

ILLUSTRATIVE ATTORNEY REPORT SAMPLE

DEMAND-READY PACKAGE

Deliverable 1 of 3: Medical Chronology | Sepsis and Septic Shock Deterioration

MATTER

Sepsis Demonstration / SEP-DEMO-002

PATIENT / CLAIMANT

Patient A, age 72 — fictional

PREPARED FOR

Prospective Attorney Clients

REPORT DATE

October 1, 2026



1. Matter Identification and Chronology Scope

Patient A is a fictional 72-year-old adult whose September 3, 2026 emergency presentation progressed to intensive care, mechanical ventilation and death on September 6. This chronology reconstructs the available course from the June 2 baseline visit through the final hospital outcome. It supplies a dated factual account for counsel and identifies the records needed to resolve timing and care-transition questions.

Matter: SEP-DEMO-002. Report date and record cutoff: October 1, 2026. Prepared for: prospective attorney clients. Clinical pathway: Sepsis and Septic Shock Deterioration, SEPSIS-001. Demonstration record set: RS-DEMO-002, version 1.0. This is a completed illustrative report, not a released report on a real patient.

The principal unresolved sequence concerns recognition and communication of deterioration, followed by assessment, antibiotic administration and escalation. The chronology covers every material event defined for this fictional case, including prehospital care, the emergency department, ICU treatment and goals-of-care transition. Where records are absent, the sequence remains expressly incomplete.

Report organization

Sections 2–4 establish the record basis, timing method and baseline. Section 5 provides the detailed event table. Sections 6–8 identify transitions, unresolved issues and the source navigation points. Section 9 states the scope limitations and reference conventions.

All people, providers, clinical events, source identifiers, and page references in this sample are fictional. Source labels demonstrate report traceability; no underlying medical-record packet exists. This expanded demonstration case is separate from the earlier screening sample. No actual clinical review, specialty approval, or QA release is represented.

2. Materials Reviewed and Record Limitations

Source range	Provider and coverage	Materials and limitations
PC001–012	Juniper Primary Care June 2 and August 20, 2026	Baseline history, medications, renal laboratory results and function; earlier longitudinal chart not supplied.
EMS001–008	Cedar County EMS September 3, 2026	Dispatch extract and transport narrative; monitor download and full dispatch audio absent.
ED001–032	Northbridge Regional Hospital September 3, 2026	Triage, nursing observations, physician note, deterioration and transfer entries; communication metadata incomplete.
LAB001–010	Northbridge laboratory September 3–6, 2026	Selected serial chemistry, lactate and culture reports; notification history absent.
MAR001–016	Northbridge pharmacy and nursing September 3–6, 2026	Selected medication and fluid administration entries; complete infusion and edit histories absent.
RAD001–004	Northbridge radiology September 3–4, 2026	Chest radiograph reports and selected metadata; original images and report acknowledgment unavailable.

Source range	Provider and coverage	Materials and limitations
ICU001-040	Northbridge intensive care September 3–6, 2026	Admission, daily progress, respiratory support, family discussion and death summary; some flowsheets absent.
POL001-006	Northbridge policy office Version not established	Sepsis escalation and critical-result excerpts; approval and effective-date pages absent.

The demonstration inventory totals 128 fictional pages. The coverage dates describe the sample inventory; they do not certify a complete production from any provider. Missing materials are not included in that count. Bracketed references identify hypothetical pages within this inventory.

No original imaging, complete EHR audit export, complete pump history, final culture report, independent renal consultation, certified death certificate or postmortem report is part of this sample inventory. The associated Record Gap List assigns a request identifier and custodian to each missing category. A missing item is not proof that an assessment, communication or treatment did not occur.

3. Chronology Method and Date/Time Convention

Dates use the year 2026 throughout. Times use the 24-hour clock as printed in the hypothetical source. The sample assumes one local hospital time zone; cross-system clock synchronization has not been established. June and August office records have dates without times. The symptom onset on September 2 is retrospective family history, not a contemporaneous measurement.

An event time describes when care is said to have occurred. An entry time describes when documentation was created. A result timestamp may describe release or another laboratory-system step; it does not alone establish clinician receipt. Order, verification, dispensing and administration are separate events. The 10:15 physician assessment and 11:10 note entry are therefore reported together without collapsing them into a single time.

