DATE and TIME	CLINICAL NOTES (**For all entries** please end each entry with your signature, name in capitals, grade and contact number)
26/9/15 continued	STJ VENTRESS
	On my arrival being bagged via ETT
	Good chest movement.
	Capnograph positive
	Sats 60%
	HR 70 → 50.
	CPR commenced at 03.26. Dr Gibbs called
	Cold light - L > R brightness.
	Needle thoracocentesis performed
	8mls air + 2mls fluid aspirated
	03.30 Adrenaline 0.25mls
	03.32 HR 92 on monitor, sats 70%
	but as soon as compressions stopped
	HR ↓ again
	03.35 Adrenaline 0.25mls.
	Dr Gibbs arrived (see notes below)
	03.39 Adrenaline 0.25mls.
	03.45 Atropine 0.1ml (60micrograms)
	03.46 compressions stopped as HR 120 → 163.
	HR held + colour slowly improving.
26/9/15 04^15	Personal Data Ventress
	Called in from home around 03:30
	Arrived 03:36
	CPR in progress (with ventilation via 'neopuff' + ETT)
	Pale, no pulse when chest compressions stopped (femoral)
	Sinus bradycardia on monitor (50-70 b/min)
	Had been given adrenaline (2nd dose at my arrival)
	Cold light = no evidence of pneumothorax
	Limited cardiac echo - no obvious pericardial fluid (tiny rim of ? air against (L) side of heart)
	Further boluses of adrenaline, then atropine (20mcg/kg ~ rounded up to 60mcg).
	Spontaneous output + ↑ HR to 160 after 22 mins (from start of bradycardia)
	Post - CPR - HR 170-190 making good resp effort on AF intermittently (crackles on left)
	Colour now pink, only requiring 30% O_2
259	Cause of 'arrest' = unclear but began with a desaturation 31

INQ0000972_0031

PLEASE AFFIX PATIENT LABEL IF AVAILABLE

NHS Number:

CC Nur Child H Adm Tm

Child H

First Na NHS: Personal Data Sex: F

DOB: PD/09/2015

Surnam

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)
27/9/15 0130	1. ETT removed due to previous issues c blocked tube
	2. No improvement with reoxygenating c pressures 30/5 and chest wall movement after this
	3. Cold light -ve
	4. Reintubated c 3.5mm ETT to 8cm at lips at ~0105
	Cords visualised easily, ETT passed through cords
	Capnography +ve, equal AE
	5. After tube change SpO2 ~70% HR 50-60
	6. Chest compression started at 0107
	7. Adrenaline requested
	8. Chest transilluminated at 0110 after reintubation
	⇒ negative transillumination
	9. 0.3mls of adrenaline given at 0108
	10. Attempted aspiration of chest drain at 0112 with yield of ~5mls of air
	11. Reassessed at 0112 - HR ~170, SpO2 100%
	12. Chest compression discontinued at 0113
	Above d/w Dr. Saladin on arrival at ~0115
	(P) CXR
	Gas
	further IV access
	Rpt bloods
	CRUSS
	D/w APH consultant.
	PD [signature]
	STS
	Personal Data
266	38

WWG316 Feb 2011

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DATE and TIME	CLINICAL NOTES (**For all entries** please end each entry with your signature, name in capitals, grade and contact number)
27/9/15 0240	written in retrospect Asked to come to NNU as Child H unwell By the time I came baby is being bagged through a new ET tube. HR: 150/mt good air entry Cap refill 2 seconds. ET tube blocked earlier in the night and ET tube changed uneventfully and tube position adjusted Stable for 2 hrs Then ≈ 1 AM Developed desaturations No intervention being done at that time Initially heart rate was normal and then Heart rate decreased to 40s Needed external cardiac compressions for 5 min + 1 dose of adrenaline + 1 saline bolus. HR improved after adrenaline bolus before I came. In SIMV: 19/5 rate 50/mt a 30% Itime 0.4 ET tube position confirmed and withdrawn by 0.5 cm No reaccumulation of pneumothorax chest drain position unchanged USG cranium (N). HR: 150/mt RR 43/mt Sat 100% Cap refill 2 seconds. Cgas pH 7.213 PCO2 8.29 PO2 6.21 BE -4.3 Lactate 3.8 glu 6.7 D/w Dr Roth consultant at APH. As no explanation for this profound desat + Bradys Needing external compressions agreed to accept the baby to more care hospital Personal Data Parents updated Informed Transport team (by Dr Neeru) Peripheral cannula placed. Blood for FBC CRP VBE Mg to start 2nd line antibiotics PD
267	

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