Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

***Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows:
"****Comments***"

Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:** Pre-existing history of the patient have been included in the history section

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on all ante natal visits, ER visits for abdominal pain on MM/DD/YYYY & MM/DD/YYYY followed by emergency cesarean section and new born care till death on MM/DD/YYYY in detail. Ob triage, labor and delivery flow sheets have been summarized in detail.*
- *Mother records after labor have been presented in brief.*
- *The baby records are summarized and highlighted in different color for ease reference.*

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Brief summary/Flow of events

08/08/YYYY-10/17/YYYY: Multiple office visits, follow-up visits for various problems including bronchitis, low back pain, narcolepsy, depression/anxiety disorder, diagnostic studies including barium swallow study, CT scan, X-rays, MRI and prenatal visits for prior pregnancies/cesarean sections

10/22/YYYY: Office visit for bleeding and cramping, early pregnancy ultrasound – assessed as threatened abortion

11/04/YYYY-12/16/YYYY: Prenatal follow-up – assessed with "supervision elderly multigravida" – screening antenatal labs ordered

01/20/YYYY: Obstetric ultrasound and follow-up visit – assessed with "large for date and unspecified complication of pregnancy"

01/21/YYYY: Fetal anatomy ultrasound – fetal heart rate and rhythm irregular – M mode echocardiography revealed fetal arrhythmia appears as blocked atrial trigeminy – assessed as suspected damage to fetus from maternal drug use – patient declines cell free fetal DNA screening and amniocentesis for FISH, fetal karyotype and microarray – recommended to stop Clonazepam – referred to pediatric cardiology for a fetal echocardiogram

02/09/YYYY: Prenatal follow-up – limited fetal ultrasound revealed majority of fetal heart rate and rhythm as normal and no blocked atrial trigeminy – rate instances of fetal premature atrial complexes occurring – fetal arrhythmia vastly improved

02/25/YYYY: Prenatal follow-up – limited fetal ultrasound revealed appropriate fetal growth – no fetal arrhythmia or blocked atrial trigeminy – fetal heart rate in normal sinus rate and rhythm

04/21/YYYY: Scheduled repeat cesarean section and bilateral tubal ligation

05/06/YYYY: ER visit for abdominal pain – assessed as discomfort and abdominal pain – recommended Demerol 50 mg and Phenergan 25 mg – educated on preterm labor – discharged home

05/07/YYYY-05/08/YYYY: Presented to ER for lower abdominal pain – refused external fetal monitoring and sterile vaginal exam as lying back made her pain worse – unable to doppler fetal heart tones after several attempts – aged Dr. XXXX – fetal heart rate 85 bpm and visibile blood and fluid on ultrasound – stat cesarean section was called due to fetal bradycardia and evidence of abruption/uterine rupture – delivered a male infant of APGARs 0, 0 at 1801 hrs – patient had a complete uterine dehiscence with active bleeding – baby was immediately resuscitated – transferred to NICU – assessed with severe birth depression, stage III hypoxic

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ischemic encephalopathy, respiratory depression, suspected sepsis, severe cardiogenic shock and severe metabolic acidosis – on SIMV (Synchronized Intermittent Mechanical Ventilation) – on 05/08/YYYY, echocardiogram revealed left patent ductus arteriosus, left to right shunt – ultrasound echo of middle cerebral artery/encephalogram revealed bilateral basal ganglia hemorrhage – remained acidotic with hypotension, poor perfusion and comatose stage – pronounced dead at 2200 hrs on 05/08/YYYY

Death certificate: Cause of death – cardiogenic shock, severe hypoxic ischemic encephalopathy, renal failure and consumptive coagulopathy. Underlying cause: Maternal uterine rupture

Patient History

Past Medical History: Anxiety disorder, generalized; depression; PTSD-childhood trauma.

Surgical History: Tonsillectomy; cesarean section.

Family History: Cardiac conduction disorder-Brother/mother; CVA (Cerebrovascular accident)-Maternal grandfather; diabetic mellitus type II-Maternal grandfather/paternal grandmother; Hodgkin's lymphoma-Mother.

Social History: Current every day smoker 1/2 pocket per day.

Allergy: Keflex-blisters; Morphine; Penicillin-unknown; Pristiq; Clindamycin-Blisters.

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
10/17/YYYY	Hospital/Provider Name	**X-ray of thoracic and lumbar spine:** **History:** Back pain, scoliosis. **Impression:** Very mild thoracolumbar s-shaped scoliosis.	150
10/20/YYYY	Hospital/Provider Name	**MRI of cervical spine:** **History:** Chronic neck pain. **Impression:** Very mild degenerative disc disease C3 through C6.	205
10/20/YYYY	Hospital/Provider Name	**MRI of thoracic spine:** **History:** Chronic mid-back pain. **Impression:** Very mild degenerative disc disease T8 through T11 consisting of disc desiccation without evidence of a disc bulge or herniated nucleus pulposus. No evidence of central, lateral recess or neuroforaminal	180

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		stenosis. The examination is otherwise unremarkable.	
11/28/YYYY	Hospital/Provider Name	**Psychiatry follow-up visit:** *(Illegible notes)* **Assessment:** Depression/anxiety. **Plan:** Agrees with medication.	1159–1160
01/31/YYYY	Hospital/Provider Name	**Psychiatry follow-up visit:** *(Illegible notes)* **Assessment:** Depression/anxiety, _ behavior. **Plan:** Agrees with medication.	1161–1162
03/07/YYYY	Hospital/Provider Name	**Psychiatry follow-up visit:** *(Illegible notes)* **Plan:** Agrees with medication.	1163–1164
05/25/YYYY	Hospital/Provider Name	**Follow-up visit for general exam**: *(Illegible notes)* **Diagnoses:** Bronchitis Chronic back pain Narcolepsy	1173–1174
07/30/YYYY	Hospital/Provider Name	**X-ray of ribs:** **History**: Pneumonia, rib pain. **Impression:** 1. No evidence of rib fracture or pleural effusion is seen. 2. Normal appearance of chest is noted with no evidence of residual pneumonia seen. It is noted the patient had pneumonia at a physician's office in XXXX.	1298
07/30/YYYY	Hospital/Provider Name	**X-ray of chest:** **History**: Pneumonia **Impression**: 1. Normal heart and lungs.	1299
09/24/YYYY	Hospital/Provider Name	**Follow-up visit:** *(Illegible notes)* **Diagnosis:** Anxiety Hypertension PTSD (Post-traumatic Stress Disorder) Narcolepsy Depression.	1175
11/06/YYYY	Hospital/Provider Name	**Follow-up visit for depression/anxiety:** **Diagnosis:**	1176

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Anxiety Hypertension PTSD (Post-traumatic Stress Disorder) Narcolepsy	
12/12/YYYY	Hospital/Provider Name	**Office visit for fever:** **Diagnosis:** URI (Upper Respiratory Infection) Anxiety Narcolepsy	1177
05/24/YYYY	Hospital/Provider Name	**Culture report (collected date: 05/21/YYYY):** **Urine culture report**: Greater than 100,000 Col/cc Gram negative rods Escherichia coli	920–921
07/31/YYYY	Hospital/Provider Name	**ER visit for dental complaint:** **Clinical impression:** 1. Dental caries 2. Acute dental pain 3. Intrauterine pregnancy	928–930
10/28/YYYY	Hospital/Provider Name	**Obstetrics:** **Indication**: Anatomy. LMP (Last Menstrual Period): GA (EDD): 22 weeks, 0 days EDD (Exact Date of Delivery): 03/03/YYYY Gravida: 2 Para: 1 DOC: GA (AUA): 21 weeks, 5 days EDD (AUA): 03/05/YYYY **Fetal heart rate:** 161 bpm. **Comment:** SIUP (Single Intrauterine Pregnancy) vertex female within normal limits. Uterus appears unremarkable. Adnexa appear unremarkable.	912–913
01/14/YYYY	Hospital/Provider Name	**ER visit for cough and left ear pain:** **Impression:** URI Bronchitis IUP (Intrauterine Pregnancy)	1184–1186
01/14/YYYY	Hospital/Provider Name	**Nursing notes/records**: The patient presents with complaints of cough and left ear pain, rates pain 4/10 scale. States has been feeling bad for 5 days. Denies fever or any	1182–1183

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		other complaints. Patient is also 33week IUP (Intra Uterine Pregnancy). Also stated she wants DR to address her left leg pain and groin pain. States it hurts to walk sometimes. Rates leg pain 4/10 scale. 0845 Discharge instructions given educated on taking antibiotics as directed and taking until gone, patient verbally understanding.	
02/06/YYYY	Hospital/Provider Name	**Labs:** Strep Group B culture/DNA probe: Negative.	956
02/20/YYYY	Hospital/Provider Name	**Ob history and physical examination:** *(Illegible notes)* **Chief complaint:** Patient desired repeat cesarean section. **History of present illness:** She is a 38 weeks, 3 days, G2, P2 desiring repeat cesarean section for ruptured membranes and onset of labor. **Ob history:** G2, P2, prior cesarean section x 1 for twins. **Review of systems:** Fluid leakage: Present. Contractions: Present. Regular painful contractions. **Physical examination:** Cervix 2-3/80/-2. **Assessment/plan:** She is a G2 P2 38 weeks, 3 days desiring repeat cesarean section for onset of labor and ruptured membranes. G2 P2 cesarean section twin pregnancy. EDD: 03/03/YYYY. A+ blood type. GBS (Group B Streptococcus) negative. Repeat cesarean section in the OR Wednesday 02/20/YYYY at 1700 hrs. Risks discussed including bleeding, infection, injury to organs, injury to fetus, fetal brain injury or death. Questions were answered and elicited.	948
02/20/YYYY	Hospital/Provider Name	**Operative report**: **Pre/post-operative diagnosis:** 1. Intrauterine pregnancy at 39+ weeks gestation 2. Previous cesarean section x 1. 3. Onset of active labor 4. Positive rupture of membranes **Procedure performed**: Repeat low transverse cesarean section **Estimated blood loss**: 900 ml	911, 915

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings: Vigorous 2116 g female infant with 8 and 9 Apgars, delivered atraumatically from the OA (Occipito Anterior) position at 1732 without complications. **Description of procedure**: Under spinal anesthesia repeat low transverse cesarean section was done. The patient was subsequently transported to recovery room in stable condition. **Disposition:** The patient to recovery room in stable condition.	
02/20/YYYY-02/22/YYYY	Hospital/Provider Name	**Cumulative inpatient progress notes:** *(Illegible notes)* **02/20/YYYY:** Status post cesarean section. Spinal anesthesia. Female infant with 8, 9 APGARs delivered atraumatically from the occipito anterior position at 1732 hrs without complications. Patient recovery in recovery room in stable condition. **02/21/YYYY:** Patient without complaints. Pain well controlled. Tolerating diet. POD #1, stable post-op. Continue routine post-op care. **02/22/YYYY:** Patient without complaints. Doing well. Pain well controlled. POD #2, continue post-op care.	1067–1134, 988–989
03/18/YYYY	Hospital/Provider Name	**Follow-up visit for refill of medications:** **Assessment:** 1. Anxiety. 2. Depression. 3. Work shift sleep disorder. **Plan:** 1. Increase the Lexapro to 20 mg once a day. 2. Klonopin 1 mg twice a day as needed for anxiety. 3. Nuvigil 250 mg once a day. 4. Return here as needed problems.	1188
04/10/YYYY	Hospital/Provider Name	**Follow-up visit for post-partum visit:** **Assessment:** Post-partum follow-up exam. **Follow-up**: 2-months.	914
10/22/YYYY	Hospital/Provider Name	**Office visit for bleeding and cramping:** **History of present illness:** The patient is G3 P3003 is here today for early pregnancy ultrasound. She is currently 6 weeks 1 day. She has a current history of bleeding and cramping. **Ultrasound findings:**	793–796

