MEMORANDUM

TO:

CC:

FROM: **MEDICAL SORTING**

DATE: **30 AUGUST 2005**

SUBJECT: **Miss A**

Have completed sorting the medical records with chronology & noted several records missing:-

C A

- Clinical notes from Hospital of admission on 24/11/94 (p.82 – 85) when bloods were obtained (p.106)

- Clinical notes from Hospital for admission referred to on p.69 & 71 when C A attended labour ward in the antenatal period. ***(Why?)***

- Operation Notes & Clinical Notes from Hospital during admission from 25/11/94 (p.46) through to discharge on 03/12/94.(p.55 – 57***)(There are midwifery records for this period but despite review by medical staff (p.46) - no clinical notes***)

- GP records are missing **all** the clinical note entries from 21/05/93 (p.1725) until 05/12/94 (p.1726). (***When did C A return to the UK for antenatal care?)***

- GP records are missing **all or any correspondence from 21/02/93 (p.1699) until 03/12/94** (p.1700) when C A may have attended for any antenatal concerns

- GP letter on p.1705 is incomplete

Baby A

- Hospital 2 Records & Radiology Reports - where he was reviewed in 1996 (p.1275) & a CT brain & EEG was performed & seen afterwards for ongoing developmental problems (p.853)

- Health Visitor Records - Health Visitor was RH (p.847 – 848)

- EEG & CT scan performed in Egypt where Baby A was diagnosed with Epilepsy in 1995 (p.1629 & 847 - 848)

- Hospital – **No Radiology Reports** in the records you presently hold despite MRI being undertaken on 30/01/97 (p.1326) & consequent MRI's during his ongoing treatment there

- Hospital – **Minimal Haematology, Biochemistry, Microbiology Results** despite numerous A & E admission for fits respiratory problems & fevers when swabs & blood test were obtained.

- Hospital 3 – Minimal Radiology Reports & no reports of CT or MRI Brain scans if undertaken there. Also after an admission from gastroenteritis on 06/12/94 , but no clinical notes referring to this admission (p.1270)

- Hospital 4 Records – where Karim attended for developmental assessments on 22/01/96 (p.847 – 848)

- Hospital 5 Records – where Baby A attended for a few A & E admissions & when his sodium valporate dose was altered in 1996 (P.847 – 848). Also attended for congenital infection screening & these results are also missing (p.851)

- Hospital 6 Records where Baby A was reviewed by an Audiology Physician prior to 1997 (p.1332 – 1333)

- S Centre where Baby A attended fro Global developmental delay from 17/03/97 (p.1328)

With reference to the chronology itself there are certain points to highlight:-

- If a woman has had a previous caesarean, there is always the risk of scar rupture during labour. As CA was booked for an elective C/S this normally is undertaken between 38 – 40 weeks. Yet CA was 42 weeks when she had her caesarean section (p. 48)

- ***Did CA present in early labour on 24/11/94 (p.82 – 85) as a vaginal examination was performed & she appeared to be contracting? Blood tests were also obtained then. Why? Was her BP high or was she showing signs of bleeding?? These showed an abnormal Hct & MCH.***

- There is likely to have a suspicion that CA may have been developing pre-eclampsia from her initial pregnancy induced hypertension (p.46)as on admission on 25/11/94, her liver function was checked as were her clotting factors, which are specific blood tests for this condition (p.109 & 107 – 108). ***These results were abnormal but would need review by an Expert as to whether they should have been repeated (which I suspect is the case or delivery expedited).***

- The CTG'S themselves appear satisfactory including the last one performed at 09.34am on 28/11/94 (p.99 - 101)

- ***Why was the Caesarean performed under GA & not Spinal anaesthetic as there is less risk to the baby & GA is often used for emergency situations?***

- There is a conflict in the records of the initial resuscitation of the baby as the Neonatal clinical notes state that Baby A required **bag & mask for a period of 3 minutes** with a heartrate of >100bpm after a **difficult delivery** (p.72)& the midwifery notes & delivery summary indicate that he **only required oxygen for 1 minute** (p.59 & 71)

- The anaesthetic notes indicate that the operation was in progress at 17.00pm (p.53), yet the baby was not delivered until 17.30pm (p.53) ***What was the delay as GA is used in emergencies as it is a quick method of putting the mother to sleep? This may indicate that there were difficulties with the delivery itself but as the operation notes are missing this is difficult to identify***.

- Unfortunately no cord PH was obtained to assess for fetal hypoxia at the time of the birth (p.69 & 71)

- The Health Visitor records would be helpful as she would have attend Baby A from 10 days old (08/12/94) & would have identified the early start of the problems

- The first attendance at the GP is on 17/12/94 , but these notes are difficult to read & better copies will need to be obtained (p.1627 – 1628)

- Prior to this there is a discharge summary from Hospital 2 after an admission from gastroenteritis on 06/12/94, but no clinical notes referring to this admission (p.1270)

- There was a suggestion of Angelman's syndrome after an abnormal EEG at GOS (p.851) referred to in a letter dated 10/04/96. This was not evident however in the Cytogenetic Report dated 27/02/96 (p.1262) , but this report did not rule out the possibility of uni-parental disomy

- The only time period that CA was not in the UK is stated as being from January 1995 until July 1995 (p.1297 – 1299)

- Baby A's ongoing condition can be better reviewed once all the Radiology reports & Records are present. At present we hold **NO MRI or CT brain reports** to identify the brain damage that has occurred apart from the review of the scans in numerous letters from the various hospitals.