IN THE PROPOSED ACTION **CLAIM No.**

BETWEEN:

MASTER JO BLOGGS
(A Child, By His Mother and Litigation Friend, MRS JOANNE BLOGGS)

Proposed Claimant

AND:

THE HOSPITAL TRUST

Proposed Defendant

CHRONOLOGY

Mrs J Bloggs	**Date of Birth:**	**03/09/1979**
Master J Bloggs	**Date of Birth:**	**27/08/2004**
Date of Incident:		**28/08/2004**

Background

Mrs Joanne Bloggs (date of birth 03/09/1979) was diagnosed as being an insulin dependent diabetic in August 1992.

Mrs Bloggs' diabetes appears to have been largely well controlled. Nevertheless, she did have a few episodes of hypoglycaemia over the years. She also required treatment in hospital in 1996, 2002 and 2004 due to hypoglycaemic attacks/problems with her diabetes.

Mrs Bloggs has no other medical history of note.

Mrs Bloggs became pregnant at the end of November 2003. Her estimated date of delivery was 6 September 2004.

Prior to becoming pregnant, Mrs Bloggs' diabetic control was noted to be excellent. Other than treatment in hospital in April 2004, due to a hypoglycaemic attack, her pregnancy largely progressed without any problems.

Mrs Bloggs was admitted to ****** Hospital on 26 August 2004 for induction of labour. The delivery unit at the hospital was busy, thus induction was delayed until the following day. Baby Jo was born at 16:18 hours on 27 August 2004 with 9 at 1 and 9 at 5 minutes. Despite a protocol document stating that Mrs Bloggs' blood glucose levels should be checked before meals and prior to bed, it appears that no check was made from 4.45pm on 28 August 2008. Mrs Bloggs was seen by a midwife around

10.00pm that evening for assistance with breast-feeding. The next time the staff checked upon Mrs Bloggs, at 1.45am on 29 August 2008, she was found slumped over Jo, having suffered a severe hypoglycaemic attack. Jo was noted to be "white and floppy", with no respiratory effort. He was given 8 rescue breaths, following which his colour improved. Jo was ventilated and intubated and noted to be suffering from seizures. An EEG was performed, which was reported as abnormal. Jo was consequently transferred to the PICU at ****** Children's Hospital on 29 August 2004 for further management until 5 September 2004. An ultrasound of his head showed fluid over the left cerebellar region. However, at that stage, the significance of this was unclear. Jo was transferred from ****** Children's Hospital to ****** General Hospital until discharge on 21 October 2004.

Jo's care continued under the paediatric team at ****** General Hospital. He had problems with feeding/weight gain, together with global developmental delay. Jo also suffered from repeated respiratory tract infections.

Jo had an MRI scan at ****** General Hospital in October 2005. No major abnormalities were reported. However, the scan was sent to ****** Infirmary for a second opinion. Dr ******, at the ****** Infirmary, reported that the pattern of abnormalities he found were consistent with a severe hypoxic event and that the lesion he identified would normally produce a dystonic cerebral palsy, although it may take some time for the signs to evolve.

The diagnosis of dystonic cerebral palsy was accepted by the paediatricians treating Jo. He was also diagnosed with a seizure disorder in around August 2007.

CHRONOLOGY ***[detailing all events/attendances by medical staff from the birth of Jo]***		
Date	**Event**	**Page(s)**
N/A	**Postnatal Glucose Management** [standard protocol document in medical records] Diabetes before pregnancy – • Continue Insulin infusion as for labour ward regime until eating and drinking • Start usual per-pregnancy regime (should be documented in notes) • Monitor blood glucose levels before main meals and bed • The diabetes team will advise about adjustments to treatment	526
27/08/04 16:18	Birth of live baby boy in good condition: • Apgars – 9 at 1; 9 at 5 • Weight – 2.78kg • Feeding – breast • Passed urine – no • Passed meconium – yes • Dilated kidneys – for paediatric review	216 233
16:23 16:35	Seen by Midwife White: • Placenta and membranes delivered • Baby skin to skin • Baby skin to skin at breast • Passed meconium++	233 233
17:00 17:10 17:45 18:15	Seen by Midwife Black: • BM 10.7mmol; Insulin continues at 2ml/hr • Baby not fed and not interested • Konakuoun 1mg with parent consent • Baby skin to skin • Still not interested in breast • Baby back to breast; licking but not latching on	233 529 233 233 233
18:25	Insulin requiring chart: • BM 9.3mmol	529

