sincerely,

B.T.B. Taylor, M.B., B.S.
Deputy Registrar

BTBT/cls

cc: Dr .A.A. Suleman
Dr. D.M. Wickham
Dr. A.R. Richmond

Office of the Chief Coroner