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Today there is a single intrauterine pregnancy with ultrasound parameters consistent with 6-weeks and 1-day, Fetal cardiac activity is visible. Heart rate is 150. Right ovary-normal left ovary-normal Today's ultrasound parameters are consistent with LMP. EDC (Expected Date of Confinement) is 06/16/YYYY. **Reproductive history:** Menstrual Age menarche: 12. Cycle interval(days): 21 Menses duration (Days): 5 Flow: Light Last menstrual period: 05/18/YYYY Method of birth control: OCPs **Pregnancy summary:** Total pregnancies: 3 Full term: 3 Ab Spontaneous: 0 Living: 3 Premature: 0 Ectopics: 0 **Pregnancy details:** Date: 07/02/ YYYY: GA 38; birth weight 6#10; male; cesarean section; Date: 07/02/ YYYY: GA 38; birth weight 6#3; male; cesarean section; Date: 02/01/YYYY: GA 38; female; cesarean section. **Social history:** Tobacco: Current every day smoker 1/2 pocket per day **Assessment:** Threatened abortion. **Plan:** Orders-Complete transvaginal obstetrical ultrasound **Medications:** Cipro 250 mg, 1 every 12 hours for 7 days.	
11/04/YYYY	Hospital/Provider Name	**Follow-up visit:** **Chief complaint:** "I'm pregnant & quot" Patient requests prenatal care	121–122

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History of present illness: Patient G3 P2003, LMP was 09/09/YYYY; EDC is 06/16/YYYY who presents for prenatal care. Pregnancy verified via US done on 10/22/YYYY. The patient has no history of previous miscarriages. The patient is at risk for complications due to advanced maternal age. Since her LMP she has experienced nausea and fatigue. She denies vaginal bleeding and abdominal pain. Her past medical history is noncontributory. Her past pregnancies have been uncomplicated. Since her LMP, she admits to the use of tobacco. She has smoked less than 1 PPD since her LMP. She is a smoker. She is counseled with pregnancy specific educational materials for intervention of smoking cessation. Consequences of maternal smoking were discussed for 3-10 minutes. Education materials were given to the patient. Patient denies any family for paternal history that relates to pregnancy. We discussed exercise safe for pregnancy, weight gain, fluid intake, prenatal vitamins and nutrition. AFP (Alpha-Fetoprotein) and CF (Cystic Fibrosis) screening was discussed and information was given. She will return at 11-weeks for her new Ob visit. Patient has a history of depression, PTSD, and anxiety disorders, patient states that she has decreased her Lexapro to 10 mg daily but states that she cannot discontinue this medication, patient also taking Clonazepam l mg as needed. Patient will discuss this with Dr. XXXX at new Ob appointment. Patient given information on Informaseq but informed that Medicaid does not cover this testing; patient also states that she will work on decreasing her smoking. **Assessment:** Supervision elderly multigravida (EDD 35/+) Screening antenatal labs **Plan:** **Orders:** Culture urine; HIV panel; initial prenatal care visit with Gina; PBP panel **Instructions:** ACOG pamphlet provided Avoid alcoholic beverages Patient encouraged not to smoke Discontinue all current prescription drug use Discontinue the use of all non-medicinal drugs and chemicals	
12/16/YYYY	Hospital/Provider Name	**Follow-up visit:** **Chief complaint:** 10-11 weeks Ob visit Ob Pap Smear/FHT	117–120

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History of present illness: Patient G3 P2003, who is at 14 weeks and 0 days gestation with an EDD of 06/16/YYYY. Since her LMP she claims she has been without significant complaints. Pap smear and GC/Chlamydia was obtained, patient informed that she may experience light spotting today due to pap smear. Fetal heart tones were dopplered fetal heart tones were 153. Notes of special importance: Pregnancy course outlined. Weight gain of 20 to 25 pounds and 20 minutes of dally walking encouraged. Physical call rotation discussed, understood and accepted. Patient will be set up for next Ob appt in 4 weeks. **Assessment:** Subsequent pregnancy. **Plan:** Orders: GC/Chlamydia/Trich; pap smear	
12/16/YYYY	Hospital/Provider Name	**Pathology report:** **HPV (high risk) mRNA by APTIMA, liquid-based preparation (ThinPrep), cervical:** Detected (Reference range: Not detected) **Molecular pathology report:** Chlamydia trachomatis rRNA by gen-probe APTIMA combo 2 assay, liquid-based preparation (ThinPrep®), cervical: Not detected (Reference range: Not detected) Neisseria gonorrhoeae rRNA by gen-probe APTIMA combo 2 assay, liquid-based preparation (ThinPrep®), cervical: Not detected (Reference range: Not detected)	123–124
12/16/YYYY	Hospital/Provider Name	**Gynecological cytology report:** **Final diagnosis:** Vaginal/cervical, liquid-based preparation (thin prep): Satisfactory for evaluation. Endocervical component present. Hormonal effect consistent with age and history Rare atypical squamous cells of undetermined significance (See comment). **Comment:** Specimen will be tested for HPV, chlamydia and gonorrhoeae as ordered. Results, when available, will be Issued under a separate report.	125
01/20/YYYY	Hospital/Provider Name	**Obstetrics ultrasound and follow-up visit**: LMP: GA (EDD) 19-week, 0-day. EDD 06/16/YYYY DOC: 09/23/YYYY GA (AUA): 20-week, 1-day. EDD (AUA) 06/05/YYYY	408–413

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Fetal heart rate: FHR 137 bpm **Fetal heart:** Cardiac rhythm: Abnormal 4 Chamber: Seen **Fetal description:** Fetal position: Transverse Face: Seen Fetal head: Right Placenta location: Anterior marginal **Comment:** S=D Trans Placenta anterior marginal Boy Abnormal rhythm **Indications:** The patient G3 P2003, LMP was 09/09/YYYY. She presents today for an ultrasound for: Size appears large for dates. **Survey:** BPD, HC, AC, and FL correspond to a mean age of 20 weeks 1 day which is consistent with dates. Intracranial as well as intrathoracic anatomy appreciated and within normal limits. Stomach, bladder, spine, anterior abdominal wall all visualized and within normal limits. Fetal position is transverse. Placenta is anterior marginal and dear of the cervical os. Fetal gender appears to boy. Family is not guaranteed such. Family understands the limitation of US in documenting congenital abnormalities. Abnormal heart rhythm noted on us and auscultated with Doppler. I spoke with Dr. XXXX about this pt. He will work her into his schedule. He recommended that she avoid caffeine, smoking and OTC decongestants. **Assessment:** Large for dates Unspecified complication of pregnancy **Plan:** **Orders**: Ultrasound of gravid uterus in third trimester with single fetus **Instructions**: Findings shared with patient	
01/21/YYYY	Hospital/Provider	**Labs:**	64–65

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	ANA: Negative Sjogren's Anti-SS-A LC: 0.2 Sjogren's Anti-SS-B LC: Less than 0.2	
01/21/YYYY	Hospital/Provider Name	**Ultrasound of second trimester:** **Indication**: Fetal anatomy ultrasound. AMA. Fetal arrhythmia. Medication exposure. **History**: Ob history. Gravida: 3. Para: 3. **Pregnancy:** Singleton pregnancy. Number of fetuses: 1 **General evaluation:** Cardiac activity: Present. FHR 128 bpm. Fetal movements: Visualized. Presentation: Breech. Placenta: Anterior. **The following structures were abnormal:** Heart cardiac rhythm: Irregular with atrial ectopic beats. Blocked ectopic atrial trigeminy. **Impression:** There is a viable singleton fetus, intrauterine pregnancy at 19 weeks l day with appropriate measurements for gestational age. There is a fetal nasal bone visualized The 4 chamber view of the heart and outflow tracts, LVOT and AO/Pa, appear normal. The fetal heart has an irregular rate and rhythm. M mode echocardiography was performed to visualize the fetal arrhythmia. The fetal arrhythmia appears as blocked atrial trigeminy. Other visualized detailed fetal anatomy appears normal. The AFI appear subjectively normal. The fetal presentation is in a breech position. The placenta is located anteriorly and there is no placenta previa present. There is a clear plane visualized between the placenta and uterine wall and bladder wall. There are no areas of hypervascularity or lacunae visualized. There are no signs of an invasive placentation. The uterus appears to be arcuate or have a minor septum. **Follow-up:** The patient declines cell free/fetal DNA screening and an amniocentesis for FISH, fetal karyotype, and fetal microarray. I will send the patient to have labs drawn for ANA, anti-SSA & SSB antibodies. I recommend that the patient stop consuming caffeinated beverages and stop smoking. I will schedule the patient to have a consultation with Pediatric Cardiology for fetal echocardiogram. I recommend that the patient have serial ultrasounds	421–424

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		performed in order to observe for fetal hydrops. I have scheduled the patient for a limited fetal ultrasound in 2 weeks.	
01/21/YYYY	Hospital/Provider Name	**Follow-up visit for abnormal fetal heart rate:** **History of present illness**: The patient advanced maternal age G3 P3Q 03 at 19 weeks l day with a past medical history of narcolepsy, anxiety, and PTSD and a past obstetric history of twins and previous cesarean deliveries x 2 presents as a request from Dr. XXXX for maternal fetal medicine consultation, evaluation, and fetal anatomic ultrasound secondary to a recent ultrasound finding of fetal arrhythmia. The patient has not had maternal serum or celi free fetal DNA screening. The patient is a smoker. The patient reports she smokes 10 cigarettes per day. The patient reports she drinks 1-2 cups of caffeinated coffee per day. The patient also reports she has taken Nuvigil (a narcolepsy medication) approximately 2 days ago. The patient denies consumption of chocolate. The patient has a history of anxiety and PTSD. The patient is currently taking Lexapro 10 mg once daily and Klonopin 1 mg as needed. The patient has been taking these medications for 6 years. The patient is not currently seeing a counselor or psychiatrist. The patient denies any suicidal or homicidal ideations. The patient reports she was diagnosed with a form of Narcolepsy on 2005 by a sleep study by Dr Little in Fayetteville, AR. The patient was taking Nuvigil 250 mg daily for treatment of the narcolepsy prior to pregnancy. When the patient became pregnant she row takes the Nuvigil 125 mg as needed. The patient does not have follow-up with Dr. XXXX scheduled. The patient denies vaginal bleeding, leaking fluid, vaginal discharge changes, cramping, or contractions. The patient is feeling fetal movements. **Problems:** Complication related to pregnancy Suspected damage to fetus from maternal drug use Abnormal fetal heart rate Multigravida of advanced maternal age **Assessment/plan**: 1. Abnormal fetal heart rate Ultrasound, fetal survey, OB fetal maternal evaluation Pediatric cardiology referral Sjogren antibody panel ANA	139–145