Date	Event	Page(s)
19:00	Seen by Midwife Black: • BM 9.3mmol • Food given to eat	233
19:30	Insulin requiring chart: • Insulin infusion off • BM – not recorded	529
20:00	Seen by Midwife Red: • Baby still not fed • Hand expression taught; 0.2ml early breast milk obtained and given to baby by syringe at 20:15	233
20:00	Insulin requiring chart: • Insulin infusion off • BM – not recorded	529
21:00	Seen by Midwife Red: • Pink and warm • 0.2ml early breast milk give at 20:15 after many attempts at breast Instructions to next shift – • * DILATED KIDNEYS * • * AT RISK (MUM IDDM) * • Needs BM's • Observe for passing urine • Insulin infusion discontinued at 20:00 • BM 8.8mmol at 21:00 • Has eating and taken normal Insulin	220 224 233 529
22:30	Seen by Midwife Blue: • BM 2.7mmols • Attempted to breast feed • Hand express – early breast milk, nil obtained • C&G 10mls given • Has passed meconium, not urine • Self administered Insulin, declined any snacks	220 233

Date	Event	Page(s)
28/08/14 01:00	Mother and baby transferred to Orange Ward	233
03:00 07:00 07:35	Seen by Midwife Green: • BM 2.1mmols • Attempted to breast feed, not interested • Given 10mls C&G via syringe • Being changed by mum • Will ring when ready for BM • Feels well, declined analgesia • BM 2.3mmols • Going to try EBF	220 220 224 220
08:00	Note on feeding chart: • Attempted to breast feed; 15mls C&G given • Pre-feed BM – 2.3mmols	223
09:45	Seen by Midwife Green: • Postnatal check complete and satisfactory • Paediatrician asked to review as ? jaundiced • Breastfeeding attempted – not latching; top-up given as charted • BM's as charted • Independently maintaining BM's and administering Insulin • BM 6.7mmol this morning pre Insulin	220 224
10:45	Note on feeding chart: • Attempted to breast feed • 0.15mls early breast milk • 10mls C&G given • Pre-feed BM 4.7mmol	223
13:00	Seen by Midwife Purple: • Baby jaundiced; SBR taken at paediatric request • Skin to skin – baby latched and sucked for approximately 5 minutes • Hand expressed and gave 0.15mls early breast milk via syringe • 10mls C&G top-up given	220

Date	Event	Page(s)
15:00	• Attempted to breast feed; latched on but not sucking • As BM 2.7mmol pre-feed A/F 10mls given slowly by mum via syringe every 15 minutes; tolerated • SBR result returned well below level	221
16:45	Note on feeding chart: • Attempted to breast feed; 10mls C&G given • Pre-feed BM – 2.7mmols	223
17:00	Seen by Midwife Purple; • Unable to remember normal Insulin dosage • Found in notes regime prior to pregnancy • Scribed overleaf – gave as per script 08/01/04 • Discussed with Dr Brown; continue with this regime	224
20:15	Note on feeding chart: • Attempted to breast feed; skin to skin	223
21:45	Seen by Midwife Purple: • Colour Pink • Eyes Clean, clear • Mouth Clean, clear • Urine Passed • Stools Meconium • Cord On clamp • Feeding Mix	220
22:00	Note on feeding chart: • Skin to skin • [Pre-feed BM not completed]	223
01:45	Seen by Midwife Cream: • *"Went… to see if Joanne was wake so I could do a blood sugar on baby. I pulled back the curtain to Joanne's bed. The position Joanne was in alerted me to a problem. The cot was empty. I pulled back the blanket and realised the baby was under Joanne… pulled the emergency buzzer for help. I rolled Joanne back and picked up the baby who was white and floppy. Staff Midwife Grey now present. I handed her the baby and she took him to the resuscitation on [*****] Ward. I gave Joanne oxygen via face mask and turned her into recovery position. Blood sugar was 1.1mmols. Pulse 80…"*	237
Date	**Event**	**Page(s)**