Repeated information is consolidated when it describes the same encounter. Material changes, contradictions and later entries remain visible. Numbers are reproduced as fictional source values without retrospective diagnostic scoring. Elapsed intervals are arithmetic comparisons of the stated times, not determinations of unreasonable delay. Clinical diagnoses are attributed to the treating record.

4. Baseline and Pre-Event Context

At the June visit, Patient A lived at home and could walk with a cane. Family assisted with shopping and medication organization. No baseline confusion was documented. This establishes some retained mobility and communication, while also showing preexisting assistance needs; the sample does not portray the patient as fully independent. [PC001-004]

The August follow-up records diabetes, chronic heart failure and chronic kidney disease, with creatinine 1.4 mg/dL and no new resting breathlessness. These conditions are relevant to physiologic reserve and to interpretation of the later renal and fluid-management course. The limited office record does not establish cardiac ejection fraction, prior hospitalizations, detailed kidney-function trend or verified medication adherence. [PC005-012]

Family history recorded during transport places cough, chills, poor intake and weakness on the evening of September 2. By the following morning, the family reported confusion and difficulty getting the patient out of bed. No earlier same-illness outpatient assessment is included. The exact onset of infection, hypotension or organ dysfunction cannot be assigned from this history. [EMS001-004; ED003]

5. Chronological Event Table

The table follows the complete defined demonstration course. All references are fictional. “Not supplied” describes the sample record boundary and does not establish absence of care.

Date and time	Provider and documented event	Source and timing qualification
Jun 2 Time not stated	Juniper Primary Care Routine visit records diabetes, chronic heart failure and chronic kidney disease. Patient lives at home, uses a cane, and receives family help with shopping and medications. No baseline confusion is described.	PC001-004 Baseline is a documented visit, not continuous observation.
Aug 20 Time not stated	Juniper Primary Care Follow-up documents stable weight, no new resting breathlessness, creatinine 1.4 mg/dL, and continued family assistance. Medication list includes a diuretic and diabetes treatment; adherence is not independently established.	PC005-012 No cardiology or nephrology source records supplied.
Sep 2 Evening, reported	Family history recorded by EMS Family later reports cough, chills, reduced intake and increasing weakness beginning the evening before transport. No contemporaneous urgent-care encounter is included.	EMS002; ED003 Retrospective symptom history; onset time is approximate.
Sep 3 06:52	Cedar County EMS Dispatch extract records a call for weakness and confusion. The caller reports difficulty getting the patient out of bed.	EMS001-002 Call-received time; dispatch audio is missing.
Sep 3 07:08	Cedar County EMS Crew arrival. Patient is awake but gives an incorrect month and requires help moving to the stretcher. Narrative records blood pressure 94/58 mmHg, pulse 112/min and oxygen saturation 91% on room air.	EMS003-004 Values are from the written narrative; monitor trace absent.
Sep 3 07:18	Cedar County EMS Oxygen by nasal cannula is documented. Intravenous access is obtained; a small crystalloid infusion is described without a reliable delivered volume in the supplied extract.	EMS005-006 Prehospital fluid volume cannot be added to hospital totals.
Sep 3 07:38	Cedar County EMS Arrival at Northbridge is recorded. Verbal handoff mentions fever, cough and altered mental status. Signature time for ED acceptance is absent.	EMS007-008 Ambulance arrival differs from ED triage time.
Sep 3 07:45	Northbridge ED triage Temperature 39.1°C, pulse 118/min, respirations 26/min, blood pressure 92/54 mmHg and saturation 90% on room air are recorded. Patient is weak and confused. Family describes the confusion as new.	ED001-004 Triage observations; not a proven time of diagnostic recognition.