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		2. Multigravida of advanced maternal age 3. Complication related to pregnancy 4. Suspected damage to fetus from maternal drug use **Discussion notes:** The patient had a fetal anatomic ultrasound was performed today. There is appropriate fetal growth. The 4 chamber view of the heart and outflow tracts, LVOT and AO/PA, appear normal. The fetal heart has an irregular rate and rhythm. M-mode echocardiography was performed. My best assessment is that this fetal arrhythmia is blocked atrial trigeminy. There are no signs of fetal hydrops. The visualized fetal anatomy appears normal. There are no markers of fetal aneuploidy visualized on ultrasound today. The AFI appears subjectively normal. **Advanced maternal age**: Patient was counseled about association between advanced maternal age and the increased risk of fetal aneuploidy. The patient declines cell free fetal DNA screening today. The patient was offered an amniocentesis for FISH and fetal karyotype; however the patient declines genetic amniocentesis today. **Fetal arrhythmia – blocked atrial trigeminy:** I plan to check the following labs on the patient: ANA, anti-SSA & SSB antibodies, in the absence of evidence of heart failure, such as fluid collections in the pleural or pericardial space or abdomen, routine follow-up visits should be adequate. I recommend that there be on evaluation of fetal cardiac anatomy by a pediatric cardiologist, I also recommend a decrease in maternal consumption of stimulants such as caffeine, chocolate, smoking, or ephedrine- containing products. **Medication use in pregnancy**: The patient was counseled about psychiatric disorders during pregnancy. I encouraged the patient to continue seeing her psychiatrist during the pregnancy and to stay on her current medications. I counseled the patient that her benefit of taking psychiatric medications during pregnancy far surpasses any risks associated with any of the medications. Some commentators have suggested that patients with severe debilitating psychiatric illness should be maintained on this and similar agents, if effective, because the benefits to the mother are compelling. Clonazepam - Respiratory distress, cyanosis, hypotonia, and other transient abnormalities of neonatal adaptation have been reported in infants of women who were treated with clonazepam at the time of delivery. Such problems may be more frequent among the children of women who take a selective serotonin release Inhibitor as well os Clonazepam at the time of delivery. The risk of transient neonatal	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		complications correlated more strongly with maternal levels of anxiety and depression at study entrance during pregnancy rather than with presence or absence of clonazepam in women treated with a serotonin reuptake inhibitor with or without Clonazepam. I counseled the patient to discontinue taking Clonazepam during pregnancy as Benzodiazepine use during the third trimester may be associated with neonatal withdrawal. **Plan**: The patient declined cell free fetal DNA screening and an amniocentesis for FISH, fetal karyotype, and fetal microarray today. I plan to follow this fetus with serial ultrasounds in order to rule out fetal hydrops. I will schedule the patient for a consultation with Pediatric Cardiology for fetal echocardiogram. I recommend that the patient quit smoking. If the patient requires Psychiatry care during pregnancy, there is a Psychiatrist at UAMS in Little Rock, AR who has special interest in psychiatric disease in pregnancy. Follow-up for limited fetal ultrasound in 2 weeks	
01/24/YYYY	Hospital/Provider Name	**Referral report:** As you recall, patient advanced maternal age G3 P3003 at 19+ weeks with a past medical history of narcolepsy, anxiety, and PTSD and a past obstetric history of twins and previous cesarean deliveries x 2 has labs drawn secondary to a fetal arrhythmia. I diagnosed the fetal arrhythmia as blocked atrial trigeminy. I ordered the following labs on the patient: ANA and anti-SSA & SSB antibodies. The patient's labs have returned negative. The patient is not at risk for fetal heart block secondary to autoimmune disease. The patient will be scheduled for a consultation with Pediatric Cardiology for a fetal echocardiogram. I will continue to evaluate the fetus by serial ultrasound. I have scheduled the patient for a repeat fetal ultrasound in 2 weeks.	146
02/09/YYYY	Hospital/Provider Name	**Ultrasound of second/third trimester:** **Indication:** Limited ultrasound to rule out fetal hydrops. AMA. Fetal arrhythmia: Frequent blocked atrial trigeminy. Medication exposure. **History:** Ob history. Gravida: 3. Para: 3. **General evaluation:** Cardiac activity: Present. FHR 134 bpm. Fetal movements: Seen. Presentation: Breech. Placenta: Placental site: Anterior. Umbilical cord: Cord vessels: Normal, 3 vessel cord. Amniotic fluid: Amount of AF: Normal amount.	828–829

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<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Impression:
There is a viable singleton fetus, intrauterine pregnancy at 21 week 6 days with appropriate measurements for gestational age.
The 4 chamber view of the heart appears grossly normal. The far majority of the fetal heart displays a regular rate and rhythm. M mode echocardiography was performed to visualize the fetal heart rate. There are rare occurrences of fetal PACs.
There are no signs of fetal hydrops.
The AFI appears subjectively normal.
The fetal presentation Is in a breech position.
The placenta is located anteriorly and there is no placenta previa present.
There is a clear plane visualized between the placenta and uterine wall and bladder wall. There are no areas of hypervascularity or lacunae visualized.
There are no signs of an invasive placentation.
The uterus appears to be arcuate or have a minor septum.

Follow-up:
The patient declines cell free fetal DNA screening and an amniocentesis for FISH, fetal karyotype, and fetal microarray. The patient had labs drawn for: ANA, anti-SSA & SSB antibodies which returned negative.

I reassured the patient that the fetal HR appears better today (resolving). I recommend that the patient stop consuming caffeinated beverages and stop smoking. I have scheduled the patient for afetal growth ultrasound in 2 weeks.</td><td></td></tr>
<tr><td>02/09/YYYY</td><td>Hospital/Provider Name</td><td>Follow-up visit:

History of present illness:
Patient advanced maternal age G3 P3003 at 21 weeks 6 days with a past medical history of narcolepsy, anxiety, and PTSD and a past obstetric history of twins and previous cesarean deliveries x 2 presents for a limited fetal ultrasound in order to rule out fetal hydrops secondary to a frequent fetal arrhythmia (blocked atrial trigeminy). The patient has not had maternal serum or cell free fetal DNA screening.

The patient is a smoker. The patient reports she smokes 10 cigarettes per day. The patient reports she drinks 1-2 cups of caffeinated coffee per day. The patient also reports she has taken Nuvigil (a narcolepsy medication) approximately 2 days ago. The patient denies consumption of chocolate.

The patient has a history of anxiety and PTSD. The patient is currently taking Lexapro 10 mg daily and Klonopin 1 mg as needed. The patient has been taking these medications for 6 years. The patient is not currently seeing a counselor or psychiatrist. The patient denies any suicidal or homicidal ideations.</td><td>134–138</td></tr>
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient reports she was diagnosed with a form of Narcolepsy on 2005 by a sleep study by Dr. XXXX in City, State. The patient was taking Nuvigil 250 mg daily for treatment of the narcolepsy prior to pregnancy. When the patient became pregnant she now takes the Nuvigil 125 mg as needed. The patient does not have follow-up with Dr. XXXX scheduled. **Review of systems**: Pre-eclampsia. **Assessment/plan:** 1. Suspected damage to fetus from maternal drug use 2. Multigravida of advanced maternal age 3. Complication related to pregnancy 4. Abnormal fetal heart rate Ultrasound, Ob limited **Discussion notes**: The patient had a limited fetal ultrasound was performed today. The 4 chamber view of the heart appears normal. During the ultrasound today, the majority of the fetal heart rate was in a regular rate and rhythm. M mode echocardiography was performed. I did not visualize blocked atrial trigeminy today. There were rare instances of fetal PACs (Premature Atrial Complexes) occurring. There are no signs of fetal hydrops. The AFI measures normal. The Doppler measurements of the fetal vessels measure normal. The patient had a fetal anatomic ultrasound performed today. The visualized fetal anatomy appears normal. There are no markers of fetal aneuploidy visualized on ultrasound today. Patient declines cell free fetal DNA screening and genetic amniocentesis today. Fetal arrhythmia – blocked atrial trigeminy (resolving): Recommended evaluation of fetal cardiac anatomy by a pediatric cardiologist. I also recommended a decrease in maternal consumption of stimulants such as caffeine, chocolate, smoking or Ephedrine-containing products. Medication use in pregnancy – counseled patient to discontinue Clonazepam during pregnancy as Benzodiazepine use during pregnancy, the third trimester may be associated with neonatal withdrawal. **Plan**: The patient previously declined cell free fetal DNA screening and an amniocentesis for FISH, fetal karyotype and fetal microarray. I reassured the patient that the fetal arrhythmia is vastly improved. I recommend that the patient quit smoking. If the patient requires psychiatric care during pregnancy, there is a psychiatrist at UAMS in Little Rock, AR who has a special interest in psychiatric disease in pregnancy. Return to office: XXXX, M.D. for follow-up at MFM Maternal Fetal	

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Medicine Center on 02/23/YYYY at 09:00 a.m.	
02/25/YYYY	Hospital/Provider Name	**Ultrasound of second/third trimester:** **Indication:** Follow-up evaluation for fetal growth. AMA. Fetal arrhythmia: Frequent blocked atrial trigeminy. Medication exposure. **History**: OB history. Gravida: 3. Para: 3. **Pregnancy:** Singleton pregnancy. Number or fetuses: 1 **General evaluation:** Cardiac activity: Present. FHR 136 bpm. Fetal movements: Visualized Presentation: Cephalic. Placenta: Placental site: Anterior. Umbilical cord: Cord vessels: 3 vessel cord. Amniotic fluid: Amount of AF: Normal amount. MVP 5.2 cm. AFI 15.3 cm. Q1 2.7 cm, Q2 4.6 cm, Q3 5.2. cm, Q4 2.7 cm. **Impression:** There is a viable singleton fetus, intrauterine pregnancy at 24 weeks 1 day with appropriate interval fetal growth at the, 65th percentile for EGA. The 4 chamber view of the heart and outflow tracts, LVOT and AO/Pa, appear normal. M mode echocardiography was utilized to demonstrate normal sinus rate and rhythm. Visualized fetal anatomy appears normal or was previously visualized as appearing normal on a prior ultrasound. The AFI measures normal at 15.3 cm. Thr. Dopplers of the fetal umbilical artery S/D ratio measure normal at 3.53 (upper limits of normal is 4.25 for EGA). Then is no absence or reversal of end diastolic blood flow noted in the fetal umbilical artery. The Dopplers of the fetal ductus venosus a wave measure normal. There is no absence or reversal of end diastolic blood flow noted in the fetal ductus venosus. The fetal presentation is in a cephalic position. The placenta is located anteriorly and there is no placenta previa present. **Follow-up:** The patient previously declined cell free fetal DNA screening and an amniocentesis for FISH, fetal karyotype, and fetal microarray. The patient had labs drawn for: ANA, anti-SSA & SSB antibodies which returned negative. I reassured the patient that the fetal HR is in a normal sinus rate and rhythm. I recommend that the patient stop consuming caffeinated beverages and stop smoking. I recommend that the prolonged auscultation of the FHR be performed by Doppler at OB clinic visits. Please refer the	835–837