01:45	Note by Midwife Purple [written retrospectively at 10:00]: • *"Joanne found in bed overlying baby – severe hypyglycaemic attack… baby went to SCBU and then transferred to [*****] PICU"*	224

MASTER JO BLOGS

(Date of Birth: 27/08/2004)

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Swift Record Sort

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Tel: 07900 507745
E-mail: swiftrecordsort@hotmail.co.uk

Date

To the instructing solicitor

Your Ref: **********

Our Ref: **********

Dear **********

Re: Master Jo Bloggs

Thank you for your kind instructions in this matter.

I can confirm that I have collated, indexed and reviewed the medical records. I have also prepared a Chronology of my findings.

Normally, in a Cerebral Palsy claim, I would document all events during labour and the birth of the child. However, this case is different, in that Jo's injury appears to have been sustained following his birth. I have therefore detailed every attendance by the medical staff following Jo's birth, rather than focusing on the birth itself. I trust this is acceptable. Nonetheless, if you would like me to add to the Chronology (i.e. detailing the labour and birth) please do let me know.

You may wish to note the following regarding the medical records:-

"The Hospital Trust"

There is a standard protocol document outlining the postnatal glucose management of patients with diabetes (please see page 526). This document states that, when diabetes has been present before pregnancy, as in Mrs Bloggs' case, blood glucose levels should be monitored before main meals and bed. It is difficult to determine whether levels were monitored before meals as taking a meal is not always documented in medical records. Nevertheless, the records suggest the following:-

(1) Mrs Bloggs was managing her own blood glucose levels and administering her own insulin from around 9.45am on 28 August 2004 (page 224). That being said, the levels were recorded in the medical notes at 10.45am, 3.00pm and 4.45pm on 28 August 2004. However, perhaps most importantly, I cannot see any references to the levels being recorded ***after*** 4.45pm (i.e. before bed, as instructed by the protocol). It was in the early hours of the following morning that Mrs Bloggs was found slumped over Jo, having suffered a severe hypoglycaemic attack.

(2) Following on from the points above, the pages following the aforementioned protocol document (e.g. pages 529-532) contain charts of the blood glucose measurements

taken. Whilst these charts appear to have been started at 2.15pm on 27 August (and re-commenced on 29 August) there is no chart for 28 August 2004. Whilst it appears that one simply does not exist, it may be worthwhile checking with the hospital whether one was created/completed and was simply omitted during disclosure of the records.

(3) The final page(s) of a letter from Dr ******, at the ****** Infirmary in ******, is missing (please see page 983). Any additional page(s) could be important, as Dr ****** is providing a second opinion on the MRI scan which appears to confirm Jo's Cerebral Palsy.

General Practitioner

(1) Mrs Bloggs' clinical records/Lloyd George cards do not commence until 1986 and the first piece of correspondence is dated 1992. That being said, even if earlier records exist, they are unlikely to be central to the enquiries into this particular claim.

(2) Page 3 of the GP records has been photocopied in such a way that information has been omitted. The page in question outlines treatment in 2005. Therefore, as above, any information on this page is unlikely affect your specific investigations into this matter.

Please note that the above list of further/missing medical records may not be exhaustive and that there may be additional records which are missing or need to be obtained.

I enclose the collated medical records, together with my Chronology and an invoice in respect of my charges.

It remains for me to thank you for your kind instructions in this matter. If I can assist in any further way, please do let me know.

With kind regards,

Yours sincerely

Audrey Scott-Furlong
Swift Record Sort