Date and time	Provider and documented event	Source and timing qualification
Sep 3 07:55	Northbridge ED nursing Oxygen at 2 L/min is documented with saturation 94%. Peripheral IV is recorded as patent. Patient follows simple commands but repeats questions.	ED005 Response to oxygen is documented; respiratory cause remains undetermined.
Sep 3 08:05	Northbridge laboratory Blood specimen collection is recorded for chemistry, blood count and lactate. Initial chemistry includes creatinine 2.1 mg/dL; white blood cell count is $18.2 \times 10^3/\mu\text{L}$.	LAB001-003 Collection time does not establish result availability.
Sep 3 08:15	Northbridge ED nursing Nursing note describes increasing confusion and need for repeated redirection. Blood pressure is 88/50 mmHg. Family remains at bedside.	ED006-008 Documented deterioration; notification sequence not included here.
Sep 3 08:20	Northbridge laboratory Export lists lactate 4.8 mmol/L with an 08:20 result timestamp. No separate verification, critical-call or clinician-view history accompanies the result.	LAB002 Use 08:20 as listed result time only.
Sep 3 08:35	Northbridge medication record A 500 mL crystalloid bolus is recorded as started. The supplied MAR does not establish a complete stop time or total infused at this point.	MAR001-002 Start is documented; completed volume is not independently established.
Sep 3 09:00	Northbridge ED nursing Persistent hypotension, 86/48 mmHg, is recorded. Note states provider notified. Recipient, method, acknowledgment and resulting instructions are not identified in the supplied entry.	ED010-012 Notification is documented; an absence of response cannot be inferred.
Sep 3 09:10	Northbridge radiology Portable chest radiograph acquisition time appears in the radiology metadata. No original image file is supplied.	RAD001 Acquisition does not establish interpretation or delivery time.
Sep 3 09:30	Northbridge radiology Report describes a right basilar opacity, with infection considered in the clinical setting, and no large pleural effusion. Report-distribution and acknowledgment data are absent.	RAD001-002 Radiologist report summarized; images not independently interpreted.
Sep 3 10:15 event 11:10 entry	Northbridge ED physician Physician entry created at 11:10 describes bedside assessment at 10:15. It notes suspected pulmonary infection, hypotension and altered mental status, with sepsis considered. Additional fluid and IV antibiotics are planned.	ED016-018 Two distinct timestamps; no assumption that either is false.
Sep 3 10:30	Northbridge order extract Antibiotic orders appear in the supplied order listing. Pharmacy verification time and original order-version history are absent.	MAR003-005 Order time is not administration time.

Date and time	Provider and documented event	Source and timing qualification
Sep 3 10:40	Northbridge medication record A second 500 mL crystalloid bolus is recorded as started. No complete linked reassessment or delivered-volume accounting is included in the extract.	MAR004-005 Two 500 mL starts do not prove 1,000 mL was fully infused.
Sep 3 11:25	Northbridge laboratory Blood-culture collection is recorded. The available sequence places collection before the first documented antibiotic administration.	LAB004 Does not establish that no earlier antimicrobial was given elsewhere.
Sep 3 11:45	Northbridge medication record First supplied administration entries record ceftriaxone and azithromycin. These entries support documented administration at 11:45; full barcode and edit histories are absent.	MAR006-008 Treatment administration supported by extract, not independently audited.
Sep 3 12:10	Northbridge ED nursing Blood pressure 90/52 mmHg and persistent confusion are recorded. Oxygen remains in use. A complete volume-status reassessment is not supplied.	ED019-021 A single pressure does not establish sustained stabilization.
Sep 3 12:30	Northbridge laboratory Repeat lactate is listed as 6.1 mmol/L. Export does not distinguish every step between collection, verification, release and notification.	LAB006 Rising value is documented; exact clinician knowledge time is unresolved.
Sep 3 14:00	Northbridge ED nursing Blood pressure 78/44 mmHg, respirations 32/min and increasing oxygen requirement are documented. Patient is less responsive to conversation.	ED024-026 Material worsening documented before escalation entry.
Sep 3 14:20	Northbridge ED physician Critical-care consultation is requested in a physician note. The supplied chart does not establish the time the consultant received or accepted the request.	ED027 Request time differs from response or bed assignment.
Sep 3 15:30	Northbridge response team Rapid response is documented for persistent hypotension and respiratory deterioration. Team note describes reassessment and preparation for higher-acuity care.	ED028-030 The reason for the interval after the consult request is not resolved.
Sep 3 15:45	Northbridge medication record Norepinephrine initiation is documented. Subsequent titration data are incomplete in the supplied extract.	MAR009-010 Start supported; complete dose trajectory unavailable.
Sep 3 16:15	Northbridge ICU ICU transfer is documented. Admission assessment lists septic shock, probable pulmonary source, acute respiratory failure and acute kidney injury.	ED031-032; ICU001-006 These are treating-team diagnoses, not independent causation findings.