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		patient back to me if the fetus re-develops a frequent arrhythmia or a tachyarrhythmia.	
02/25/YYYY	Hospital/Provider Name	**Follow-up visit**: **History of present illness:** Follow-up, patient advanced maternal age G3 P3003 at 24 weeks 1 days with a past medical history of narcolepsy, anxiety and PTSD and a past obstetric history of twins and previous cesarean deliveries x 2 and a current obsteric history of frequent fetal arrhythmia (blocked atrial trigeminy) presents for a fetal growth ultrasound. The patient has not had maternal serum or cell free fetal DNA screening. Patient reports she smokes 10 cigarettes per day and drinks 1-2 cups of caffeinated coffee per day. She also reports taking Nuvigil approximately 2 days ago. Currently taking Lexapro 10 mg daily, weaned off Klonopin 1 mg as needed. Has been taking medications for 6 years. Patient is not currently seeing a counselor or psychiatrist. Patient is feeling good fetal movements. **Review of systems**: + fetal movements. **Assessment/plan:** 1. Suspected damage to fetus from maternal drug use 2. Multigravida of advanced maternal age 3. Complication related to pregnancy 4. Abnormal fetal heart rate 5. Maternal tobacco use **Discussion notes**: Fetal growth ultrasound today showed appropriate fetal growth. I did not visualize any fetal arrhythmia or blocked atrial trigeminy today. No signs of fetal hydrops. **Plan**: The patient previously declined cell free fetal DNA screening and an amniocentesis for FISH, fetal karyotype and fetal microarray. ANA, anti-SSA and SSB bodies negative. I reassured the patient that the fetal heart rate is in a normal sinus rate and rhythm. Follow-up as needed.	129–133
04/21/YYYY	Hospital/Provider Name	**Follow-up visit:** **History of present illness:** Patient present today for testing. **Assessment:** Pregnant	843

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: **Orders**: 1-hour GTT (Glucose Tolerance Test).	
04/21/YYYY	Hospital/Provider Name	**Work status report:** **To whom it may concern:** This is to certify that patient is currently under the professional care of XXXX M.D. She has been unable to work since 01/20/YYYY due to complications with pregnancy.	844
11/04/YYYY-04/21/YYYY	Hospital/Provider Name	**Prenatal flow sheet:** **11/04/YYYY:** Gestation weeks: 8. **12/16/YYYY:** Gestation weeks: 14. Fetal heart rate 153. Fetal movement-Positive. **01/20/YYYY:** Gestation weeks: 19. Position-Transverse. Fetal heart rate positive. **04/21/YYYY:** Gestation weeks: 32. Fetal heart rate 145 bpm. Fetal movement-Positive. Patient was seen in January. She has been out of work since that time. 1 hour PG today. Schedule repeat cesarean section and bilateral tubal ligation. Note for work.	399
05/06/YYYY	Hospital/Provider Name	**Triage report:** **Time:** @1730 hrs. **Acuity:** 4. **Mode of arrival:** Private vehicle, walking. **Triage note:** 37-year-old G3 P3, EDC (Estimated Date of Confinement) 06/16, gestation age 35.4, comes into ER with complains of abdominal pain that started around 1730 hrs that is constant with no relief. **Vitals:** BP 129/71, PR 118 bpm, RR 20, Spo2 99%, pain level at rest 6/10. **Active problems:** Abdominal pain in pregnancy. Anxiety. Post-traumatic stress disorder.	105–107
05/06/YYYY	Hospital/Provider Name	**ER visit:** **Associated diagnosis:** Discomfort, abdominal pain complicating pregnancy. **History of present illness:** The patient presents with pelvic pain, not leaking fluid and not decreased fetal movement.	101–105

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The onset was today. The course/duration of symptoms is fluctuating in intensity. Pregnancy status-Gravida 3, 35.4 weeks. Estimated date of confinement-06/16/YYYY at Park Hill Clinic. Contractions: 3-minutes apart lasting 30 seconds Fetal movement: Present. Character of pain: Location: Bilateral and pelvic crampy. Bleeding: None, not passing tissue not passing clots. The exacerbating factor is none. The relieving factor is none. Therapy today: See nurses notes. Associated symptoms: Denies dysuria, denies edema, denies nausea and denies vomiting. Additional history: Patient reports having an appointment in clinic tomorrow with Dr. XXXX. **Review of systems:** Eye: Vision unchanged. **Physical examination:** General: Alert, anxious, intermittently breathing through contractions; tearful initially upon exam asking for pain medication repeatedly; patient is resting quietly when no one present in room. Gastrointestinal: Soft, normal bowel sounds, gravid, patient complain of pain initially upon palpation but not when distracted thereafter. **Medical decision making:** **Differential diagnosis:** Labor, false labor, discomforts of pregnancy, round ligament pain. **Re-examination/re-evaluation:** **Course:** Improving. **Notes:** The patient is sitting up in bed; loved one at bedside. FHT's: Reactive. TOCO: Positive irregular contractions, positive uterine irritability. Warm compresses to low pelvis for comfort. IV Fluids and Demerol/Phenergan given. Cervix with no change per repeat nurse exam. Patient is discharged home with ER/PT Labor precautions. Patient is encouraged to keep her clinic appointment tomorrow, unless she goes into labor first at which time she should return to the ER.	

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Diagnosis: Discomfort. Abdominal pain complicating pregnancy. **Calls-consult:** XXXX, M.D. Recommended Demerol 50mg/Phenergan 25mg then ok to discharge home. **Plan:** **Condition:** Improved, stable. **Disposition:** Medically cleared. Discharged at 2210 hrs to home/self-care. **Rx:** Vistaril 25mg 1 to 2 thrice daily as needed for anxiety, Promethazine 25mg every 4 hours as needed for nausea/vomiting. Patient was given the following educational materials: Abdominal pain during pregnancy, easy-to-read, preterm labor information, and easy-to-read. **Limitations:** No heavy lifting, no sexual intercourse. **Follow up with:** Joel Jones within 1 to 2 days; return to ER if symptoms worsen within 1 to 2 days; Paige Partridge within 1 to 2 days; please keep appointment tomorrow as scheduled. **Counseled:** Patient, family, regarding diagnosis, regarding diagnostic results, regarding treatment plan, regarding prescription, patient indicated understanding of instructions.	
05/06/YYYY	**Obstetrics triage:** **Facility:** Hospital/Provider Name **@1951 hrs:** **Uterine activity:** Monitor mode: External Frequency: Uterine irritability noted. Palpated 1951 hrs soft-non-tender. Resting tone Toco: Relaxed **Fetal assessment A:** Mode: External ultrasound FHR baseline: 125 bpm Variability: Moderate 6-25 bpm Accelerations: 10 x 10, FHTs noted in 160s Decelerations: None		111-115

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pain: 6-7/10, constant, stabbing, located at abdomen. Patient claims to belly button down. Patient positioned for comfort sitting high fowlers and hot packs provided along with extra pillows. **Vaginal exam:** Dilation: Closed Effacement: Thick **Exam by:** XXXX. **Annotation:** Small bloody show noted on exam glove. **Membrane status:** Intact. **@YYYY hrs:** RN at bedside; RN reviewed strip. Annotation: Medicated per MAR. Patient complains of pain 6-7 in abdomen. Plan of care discussed on pain and side rails placed. **@2035 hrs:** IV started; IV bolus started; labs drawn with IV start; IV infusing per order. 18g x 1 attempt in left hand. *(XXXX)* **@2050 hrs:** Dr. XXXX updated on patient contractions/SVE/complaints/Vitals stable; orders for pain management at this time. *(XXXX)* **@2100 hrs:** **Uterine activity:** Monitor mode: External Frequency: 1.5-9 per min Annotation: Uterine irritability noted Quality: Mild Resting tone Toco: Relaxed **Fetal assessment A:** Mode: External ultrasound FHR baseline: 130 bpm Annotation: Baseline change to 140 at 2006 hrs Variability: Moderate 6-25 bpm Accelerations: Prolonged. Decelerations: None *(XXXX)* **@2201 hrs:** **Vaginal exam:** Dilations: Closed. Vaginal bleeding: Normal show	

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Cervix, consistency: Firm Cervix position, posterior *(XXXX)* **@2203 hrs:** **Uterine activity:** Monitor mode: External Frequency: 1.5-5 Uterine irritability noted. Patient claims they are getting better but still complains of pulling. Duration: 50-100 Quality: Mild Resting tone Toco: Relaxed **Fetal assessment A:** Mode: External ultrasound FHR baseline: 125-130 bpm Variability: Moderate 6-25 bpm Accelerations: 15 x 15 Decelerations: None *(XXXX)* **@2205 hrs:** IV discontinued with tip intact. Pressure applied with gauze. RN at bedside. Dr. XXXX on discharge instructions and possible prescriptions FOB at bedside supportive. *(XXXX)* **@2222 hrs:** Discharge teaching given to patient and FOB with VU. Prescriptions given with VU. No questions or concerns at this time. No distress noted. *(XXXX)* **@2224 hrs:** Patient discharged home ambulatory to private car with FOB at side supportive. Patient gait steady with her slumped over holding abdominal while walking. *(XXXX)*		
05/07/YYYY	Hospital/Provider Name	**Triage report:** **Time seen:** @1113 hrs. **Acuity:** 3. **Mode of arrival:** Wheelchair. **Triage note:** Patient was brought to ER in wheelchair as outpatient for lower abdominal pain. Gestational age 34-weeks. Patient shown to bay 7. **Vitals:** BP 129/64, PR 112 bpm, RR 19, Spo2 96%, pain level 10/10. ER pulse method: Peripheral pulse. ER sepsis criteria: Tachycardia > 9. **Assessment:** Orientation: Oriented x 4. Affect/behavior: Agitated.	294–298
05/07/YYYY	Hospital/Provider	**@1742 hrs: ER progress notes:**	302–303

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	Called to patient's bedside in the ER at approximately 1620 hrs to write prescription for Flexeril per Dr. XXXX. Patient was to be discharged to home. I received report from patient's nurse, Melissa, indicating that patient was refusing all sterile vaginal exams and external fetal monitoring. She allowed Melissa to perform vaginal exam upon arrival to triage, but refused any exams thereafter. She complains of pain and requested pain medication on multiple occasions, but would not allow us to monitor fetal heart rate or assess for labor. I spoke with Dr. XXXX earlier in the day who informed me that the patient was seen in clinic today by Dr. XXXX and sent to triage to rule out labor. She also refused a vaginal exam in the clinic. After discussing the case with Melissa, I spoke to the patient regarding the importance of vaginal exams and fetal monitoring. She continued to complain of pain and initially refused my requests because she said she did not want to lie back and the exam "would make her feel worse." Melissa and I explained that the pain she was feeling may be related to contractions, but we could not assess for labor or contraction pattern without examining and monitoring her. Patient eventually consented to vaginal exam after several minutes of discussion. Cervix was FT and posterior. We then requested to doppler FHTs which she refused initially, but ultimately obliged. Per Melissa, FHTs earlier in the day were in the 150s. We were unable to doppler fetal heart tones after several attempts, so I ordered a STAT Biophysical Profile ultrasound. Ultrasound tech was called in at that time. I then paged Dr. XXXX to update him. Immediately after the phone call, I returned to the ER where the ultrasound technician requested me at bedside and informed me that fetal heart rate was 85 and there was visible blood and fluid. Dr. XXXX and Dr. XXXX simultaneously called triage for an update, I updated them of the findings and a STAT cesarean section was called. Patient's spouse asked if everything was okay. I explained that we would need to do an emergent cesarean section due to fetal bradycardia and evidence of abruption or uterine rupture. The patient then yelled out and demanded something for pain. My response was "I don't think you are hearing me. Something is wrong with your baby. That's why you are in pain. Do you understand me questionable, After the cesarean section, we will give you pain medication. Until then, we are more concerned about your baby." She verbalized understanding at that point. IV access was immediately established and pt was taken to the OR at 1730 hrs. Dr. XXXX and Dr. XXXX then met us in the OR and proceeded with the case.	
05/07/YYYY	Hospital/Provider Name	**@1748 hrs: Ultrasound fetal biophysical profile without Non-STR:** **History:** Decreased fetal heart tones. **Technique:** Limited imaging was performed for biophysical profile. However, the examination was terminated prematurely secondary to fetal bradycardia of 85 beats per minute. Physician was present during the examination and chose to terminate the examination.	430

