DATE and TIME	CLINICAL NOTES (For all entries please end each entry with your signature, name in capitals, grade and contact number)
9/6/15 1450	Beecn ST3
	Phone call taken from haematology SpR at AHCH
	→ she has spoken to 'a couple' of her consultants
	& they have recommended we send a coagulation screen
	& D-dimer.
	Also if possible to send these samples on Child A
	& to ask for urgent post-mortem on twin 2 particularly
	to look for thrombosis as this may have
	implications on Child B Personal Data
	Personal Data Beecn ST3
	PD
1700	ST4 K DAVIS
	Message from Consultant Obstetrician
	- she has d/w Dr Cohen (haematologist in London) who has liaised with GOSH consultant
	- feel death is unrelated to I&S
	- would advise against any clotting or antibody screening
	- wondered whether tertiary referral would be indicated
	- only further Ix would be MRI and investigations for renal artery stenosis
	Plan I will inform consultant of the above
	Personal Data DAVIS
1800	- D/w Doctor V
	- Hold off clotting screen tonight
	Rediscuss whether needs these bloods in the morning
	Personal Data [illegible] SpR2 I&S

PLEASE AFFIX PATIENT LABEL IF AVAILABLE

NHS Number:

Child B Adm Tm
Child B
NHS:
Sex: F
DOB: PD/06/2015

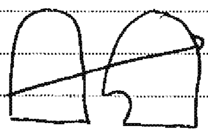
Date of Birth:

PAEDIATRIC DEPARTMENT

Countess of Chester Hospital NHS
NHS Foundation Trust

HISTORY SHEET

LOCATION:

DATE and TIME	CLINICAL NOTES (For all entries please end each entry with your signature, name in capitals, grade and contact number)
9/6/15 0230	Lambie ST6
	written in retrospect
	crashcalled to NNU @ 0033
	Bag + mask ventilation in process.
	Had acute apnoea within no coming
	Widespread purple discolouration of skin with white patches.
	Gradual ↓ HR. Lowest 80-90.
-	Neopuff + guedel - good chest wall mvt ē pressure ↑ to 35.
-	Intubated size 3.0 second attempt - secured 7cm lips (vocal cords look normal)
-	Bolus 10ml/kg NaCl given CRT 3-4s.
	Responded well CRT ↓ to 2-3s.
-	within 10mins - becoming active + breathing - morphine bolus ✓
-	Bloods urgently coag / FBC / U+E / CRP / diner / Fib ✓
-	Placed on ventilator - needing morphine infusion to settle.
	Doctor V arrived).
-	Gradual improvement in perfusion over next 30mins
	Second bolus 10ml/kg given
	A - ETT 3.0 7cm @ lips @ T, on xray.
	B - SIMV 20/6 rate 30 (A) sats 96%.
	 good AE B/L. CXR - nil acute.
	gas: pH 7.21 BXS -8.4
	CO2 6.78 glc 7.5
108	HCO3 19.7 lact 4.5

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PLEASE AFFIX PATIENT LABEL IF AVAILABLE

NHS Number:

CC Child B Adm Tm

First Child B NHS: Sex: F

DOB: PD 06/2015

Surn

Date of Birth:

PAEDIATRIC DEPARTMENT

Countess of Chester Hospital NHS
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HISTORY SHEET

LOCATION:

DATE and TIME	CLINICAL NOTES (For all entries please end each entry with your signature, name in capitals, grade and contact number)
10/6/15 2.40 am.	Written retrospectively from ~ 12.50am. Called at home ~ 12.36 am. Arrived at ~ 12.50 am. Baby tubed already by reg. Went apnoeic suddenly purple blotching of body all over with slowing of heart rate. Bagged & then tubed by reg. Heart rate came up. Adrenaline not required. 10mls/kg bolus given upon my arrival purple blotching RF mid abdomen & right hand. pink & active. On 40% O_2 Sats 100%. H. Rate 143.
00.51 ← gas:	PH 7.20 PCO_2 6.76 PO_2 1046 BE −8.4. glucose 7.5. lactate 2.5 On 20/6 40% O_2.
	FBC ~ WC 8.4. Plts 103 (small clumps) N ~ 3.30 L. 4.5.
	CRP ~ 1.
	PT 12.2. APTT 37.8.
	Fibrinogen 2.43.
	Platelets & FFP had been requested but have held off in view of above results

DATE and TIME	CLINICAL NOTES (For all entries please end each entry with your signature, name in capitals, grade and contact number)

2 Clinical improvement
Restarted on Abx.
Second line Teic + Cefotaxime.
Cap. refl ~ 3-4 secs. → 2nd 10mls/kg bolus given.
CXR + AXR. — reviewed.
ETT tube OK
AXR — dilated loops & gas filled bowel
rpt gas PH 7.33 PCO2 5.56.
PO2 4.48
Lactate 2.1
Dr Chir 20/6.
Spoke to parents.
purple discoloration almost resolved
?? cause
- Stabilised at present
- Cont. Abx
NBM
- rpt gas & wean on tolerated
rpt clotting + FBC + U&E + CRP
@ 7.30am

Doctor V