Date and time	Provider and documented event	Source and timing qualification
Sep 3 17:05	Northbridge ICU Intubation is documented for worsening respiratory failure. Procedure note records tube placement and initiation of mechanical ventilation.	ICU007-010 No independent assessment of procedural appropriateness is made.
Sep 3 18:00	Northbridge ICU Vasopressor support and mechanical ventilation continue. Urine output is described as reduced. Selected progress documentation identifies ongoing shock despite treatment.	ICU011-014; MAR011 Detailed hourly balances and all titrations are not supplied.
Sep 4 06:00	Northbridge laboratory Creatinine 3.2 mg/dL and lactate 5.4 mmol/L are listed. The lactate is lower than the prior listed value; organ dysfunction remains documented.	LAB007-008 Improvement in one value is not equivalent to clinical recovery.
Sep 4 09:00	Northbridge ICU Progress note documents continued ventilator and vasopressor requirements. Renal consultation is referenced for worsening kidney function; the separate consultation report is not included.	ICU015-018 Recommendations cannot be reconstructed from a reference alone.
Sep 4 10:20	Northbridge radiology Follow-up chest report describes persistent right basilar opacity and interval bilateral interstitial opacities. Clinical correlation is advised in the fictional report.	RAD003-004 No independent distinction between infection, edema or other causes.
Sep 4 14:00	Northbridge microbiology Preliminary blood-culture entry reports gram-positive cocci. A final organism identification and susceptibility report is not supplied.	LAB009 Preliminary finding does not establish definitive organism or final treatment fit.
Sep 4 16:00	Northbridge ICU Antimicrobial treatment is revised in the ICU record after reassessment. Supplied extracts do not show the complete consultant rationale or every subsequent dose.	ICU019-022; MAR012-014 No conclusion regarding drug selection can be made from this extract alone.
Sep 5 09:00	Northbridge ICU Daily note records persistent shock, renal dysfunction and ventilator dependence. Patient remains sedated for ongoing ventilation. No return to baseline interaction is documented.	ICU023-028 Sedation limits assessment of cognition and subjective distress.
Sep 5 15:00	Northbridge ICU Family conference documents discussion of critical illness and uncertain prognosis. Continued intensive treatment is recorded at that time.	ICU029-032 Discussion does not establish a decision to limit treatment.
Sep 6 08:00	Northbridge ICU Progress note describes worsening shock and multiorgan dysfunction despite ongoing intensive support. A new family discussion is planned.	ICU033-034; MAR015-016 Outcome attribution remains outside this chronology.

Date and time	Provider and documented event	Source and timing qualification
Sep 6 10:30	Northbridge ICU Family discussion and treating-team entry document a transition to comfort-focused care in light of the clinical course. Full standalone goals-of-care order history is not supplied.	ICU035-037 Decision documented in narrative; retrieve orders for complete sequence.
Sep 6 12:10	Northbridge ICU Withdrawal of ventilatory support is documented after the comfort-care decision. Comfort medication administration is described in the available extract.	ICU038; MAR016 Exact medication doses and all administration times are not reproduced here.
Sep 6 12:42	Northbridge ICU Death is pronounced. Death summary describes septic shock, respiratory failure and kidney injury during the admission. Certified death certificate and any postmortem report are absent.	ICU039-040 Pronouncement time is documented; certified cause-of-death record is not supplied.

6. Material Transitions, Escalations, and Outcomes

Home to emergency transport

The transition from assisted community living to emergency transport is supported by new confusion, weakness and abnormal prehospital observations. EMS documented arrival at the hospital at 07:38; ED triage followed at 07:45. The seven-minute difference reflects two identified workflow events and is not treated as a gap in treatment. The full handoff record is needed to identify who received the prehospital findings. [PC001-012; EMS001-008; ED001-004]

Emergency assessment and treatment

Triage and subsequent nursing entries show hypotension, altered mental status and respiratory concerns. The 08:20 lactate listing and 09:30 imaging report add laboratory and radiology information, but availability to an individual clinician is unresolved. A 09:00 notification entry precedes the physician assessment described as occurring at 10:15. Antibiotics are ordered at 10:30 and documented as administered at 11:45. [ED001-018; LAB002; RAD001-002; MAR003-008]