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings: There is a single live intrauterine pregnancy cephalic in presentation. Fetal heart tones are bradycardic at 85 beats per minute. Placenta is anterior in location. Fetal age cannot be determined due to inadequate images. **Impression:** Prematurely terminated biophysical profile examination secondary to fetal bradycardia requiring emergent cesarean section.	
05/07/YYYY	**Labor and delivery flow sheet:** **Facility:** Hospital/Provider Name **@1113 hrs:** Patient brought to ER in private vehicle as outpatient from Park Hill clinic Bentonville. GA 34.2. Diagnosis: Lower abdominal pain. Patient shown to bay 7. Patient refuses help with gown or help into bed from wheelchair. Patient states she refuses vaginal exam until pain is controlled. *(XXXX)* **@1116 hrs:** **Uterine activity:** **Contraction comments:** Abdomen firm, then soft. RN reviewed fetal monitor strip from clinic and from last night, both which showed contractions. **Fetal assessment A:** **Comments:** Patient refuses fetal monitoring at this time. *(XXXX)* **@1129 hrs:** **BP:** 129/64/90, PR 112 bpm. **Fetal assessment A:** Patient states she refuses fetal monitoring at this time "until I get something for pain." Patient reports she cannot tolerate the position needed for fetal monitoring or the EFM belt. *(XXXX)* **@1133 hrs:** Dr. XXXX notified of patient's status, patient's refusal for fetal monitoring, refusal of vaginal exam and patient's request for pain medication. Dr. XXXX updated on patient. States he will see her right after the current surgery case. *(XXXX)* **@1139 hrs:** Patient declines hot packs for pain stating, "they didn't help last night." *(XXXX)* **@1152 hrs:** **Fetal assessment A:** External fetal monitor attempted with patient in high fowler. Maternal heart rate recorded on fetal monitor. Patient declines to rest in low fowler and monitor will not pick up fetal heart rate in high fowler. Maternal heart rate verified with pulse oximeter. Patient position/activity: High Fowlers *(XXXX)* **@1159 hrs:** BP 117/82/95, PR 115 bpm *(XXXX)* **@1204 hrs:** **Fetal assessment A:**		337-353, 379-385

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Fetal heart rate baseline: 150 bpm. **Comments:** With variability as assessed by Doppler with patient in high fowlers *(XXXX)* **@1214 hrs:** BP 114/79/92, PR 121 bpm *(XXXX)* **@1229 hrs:** BP 113/78/91, PR 111 bpm *(XXXX)* **@1244 hrs:** BP 116/66/85, PR 122 bpm. Patient occasionally moans softly. Patient's face has sweat on it. Faces pain scale 8/10. *(XXXX)* **@1248 hrs:** **Fetal assessment A:** Patient still declines to be repositioned from high fowlers to allow for fetal monitoring. Continues fetal heart rate recording turned off. *(XXXX)* **@1251 hrs:** Dr. XXXX at bedside. Patient moaned loudly and gripped MD's arm when he entered triage bay 7. *(XXXX)* **@1259 hrs:** BP 119/61/88, PR 122 bpm. *(XXXX)* **@1300 hrs:** Liver function labs and medication per MAR *(XXXX)* **@1310 hrs:** Pain medication given annotation: Per MAR. *(XXXX)* **@1314 hrs:** BP 120/61/87, PR 118 bpm. *(XXXX)* **@1340 hrs:** Patient reports pain 9/10 with re-evaluation and states "I still can't move." Patient refuses to reposition for monitoring. *(XXXX)* **@1402 hrs:** Lab blood analyzer malfunctioned, and blood samples must be sent to Springdale. ETA of results 1.5-2 hours. Dr. XXXX paged to notify *(XXXX)* **@1412 hrs:** Dr. XXXX paged and returned call. MD notified of patient pain, maternal heart rate by Doppler since patient refused monitoring, delayed labs. No new orders received. Will wait for lab results. *(XXXX)* **@1429 hrs:** BP 97/64/76, PR 127 bpm. *(XXXX)* **@1444 hrs:** BP 99/70/80, PR 129 bpm *(XXXX)* **@1459 hrs:** BP 104/69/82, PR 126 bpm. *(XXXX)* **@1514 hrs:** BP 105/69/81, PR 125 bpm *(XXXX)* **@1529 hrs:** BP 112/58/78, PR 129 bpm *(XXXX)* **@1540 hrs:** Lab results available. Dr. XXXX paged. *(XXXX)*		

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		@1545 hrs: Dr. XXXX returned page. Patient's pain concern reported. VTD-may give patient 2 Percocet before discharge, then discharge home. *(XXXX)* **@1549 hrs:** 2 Percocet given per MAR *(XXXX)* **@1604 hrs:** Patient given 2 Percocet, then states she will not leave until she is prescribed something for pain *(XXXX)* **@1609 hrs:** Dr. XXXX paged and returned page. He states patient may have a prescription for Flexeril and have Dr. XXXX write the Rx *(XXXX)* **@1610 hrs:** Patient states Flexeril is not sufficient and she will refuse to leave if that is all she is prescribed. *(XXXX)* **@1625 hrs:** Dr. XXXX and XXXXris RN at bedside discussing options and limitations with patient including risks of leaving hospital without reassessing fetus and labor status. Patient agreed to SVE to rule out labor and agreed to assessment and fetal heart tones. *(XXXX)* **@1632 hrs:** Contraction comments: Abdomen firm. Doppler of heart tones is inconclusive maternal heart tones very clear by auscultation of abdomen. Other heart tones heard sporadically, once slower than maternal heart rate, then faster than maternal heart rate. This is over approximately 10 minutes of auscultating by *XXXX*. *(XXXX)* **Vaginal exam:** Dilations: FT Effacement: 0 Station: -4 Membrane status: Intact Exam by: Fitzmorris **@1650 hrs:** Dr. XXXX ordered STAT BPP ultrasound since auscultation of heart tones is inconclusive. *(XXXX)* **@1714 hrs:** Ultrasound at bedside. *(XXXX)* **@1725 hrs:** Dr. XXXX called ER for update on patient. While ultrasound taking place. Ultrasound tech reports fetal HR in 80s. This is reported to Dr. XXXX. Stat cesarean section called. By phone by Dr. XXXX. *(XXXX)* **@1727 hrs:** IV started by Alexander Brand, labs drawn. Charge nurse *XXXX*, RN at bedside. *(XXXX)* **@1729 hrs:** Patient taken to OR for stat cesarean section. Patient verbally consents to the surgery. **@1730 hrs:** Patient is OR and transferred to OR bed with assistance. (*XXXX)*	

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		@1731 hrs: External ultrasound. FHR baseline 124. Verified by patient fetal radial PR 135 bpm. K. Mason aware of FHT. *(XXXX)* **@1732 hrs:** Ob triage response called by Debbie Rodgers RNC-Director to OR room 1. *(XXXX)*	
05/07/YYYY	Hospital/Provider Name	**Operative report:** **Pre-operative diagnoses:** I was called emergently for a patient who was taken to the OR with fetal heart tones in the 80s with severe abdominal and back pain. **Post-operative diagnoses:** 34-weeks intrauterine pregnancy with complete uterine dehiscence, large amount of hemoperitoneum. My partial part of the procedure was an emergent repeat cesarean section. The remainder following delivery of this surgery will be dictated by Dr. XXXX, her attending physician. **Anesthesia:** General endotracheal under rapid sequence, Dr. XXXX, anesthesiologist. **Findings:** Delivered a male infant at 1737 hours. Apgars were 0, 0 and at 18 minutes 1. **Findings:** The patient had a large hemoperitoneum and a complete uterine dehiscence with active bleeding. Delivered a male infant, at 1737 hours. **Operative report:** I was notified of an emergent situation where the patient had been taken to the OR with fetal heart tones in the 80s, her attending physician, was not immediately available in the hospital and I was requested to present to the operating room to begin emergent cesarean section for fetal distress in this woman who was approximately 34-weeks' gestation. Upon arriving in the OR, the patient was on the OR table. They began the preparation. Once she was prepped and draped. She underwent rapid sequence intubation per Dr. XXXX. Once cleared by Anesthesia, a Pfannenstiel skin incision was made 2 fingerbreadths above the symphysis, slightly above the old scar. This was carried down sharply to the level of the fascia which was incised transversely. The anterior fascia was dissected sharply and bluntly off the underlying rectus muscles. At this point, the peritoneum was readily available, and a hemoperitoneum could be readily identified. As a result, I went ahead and entered the peritoneum superiorly and extended bilaterally bluntly. Bladder blade was applied, and the patient was noted to have uterine rupture through the old scar and membranes present with active bleeding. Membranes were ruptured with clear fluid. The infant's head was immediately grasped and delivered. Nuchal cord was reduced. Body was delivered. Cord was	312–314, 304–310

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		doubly clamped, cut, and ligated. The infant was then handed to the awaiting nursery staff that began active resuscitative efforts with the assistance of the neonatal intensive care unit. Cord gases were obtained from one of the arteries of the umbilical cord. Cord blood was obtained from the umbilical vein. Uterus was delivered onto the abdominal wall, wrapped in a moistened lap sponge and placenta was expressed. At this point, Dr. XXXX presented and took over the remainder of the procedure. Completion of this procedure as well as estimated blood loss, sponge and needle counts, we will defer to the dictation by Dr. XXXX.	
05/07/YYYY	Hospital/Provider Name	**Operative report:** **Pre-operative note:** She is a XX-year-old, gravida 3, para 2, Caucasian female, who was sent from *XXXX* Clinic with abdominal pain. The patient had presented to the ER at Willow Creek the night before, had been evaluated and sent home with what was felt to be preterm contractions. She re-presented to the clinic and was still complaining of contractions and pain. The patient denied bleeding, her cervical exam was unchanged. She was sent to the ER for further evaluation. Upon arrival to the ER, her vitals were stable. She was afebrile. She was complaining of diffuse pain and in her abdomen, specifically in the right upper quadrant as well as some pain that she stated was "shooting up her spine." She reported that she had no vaginal bleeding. Cervical exam again revealed no _ *(Left as blank)*. We had requested to monitor for contractions in the baby and she had that refused that repeatedly. However, the fetal heart tones were in the 120s on several occasions when she would allow it. On exam, she would only allow me to touch really in the right upper quadrant and did report pain there. I am suspicious of possible gallstones. At that point, liver function tests were ordered which were negative. She did receive some relief with IM Demerol and Phenergan as well as Flexeril which she had taken previously for back spasms. I explained her husband as well as her mother-in-law that we are unsure what was causing the pain, felt that it could be due to scar tissue and stretching from previous surgery but she did appear stable. I had no reason to believe that she is having an abruption. She has had no vaginal bleeding and her vitals were stable. However, prior to discharge, review of the monitor strip the night before the infant had appeared to be reactive and so suspicion for an obstetrical complication was low on the left. However, prior to discharge, the nurse was unable to auscultate fetal heart tones on several attempts with some difficulty because of the patient's unwillingness to sit still for this. Therefore, a stat ultrasound was ordered which revealed heart tones in the 80s. The patient was then taken back for a STAT cesarean section. Fetal heart tones were in the 80s to 120s prior to incision. Dr. XXXX started the cesarean section and I will refer to his note for the operative procedure till the time just after delivery. **Operative note:** Upon entering the operating room, Dr. XXXX was delivering the infant. I gowned and gloved, and proceeded to assist with	310–312

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		the surgery. Apparently the patient had a complete uterine rupture at the previous hysterotomy site. The baby was not extruded and was still in situ nor was the placenta abrupted. After delivery of the infant, cord was clamped and cut and placenta was delivered. The hysterotomy was then sewn in a running, locking fashion with #1 chromic with good hemostasis. There was approximately 1500 cc of clotted blood noted in the paracolic gutters as well as around the diaphragm. This was all removed and irrigated. There appeared to be no bleeding from any other site. The uterus was returned to the abdominal cavity and the pelvis was once again irrigated. Appeared to be normal tubes and ovaries. It was elected not to perform a tubal ligation at time due to emergent nature of the cesarean section. The hysterotomy site was inspected once again with no bleeding noted after assuring hemostasis and thorough irrigation. The rectus muscles were re-approximated in the midline with 2-0 chromic figure-of-eight suture. The rectus fascia was then closed two-thirds of way with running 0-Vicryl and On-Q pain pump was then placed through a separate stab wound incision on the right, tunneled underneath rectus fascia overlying the rectus muscles. Remainder of the rectus fascia was then closed. The incision was irrigated. Hemostasis of the subcutaneous tissue was assured, and the skin was then closed with Insorb staples. A Dermabond was then placed on the skin as well as the site of the pain pump. Dressings were then applied. DIC screen was drawn intraoperatively though she did appear to be clotting well. The patient was extubated and taken to recovery room in stable condition. The infant was taken to the NICU after resuscitation was successful in obtaining a heart rate of 140s prior to departure to the NICU. Estimated blood loss was 600 cc during the surgery plus 1500 cc of clotted blood comprising the hemoperitoneum. Sponge and needle counts correct x 2, and the patient was taken to the recovery room in stable condition.	
05/07/YYYY	Hospital/Provider Name	**Neonatal admission summary:** *(Poor Photocopy)* **History of present illness:** This is a 34 2/7 weeks gestation, AGA, preterm male, delivered via slat cesarean section for severe fetal bradycardia with uterine rupture and suspected abruption. He is being transferred to NICU alter delivery for severe respiratory depression, hypoxic ischemic encephalopathy, birth depression, prematurity and suspected sepsis. **Maternal history:** Mother (Aleshia) is a 37-year-old G3 P2 A0 L3 (Now 4) single Caucasian woman. She is A positive; antibody negative; Rubella immune; VDRL non-reactive; HBsAg negative; HIV non-reactive; and GBS unknown. Site had adequate prenatal care. Medications during pregnancy include PNV. **Antenatal course:** Mother has received prenatal care since first trimester at 8-weeks. Her EDC of 06/16/YYYY was consistent with LMP 09/09/YYYY which places gestational age at 34 3/7 weeks at time of	1339–1343

Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		delivery. Her pregnancy was complicated by atrial trigeminy and fetal arrhythmia which resolved. She was then seen in clinic this morning for abdominal pain and was sent to ER at WCWH for evaluation. On arrival, she refused further evaluation and examination and FHT monitoring. Abdominal ultrasound however revealed acute abruptions and was emergently delivered by cesarean section. Infant had heart rate in the 80s prior to delivery. Rupture was membrane was at cesarean section. No maternal fever prior to delivery. **Resuscitation:** The delivery was attended by XXXX, and NICU team with RN and RT at WCWH. Infant was delivered by cesarean section under general anesthesia. Infant had no heart rate, apnea, blue and limp and lifeless. He was immediately dried and suctioned with no response. ET placement was attempted due to severe depression. There was copious amount of fluid in oropharynx making intubation difficult, ET was removed and PPV was continued with mask with adequate chest rise and breath sounds bilaterally100% FiO2.Chest compressions were begun as well at 1st min of life. No response noted. ET was then placed by 5 min of age and Epinephrine was given via ET x 2 with no response. UVC was then placed and 1% Epinephrine was given at IS min followed by NS bolus 30ml. I arrived at bedside by 17 min and was called as Baby was being delivered, I confirmed endotracheal tube placement with adequate chest rise and breathe sounds. Chest compressions were being continued throughout but no heart rate was audible. He received 2nd dose of IV Epinephrine and 15 mins followed by NS bolus at 20 min followed by heart rate noted on cardiac monitor above100, Chest compressions were discontinued and he was transferred to NICU for Neonatal intensive care, Fio2 weaned to 40%, Apgar scores were 0, 0, 0, 0 and 2. **Admission examination upon arrival to NICU:** **General:** Pre-term male infant, AGA, under warmer. Mottled, with pink and well-perfused on SIMV support. Vitals: Temp 33.0, HR 111/min, RR 45/min, BP 51/30 (37) mm of hg & Spo2 97%. **HEENT:** Normocephalic, sutures over riding and mobile. Anterior fontanelle open and flat. Patent nostrils. Normal set eyes and ears. Red reflex noted. **CV:** AP with RRR. Muffled heart sounds. No murmur. Brachial and femoral pulses +1/4 bilaterally with severely capillary delayed refill. Abdomen: 3-vessel cord UVC/UAC in place. Anal opening present and appears patent. GU: Tests palpable bilaterally in scrotum. Neurologic: Absent activity, unresponsive, pupils fixed and dilated.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Absent tone and absent reflexes including gag and corneals. **Labs:** **Chest X-ray:** 7 rib lung expansion; hazy lung field without air bronchogram, normal heart size and position, visible small bowel gas pattern, UVC tip at diaphragm at T7.UAC at T7. All bones intact. **Cord gas:** Unreportable results. **ABG at 1900 hrs:** 6.69/31/132/3.7/-33. **Admission diagnosis:** Severe birth depression Stage III HIE (Hypoxic Ischemic Encephalopathy) Pre-term 34 3/4, AGA male Respiratory depression Suspected sepsis Cesarean section delivery Maternal uterine rupture and abruption Severe cardiogenic shock Severe metabolic acidosis **NICU care plan:** **Respiratory:** NICU care with continues cardiac monitor and pulse oximetry. Begin SIMV (Synchronized Intermittent Mechanical Ventilation) support for respiratory depression. Consider Curosurf. Monitor blood gases every 2-4 hours. Follow ABG and chest X-ray closely. **Cardiovascular:** Monitor BP and perfusion closely. Start Inotropes if mean BP < 34 mm of hg. Obtain Echo tomorrow to assess function and pulmonary pressure, day of life #5. **ID:** Blood culture obtained in nursery. Commence with Ampicillin and Cefotaxime while culture pending. Follow blood culture results and serial CBCs with differential and CRPs. Administer Inotropes-Dobutamine and Dopamine to keep mean BP > 34 mm. **Hematology:** Monitor daily CBCs for first 3-days then weekly. Keep PLT count above 50k if no obvious clinical bleeding. Monitor daily coagulation profile and maintain fibrinogen > 150mg/dl. Transfuse PRBCs; uncross matched 10ml/kg over 1 hour. **FEN:** Begin TPN starter via UVC at 60ml/kg/day. Nil per oral for now. Monitor serum glucose closely until stabilizes then per routine and obtain daily electrolytes. Maintain glucose levels > 50mg/dl.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hyperbilirubinemia: Monitor total bilirubin daily x 3 days, starting in morning. Begin phototherapy if total bilirubin > 15mg/dl. **Neurologic:** Begin systemic hypothermia therapy to decrease temp to 33.5. Monitor for seizures. Neurology consult and EEG if possible in morning. Monitor clinically. Head ultrasound in morning and daily with Phenobarbital and Keppra. **Social:** Parents and grandparents were updated on infant's critical clinical condition, diagnosis, prognosis and plan of care including poor survival and high incidence of developmental impairment.	
05/07/YYYY	Hospital/Provider Name	**X-ray of chest:** **History:** Line placement. **Impression**: Mild RDS (Respiratory Distress Syndrome).	1555–1556
05/07/YYYY	Hospital/Provider Name	**Prenatal flow sheet:** **05/07/YYYY:** Gestation weeks: 34 2/7. Fetal heart rate 150 bpm. Fetal movement-Positive. Contractions positive. FT/10/-4. BP 120/68. Pain level 9/10. The patient is in severe pain was recommended to be sent back to WCMH for evaluation. Mother states she is driving her personally to WCWH. Patient seen in ER last night and discharged at 2300 hrs with no labor.	399
05/08/YYYY	Hospital/Provider Name	**@0921 hrs: X-ray of chest:** **History:** Respiratory distress syndrome. Endotracheal tube and umbilical catheters are unchanged in position. An EG catheter is well-positioned. A pH probe tip is at mid esophagus. Streaky and hazy densities persist throughout the lungs. There is a relative positive gas through the abdomen.	1555
05/08/YYYY	Hospital/Provider Name	**Cesarean section progress notes:** **Subjective:** Patient is very tearful this morning. The infant is in NICU and not doing well. We discussed starting antianxiety meds and she is in favor of this plan. We also discussed a blood transfusion with 2 units of blood which we will order. Will alert SHARE team. **Physical examination:** Abdomen: Uterus firm, incision clean and dry. Extremity: Trace edema. **Assessment/plan:** POD # 1 status post cesarean section for uterine rupture. Transfuse 2 units PRBC's Start Anxiolytics.	301–302