Escalation to intensive care

At 14:00, blood pressure, respiratory rate and responsiveness worsen in the nursing documentation. A 14:20 consultation request is followed by a 15:30 rapid response, 15:45 vasopressor initiation and 16:15 ICU transfer. At 17:05 the patient is intubated. The transition is established, but the consultation response, bed request, bed availability and transport steps are not fully shown. [ED024-032; MAR009-010; ICU001-010]

Intensive treatment and final outcome

The ICU course includes ventilator and vasopressor support, worsening renal function, antimicrobial reassessment and family conferences. The September 5 conference documents continued intensive care. A

separate September 6 discussion documents a transition to comfort-focused treatment, followed by withdrawal of ventilatory support at 12:10 and death at 12:42. These separate decisions must not be compressed into an earlier treatment limitation. [ICU015-040; MAR012-016]

7. Documentation Gaps, Conflicts, and Unresolved Timing Issues

Issue	Established fact	Unresolved question and request
Result availability	Lactate 4.8 at listed 08:20 time. [LAB002]	When was the result verified, released, called and acknowledged? Request G02.
Provider notification	Nursing entry states provider notified at 09:00. [ED010-012]	Who received it and what response followed? Request G01.
Assessment versus entry	Assessment described at 10:15; note entered 11:10. [ED016-018]	Audit versions and associated orders may clarify sequence. Request G01.
Medication interval	10:30 order; 11:45 administration. [MAR003-008]	Verification, dispensing, access and administration history are incomplete. Request G03.
Fluid accounting	Two 500 mL bolus starts appear. [MAR001-005]	Delivered volume, interruptions and reassessment are not established. Request G03.
ICU transition	14:20 request; 16:15 transfer. [ED027-032]	Consult receipt, acceptance and bed history are absent. Request G04.
Infection source	Chest opacity; preliminary culture. [RAD001-004; LAB009]	Final culture, sensitivities and specialist rationale not supplied. Requests G02 and G05.
Outcome certification	Death pronounced September 6 at 12:42. [ICU039-040]	Certified death and possible postmortem records absent. Request G08.

The above entries identify incomplete corroboration, not proven contradictory testimony. No fabricated-entry finding is made. The comfort-care narrative and missing standalone orders also require reconciliation through G04. Policy applicability remains unverified pending G07.

8. Key Record References

Question	Primary source anchors
What was the documented baseline?	PC001-004 for function; PC005-012 for comorbidity and renal baseline.
What changed before hospital arrival?	EMS001-008 and ED003 for symptom history, transport observations and handoff.
What were the key early findings?	ED001-012, LAB001-003 and RAD001-002.
What treatment times are documented?	MAR001-010 and ED016-018 for assessment, orders, fluids and administration.

Question	Primary source anchors
How did the patient reach intensive care?	ED024-032 and ICU001-010 for worsening, response, transfer and intubation.
What happened in intensive care?	ICU011-034, LAB007-010, MAR011-016 and RAD003-004.
What documents the final decision and death?	ICU035-040; MAR016. Certified death record not supplied.

9. Limitations and Appendix

The chronology is an organized account of the reviewed documentation. It does not independently determine standard of care, legal causation, liability, or expert opinion unless separately authorized through another report type.

The stated course ends at death on September 6; there is no post-discharge recovery period in this fictional case. The chronology does not quantify suffering, assign responsibility for a treatment interval, or assume that an earlier intervention would have prevented the outcome. Imaging entries reproduce report findings only. Missing information remains missing even where a plausible sequence could be constructed.

Appendix A — Reference conventions

PC = primary care; EMS = emergency medical services; ED = emergency department; LAB = laboratory and microbiology; MAR = medication administration and order extracts; RAD = radiology reports; ICU = intensive care; POL = supplied policy excerpts. Each three-digit number identifies a hypothetical page. G01-G08 refer to the separate Record Gap List, not additional reviewed records.

Appendix B — Selected elapsed intervals

Start and endpoint	Elapsed time	Interpretive boundary
07:45 triage → 10:15 described assessment	2 h 30 min	Does not rule out earlier assessment not located in the extract.
08:20 listed lactate → 11:45 antibiotics	3 h 25 min	Result acknowledgment time remains unknown.
10:30 order → 11:45 antibiotics	1 h 15 min	Not a finding that the entire interval was avoidable.
14:20 consultation request → 16:15 ICU transfer	1 h 55 min	Receipt, acceptance and bed availability not established.

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