Medical Request

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
05/08/YYYY	Hospital/Provider Name	**NICU progress notes:** *(Poor photocopy)* **Interim history:** This is a 34 2/7 weeks gestation, AGA, pre-term male, delivered via stat cesarean section for severe fetal bradycardia with uterine rupture and suspected abruption. He is being transferred to NICU after delivery for severe respiratory depression, hypoxic ischemic encephalopathy, and birth depression, prematurity and suspected sepsis. He was born lifeless with no heart rate and needed prolonged resuscitation including PPV, chest compressions, and ET placement, Epinephrine x 4 via ET and IV and normal saline bolus x 2 with delayed heart rate recovery at 20 mins of life. He was admitted on SIMV support and was weaned to room air rapidly. He started to show spontaneous respirations by 2 hours of age and has severe hypoxic ischemic encephalopathy by exam. His cord pH was unrecordable and so was the first ABG but ABG at 1.5 hours showed severe metabolic acidosis. He progressed to severe cardiogenic shock and has required Dopamine at 20mcg, Dobutamine 20mcg and Epinephrine at 0.8 mcg/kg/min with volume expansion with normal saline 30 ml/kg, PRBCs x 10 ml/kg and FFP x 2 (15 ml/kg). He is also on stress dose Hydrocortisone. He has continued severe metabolic acidosis with partial respiratory compensation in spite of several NAHCO3 boluses overnight continued with severe widespread multi-system injury. His exam is consistent with severe stage III hypoxic ischemic encephalopathy. He was started on systemic hypothermia therapy with critic-cool blankets since admission. Brain EEG pattern is _ showing minimal brain activity. No seizures were noted. But he is loaded with Phenobarbital. **Overnight:** His vitals stable, but hypotension with poor perfusion under warmer. He remains on SIMV support overnight, 0.21 Fio2 within the first hour after NICU admission, no surfactant was required so far. Serial ABGs showed persistent severe metabolic acidosis with respiratory alkalosis in-spite of minimal ventilation support. Chest X-ray this morning showed 7 rid expansion with ET at T2, hazy lungs consistent with TTN, normal heart, gasless abdomen with ascites and UAC and UVC in good position. Current settings: SIMV 15/5, rate 20, Ti 0.4 sec, Pio2 0.21. He was made nil per oral since admission and is on starter TPN overnight with tube feed at 60ml/kg/day. Normal lytes and elevated glucose treated with insulin as needed. Elevated creatinine. A blood culture was sent on admission and he is on IV Ampicillin and Cefotaxime. No void overnights. **Plan:** Continue SIMV support; follow ABGs, chest X-ray indicated. Continue Inotropes; continue advancing TPN and start 1 liter with TF 40ml/kg/day, nil per oral for now. Continue IV antibiotics and follow blood culture, monitor serum lytes and glucose closely. Continue systemic hypothermic therapy. Monitor for seizure. Father and mother updated about current clinical condition, prognosis, and diagnosis care plan up to	1347–1351

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		date. Continue cardiorespiratory monitoring. **General:** Pre-term day of life #1. **Medications:** Ampicillin. Cefotaxime. **Steroids:** Hydrocortisone day #1. **CV:** Dopamine, Dobutamine, Epinephrine. **Neuro:** Phenobarbital. **Physical examination:** General: Infant resting under warmer wrapped in cooling blanket. Resp: On SIMV support with adequate chest wall rise on mechanical breath, good aeration throughout, breathing above the vent. Abdomen: Absent bowel sounds. UVC and UAC in place. Extremities: MAE with no limitation, generalized edema. Neuro: Unresponsive to pain with absent pupillary light and corneal and gag reflux, absent deep tendon reflexes, plantars absent, severe hypotonia with stiff extremities, absent activity. Skin: Pale, cold dry and intact. Ready recall, mottled extremities. **Fluids/lytes/nutrition:** Birth weight; 2661gms Lines: UAC/UVC. Arterial line fluids: 12 ml. TPN 82 ml/day. **Formula:** Nil per oral. **Assessment:** Receiving starter TPN via central UVC with residual restricted TF at 60 ml/kg/day, nil per oral overnight, stable lytes, elevated creatinine and glucose, given insulin x 4, no urine output. **Plan:** Continue advancing TPN and start 1 liter with restricted TF at 40ml/kg/day, nil per oral today. Monitor serum lytes and glucose monitor. **Resp:** **X-ray:** Questionable rib expansion and hazy lungs, normal heart size, absent bowel gas pattern, UVC up at T8, UAC tip at T7. **Assess:** Severe birth depression and poor inspiratory drive, on SIMV support, minimal lung disease, continued low CO2 with low support and normal resp rate. **Plan:** Continue SIMV support. Follow ABGs. Chest X-ray indicated. **Apnea/bradycardia/desaturation:** **Assessment:** No events on SIMV support. **Plan:** Monitor for events, continue current meds. **CV:** Hypotension. **Meds:** Dopamine at 20mcg/kg/min, Dobutamine 20mcg/kg/min Epinephrine at 0.8mcg/kg/min **Assess:** Low BP since admission, poor response to Dopamine,	

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		Dobutamine and Epinephrine in high doses, on stress Hydrocortisone, low cortisol level **Plan:** Monitor clinically, echo today to assess function, increase Epinephrine and wean Dopamine to renal doses, continue Dobutamine. **Infectious disease:** Suspected sepsis. Treatment in progress day #1 of 2-3. **Cultures pending:** Blood. **Assess:** blood cultures pending, receiving Ampicillin, Cefotaxime, CBC-mild left shift, normal CRP, GBS unknown. **Plan:** Follow blood culture, plan 5-7 days course of IV antibiotics if blood culture negative. **Jaundice:** Lateral LFTs 05/08-Abnormal. **Assessment:** Low total bilirubin overnight; elevated liver enzymes. **Plan:** Total bilirubin in morning. **Hematologic:** **Transfusion:** FFP x 2. **Assessment:** Normal HCT & Hgb at birth in spite of uterine rupture and apparent blood loss, given PRBCs, FFP x 2 overnight due to depleted fibrinogen from coagulopathy, declining platelet count on morning lab. **Plan:** CBC daily and coagulation profile daily, keep HCT > 35 and PLTs > 50. **Neurological:** Head ultrasound on 05/08 showed bilateral basal ganglia bleeds with elevated MVA right 0.96. sEEG on 04/07-flat aEEG, no seizure Eyes: No problems Ears: Screening-Pending **Assess:** Severe hypoxic ischemic encephalopathy with basal ganglia involvement and multi-system organ injury, unresponsive with absent reflexes, minimal pain activity, given PB (Phenobarbital) bolus overnight. **Plan:** Monitor clinically, Phenobarbital after 24-hours in maintenance dose, head ultrasound in morning, EEG in afternoon, if response to treatment. **Other:** Parents were told about severe involvement of all organs and severe brain injury with likely high mortality and almost certain severe morbidity with vegetative assistance. They were offered withdrawal of support. **Diagnosis:** Prematurity 34 3/7, AGA male Respiratory depression Severe hypoxic encephalopathy Cardiogenic shock	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nutritional support Metabolic acidosis Bilateral basal ganglia bleeds Suspected sepsis Renal failure Elevated liver enzymes	
05/08/YYYY	Hospital/Provider Name	**Echocardiogram:** **Indication:** Heart disease, patent ductus arteriosus, murmur. **Summary:** Left patent ductus arteriosus, left to right shunt, moderate. Patent ductus arteriosus peak gradient is 15 mm of hg. Right ventricular systolic pressure estimate 47.0 mm of hg. The PDA is moderate large with minimal restriction and accounts for the elevated RV pressure estimate suggesting systemic RV pressure. Small secundum systemic RV pressure. Left to right interatrial shunt. The left ventricle is borderline dilated. Normal left ventricular systolic function. Normal pulmonary veins. No pericardial effusion.	1375–1376
05/08/YYYY	Hospital/Provider Name	**Ultrasound echo of middle cerebral artery/encephalogram:** **History:** Pre-term birth depression. Bilateral echogenic foci are present in the basal ganglia. Largest on right measures 2.2 x 1.5 cm. Largest on left measures 2.3 x 1.5 cm. These are consistent with hemorrhages. Ventricles are normal. Right middle cerebral artery resistive indices are elevated averaging 0.95. **Impression:** 1. Bilateral basal ganglia hemorrhage. 2. Elevated resistive indices in the MCA (Mid-cerebral artery).	1557–1558
05/08/YYYY	Hospital/Provider Name	**Neonatal discharge summary:** *(Poor photocopy)* **GA:** 34 3/7 weeks. **Age:** 1 day. **CGA:** 34 4/7 weeks. **Chief complaint upon admission to the NICU:** This is a 34 2/7 weeks' gestation, AGA, pre-term male, delivered via stat cesarean section for severe fetal bradycardia with uterine rupture and suspected abruption. He is being transferred to NICU after delivery for severe respiratory depression, hypoxic ischemic encephalopathy, and birth depression, pre-maturity and suspected sepsis.	1332–1335

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Admission diagnosis: Sever birth depression Stage III hypoxic ischemic encephalopathy Pre-term 34 3/7, AGA male Respiratory depression Suspected sepsis Cesarean section delivery Maternal uterine rupture and abruption Severe cardiogenic shock Severe metabolic acidosis **Discharge diagnosis and cause of death:** Severe cardiogenic shock. Severe metabolic acidosis. Stage III hypoxic ischemic encephalopathy with minimal brain activity Bilateral basal ganglia hemorrhage Multi-system organ injury Renal failure Elevated liver enzymes Consumptive coagulopathy Sever birth depression Pre-term 34 3/7, AGA male Stress induced hyperglycemia Suspected sepsis **Consultations:** None. **Procedure in the hospital:** Echo, head ultrasound, SIM, UAC, UVC **APGARS:** 0, 0, 0 **Anthropometry:**	

	Birth (%)	Discharge (%)
Wight	2661 gms (75%)	2661 gms (75%)
Head circumference	32.5 cm (75%)	32.5 cm (75%)
Length	46 cm (50%)	46 cm (50%)

Past maternal medical history: Cesarean section x 2, tonsillectomy, post-traumatic stress disorder, generalized anxiety disorder, depression controlled with Lexapro, Clonazepam, Nuvigil and Buspirone.

Antenatal course: Mother has received prenatal care since first trimester at 8-weeks. Her EDC of 06/16/YYYY was consistent with LMP 09/09/YYYY which places gestational age at 34 3/7 weeks at time of delivery. Her pregnancy was complicated by atrial trigeminy and fetal arrhythmia which resolved. She was then seen in clinic this morning for

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		abdominal pain and was sent to ER at WCWH for evaluation. On arrival, she refused further evaluation and examination and FHT monitoring. Abdominal ultrasound however revealed acute abruptions and was emergently delivered by cesarean section. Infant had heart rate in the 80s prior to delivery. Rupture was membrane was at cesarean section. No maternal fever prior to delivery. **Resuscitation:** The delivery was attended by H. Newell, APN, and NICU team with RN and RT at WCWH. Infant was delivered by cesarean section under general anesthesia. Infant had no heart rate, apnea, blue and limp and lifeless. He was immediately dried and suctioned with no response. ET placement was attempted due to severe depression. There was copious amount of fluid in oropharynx making intubation difficult, ET was removed and PPV was continued with mask with adequate chest rise and breath sounds bilaterally100% Fio2.Chest compressions were begun as well at 1st min of life. No response noted. ET was then placed by 5 min of age and Epinephrine was given via ET x 2 with no response. UVC was then placed and 1% Epinephrine was given at IS min followed by NS bolus 30ml. I arrived at bedside by 17 min and was called as Baby was being delivered, I confirmed endotracheal tube placement with adequate chest rise and breathe sounds, Chest compressions were being continued throughout but no heart rate was audible. He received 2nd dose of IV Epinephrine and 15 mins followed by NS bolus at 20 min followed by heart rate noted on cardiac monitor above100, Chest compressions were discontinued and he was transferred to NICU for Neonatal intensive care, Fio2 weaned to 40%, Apgar scores were 0, 0, 0, 0 and 2. **Hospital course:** **Resp:** He was admitted on SIMV support due to sever birth depression and remained on low support and FIO2 with normal oxygenation. His chest X-ray on admission showed mild lung haziness consistent with TTN. ABGs showed persistent low PCO2 despite very low ventilator pressure and rate. There was not spontaneous hyperventilation. **CV:** Sever hypotension since admission that never responded to volume expansion with normal saline, NaHCO3, PRBCs, FFP followed by Dopamine (20mcg/kg/min), Dobutamine 20mcg/kg/min, Epinephrine drip 1mcg/kg/min and also stress doses Hydrocortisone. ABGs continued to show persistent sever metabolic acidosis. Severe delayed peripheral perfusion on admission that showed some improvement but appreciated during his hospitalization. His myocardial injury markers were severely elevated. Echo cardiogram done on 05/08/YYYY pending. **ID:** Blood culture remained negative. CBC/CRP was not suggestive of infection. He remained on antibiotics (Ampicillin and Cefotaxime) since admission.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		FEN: Upon admission to NICU he was initially nil per oral with D7.5 TPN. Fluids were resuscitated at 40 ml/kg/day. He manifested severe hyperglycemia and was treated with as needed insulin boluses. He had severe and persistent metabolic acidosis and elevated Creat during NICU stay. **Heme:** Stable Hgb/HCT throughout NICU stay. Coagulation profile showed consumptive coagulopathy with very low fibrinogen. He received PRBCs x 1, FFP x 2 blood products during this NICU stay. **GI:** Absent bowel sounds. No stool. **Endo:** State newborn screen sent on 05/08/YYYY prior to demise. **Bilirubin:** Mother's blood type was "O" positive and infant's blood type was "A" positive: DAT negative. No phototherapy needed during hospital stay. LFTs showed severe elevation of AST and ALT with normal direct bilirubin. **Urinary:** Severe oliguria since admission with no urine output. **Neuro:** Infant with abnormal neurological exam throughout his NICU stay consistent with severe stage III hypoxic ischemic encephalopathy. Severe hypotonia with absent brain stem reflexes and DTRs, unresponsive to pain, pupils dilated and fixed, absent gag and corneal reflex. Occasional spontaneous activity. No clinical seizures, aEEG showed flat background with occasional burst. No seizures. Head ultrasound showed elevated MCA resistive indices consistent with edema with bilateral basal ganglia bleeds. **Ophthal:** No concerns. **Social:** Mother and father were updated from time of birth regarding critical condition with severe injury to brain and multiple body organs with extremely high chance of mortality and severe neurologic morbidity. There were counseled about plan of care and prognosis. They were told about poor response to therapy so far. They were told about prolonged death and suffering from continued NICU care. They agreed to hold the baby and withdraw support which was recommended. There were no social problems noted during NICU stay. **Screening exams:** Hearing screening: N/A. Parent CPR trained: N/A. Car seat study: N/A. Newborn screen: 05/08/YYYY.	

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		Current meds: Ampicillin, Cefotaxime, Dopamine, Dobutamine, Epinephrine, Hydrocortisone, TPN, IL & NA Acetate Flush. **Discharge disposition:** He remained acidotic with hypotension, poor perfusion, and comatose stage until death. After infant was removed from the SIMV support at 2040 hrs, he was held by both parents. He passed away peacefully at 2200 hrs. He was pronounced dead on 05/08/YYYY at 2200 hrs.	
05/08/YYYY	Hospital/Provider Name	**Death certificate:** *(Poor photocopy)* **Name:** XXXX. **Date/time of death:** 05/08/YYYY at 2200 hrs **Cause of death:** Cardiogenic shock-29 hours Severe hypoxic ischemic encephalopathy-29 hours Renal failure-29 hours Consumptive coagulopathy-29 hours **Underlying cause:** Maternal uterine rupture.	1337
05/08/YYYY	Hospital/Provider Name	**Death certificate:** **Name:** XXXX. **Residence state or foreign country:** State. **County:** XXXX. **City or town:** XXXX. **Date/time of death:** 05/08/YYYY at 2200 hrs **Death occurred in hospital:** Inpatient. **Facility name:** XXXX. **City or town:** XXXX. **Place of disposition:** XXXX, Inc **Cause of death:** Cardiogenic shock, severe hypoxic ischemic encephalopathy, renal failure. **Manner of death:** Natural.	1326
05/09/YYYY	Hospital/Provider Name	**Discharge summary:** This is a post-partum day #2/discharge summary. The patient is status post emergent cesarean section with subsequent neonatal demise. **Subjective:** The patient is ambulating well. The patient denies nausea or vomiting. The patient is passing flatus. The patient is voiding well. The patient requests discharge. **History of present illness:** The patient is appropriately sad. The grief	240–246

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		process was discussed. The patient reports she has a history of anxiety, and she was started on Lexapro yesterday. She has used Lexapro in the past under the care of her primary care physician. In addition, she has used clonazepam in the past and requests a prescription for this. I discussed this with her and instead of Clonazepam; she will be provided prescriptions for Xanax. The patient denies thoughts of hurting herself or others. **Objective:** **Vital signs:** Stable. The patient is afebrile. Hemoglobin was 7.7 yesterday; the patient did not require transfusion. **Abdomen:** On exam, the abdomen is soft and nondistended. Bowel sounds are present. The fundus is firm and nontender. **Incision:** The incision is clean and dry. The ON-Q pump was removed. Extremities: Homans is negative. **Neurologic:** Mental status exam: The patient is alert and oriented x 3. The patient's mood is depressed. The patient's affect is sad. The patient denies suicidal or homicidal ideation. The patient denies psychotic thinking. The patient has normal memory recall. **Assessment:** Post-operative day #2/post-operative day #2 from emergent cesarean section with subsequent neonatal demise. **Plan:** 1. Dismissed. 2. The patient will follow up this week. 3. The patient is given prescription for Percocet #35; Ibuprofen 800 mg, #30; Lexapro 10 mg, #30; and Xanax 0.5 mg (One-half to one per oral in the evening as needed anxiety) #30. The patient was encouraged to call and be seen for any problems. The patient's husband will likely apply for FMLA through the next 10-days.	
05/11/YYYY	Hospital/Provider Name	**Pathology report (collected date: 05/07/YYYY):** **Final diagnosis:** **Placenta:** Placenta and tri-vascular umbilical cord showing focal prominent syncytial Knots and dystrophic calcification with focal blood and fibrin on maternal surface. **Comment:** This is compatible with disruption. Suggest clinical correlation.	852
05/12/YYYY	Hospital/Provider Name	**Labs (collected date: 05/07/YYYY):** **Blood culture:** No growth at 5-days.	1578

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
05/13/YYYY	Hospital/Provider Name	**Office visit:** **History of present illness:** Patient is gravida 3, para 2, Caucasian female, currently at 34 weeks, who presented to the dental clinic with abdominal pain. She has seen in the ER at Willow Creek the night previously, had been evaluated and sent home with preterm contractions but no change in her cervix. She represented to the clinic with complaint of contractions and pain, did not vaginal bleeding. Her cervical exam was unchanged, she was sent to the ER for further evaluation. Upon arrival to the ER, her vitals were stable. She was afebrile. She does complain of diffuse pain in her abdomen especially in the right upper quadrant as well as pain "shooting up her spine." Her prenatal care has been complicated by sporadic visits. She was also evaluated for what was felt to be a fetal arrhythmia. Her prenatal care was also complicated by positive history of smoking. **Physical examination:** Abdomen: Soft but refused a thorough abdominal exam, in fact would only allow me to palpate in the right upper quadrant, which was somewhat tender. She reported some tenderness in her back as well. Her cervix was fingertip and essentially unchanged from the previous night's exam. **Impression:** 1. Intrauterine pregnancy at 34 weeks. 2. Prior cesarean section. 3. Preterm contractions. 4. Possible cholelithiasis/cholecystitis. **Plan:** 1. Pain medication 2. Flexeril for back spasms 3. LFTs	299–300
05/14/YYYY	Hospital/Provider Name	**Follow-up visit for post-op:** **History of present illness:** She returns for the first post-operative evaluation after undergoing an emergency c-section due to uterine abruption, on 05/07/YYYY. The incision appears dry, clean, and intact. She presents with in sorb staples. She reports insomnia that developed 1-week ago. Patient will return to clinic for follow-up incision check in 1-week. She states she has a lot of pain from her c-section especially since she has been crying so much after the loss of her baby. She is unable to sleep and complaints of anxiety and depression symptoms.	861–862

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Ambien 10mg is instructed for insomnia. Prescription given. She is instructed to increase the Lexapro to 20mg. Prescription sent. Demerol 50mg #30 prescription given for pain. Clonazepam 1mg #30 instructed for anxiety and treatment given. **Physical examination:** Abdomen: Abdomen appropriately tender to palpation, incision healing well, umbilicus without lesions **Assessment:** Post-operative follow-up exam.	
05/20/YYYY	Hospital/Provider Name	**Office visit for distraught:** **Assessment:** L Anxiety. 2. Depression. 3. Shift work sleep disorder	1193
06/11/YYYY	Hospital/Provider Name	**Follow-up visit for post-op:** **Assessment:** Post-operative follow-up exam. Return in 1-week for incision ok. Return to clinic in 4-weeks for obstetrics follow-up appointment and follow-up on anxiety.	864–865
06/29/YYYY	Hospital/Provider Name	**Follow-up visit for depression:** **Impression:** 1. Anxiety 2. Depression	1194
09/25/YYYY	Hospital/Provider Name	**Follow-up visit:** **Assessment/plan:** 1. Depression. Continue Prozac 20mg, 2 tablets daily; Klonopin 1mg, twice a day as needed.	1195
02/25/YYYY	Hospital/Provider Name	**Office visit for refills and check-up:** **Impression:** Anxiety. Depression. Shift work sleep disorder	1197–1199
03/22/YYYY	Hospital/Provider Name	**X-ray of thoracic spine complete:** **Clinical history**: Pain without trauma. **Findings:** There are mild endplate changes and very small anterior osteophytes.	1200

Medico Legal Request LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		There is a mildly exaggerated thoracic kyphosis and there is mild scoliosis. Mild compression fractures can be occult radiographic maul be excluded **Impression:** 1. Mild thoracic spondylosis. 2. Slight kyphoscoliosis.	
03/22/YYYY	Hospital/Provider Name	**Office visit for back pain:** **Impression:** Low back pain Anxiety	1101–1103

Related records:

Discharge instructions, assessment, vitals, intake/output records, medication sheet, rhythm strips, flow sheets, orders, assessment, labs, referral report, legal records

PDF Ref: 404–407, 899–902, 57–60, 62, 147, 990–993, 998–1002, 1149–1156, 981–987, 1003, 1004, 1005–1006, 957–962, 967–977, 994, 938–943, 978–980, 1187, 931–932, 925–926, 917–919, 1297, 1206–1228, 1230–1288, 1294–1296, 337–398, 425, 428–429, 439–710, 781, 787–788, 789–792, 797, 853–854, 858–860, 863, 888, 903–910, 916, 927, 933–937, 944–947, 949–955, 965–966, 995, 1007–1066, 1135–1144, 1157–1158, 1165–1166, 1181, 1205, 1229, 1289–1293, 1559–1577, 77–80, 81–100, 189–202, 154–159, 1378–1386, 1389, 1579, 237–239, 427.

***Reviewer's Comments:** All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.*

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