

ILLUSTRATIVE ATTORNEY REPORT SAMPLE

DEMAND-READY PACKAGE

Deliverable 2 of 3: Narrative Summary & Demand Support | Medical narrative for demand preparation

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 Narrative Scope

This report provides the completed medical narrative for fictional matter SEP-DEMO-002. Patient A, age 72, presented to Northbridge Regional Hospital on September 3, 2026 with fever, weakness, new confusion and hypotension. The treating record subsequently describes septic shock, respiratory failure and acute kidney injury. The patient required intensive care and died on September 6 after a documented transition to comfort-focused treatment.

The narrative covers the baseline visits of June 2 and August 20, the reported onset of illness on September 2, prehospital care, the entire defined hospital episode and the documented outcome. Report date and source cutoff are October 1, 2026. Demonstration record set RS-DEMO-002 contains 128 fictional pages. Prepared for prospective attorney clients; version 1.0, completed illustrative sample.

Section 4 is written as a continuous factual medical narrative for counsel to review and incorporate into the medical-history portion of a demand. Sections 5–8 preserve the treatment summary, qualifications and source map. Appendix B supplies the separate Demand Letter Medical Support headings and their completed clinical content. No demand amount, liability argument or settlement recommendation is included.

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.
ICU001–040	Northbridge intensive care September 3–6, 2026	Admission, daily progress, respiratory support, family discussion and death summary; some flowsheets absent.

Source range	Provider and coverage	Materials and limitations
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.

The record limitations affect both the chronology and narrative. Result acknowledgment, provider communication, medication processing and ICU transfer metadata are incomplete. The baseline is supported by two office visits rather than a full longitudinal record. A separate renal consultation and final culture results are referenced or expected but not supplied. The narrative therefore distinguishes what is documented from what remains unresolved.

3. Baseline Clinical Context

Before the acute illness, Patient A lived at home, walked with a cane and received family assistance with shopping and medication organization. The June primary-care visit did not describe confusion. The patient was neither documented as fully independent nor described as requiring institutional care. This is the available functional comparison for the later acute deterioration. [PC001-004]

The August follow-up documented diabetes, chronic heart failure and chronic kidney disease. Creatinine was 1.4 mg/dL, weight was described as stable, and no new resting breathlessness was reported. The supplied medication list included a diuretic and diabetes treatment. The record does not confirm every medication actually taken before admission, the patient's cardiac ejection fraction, or a complete history of prior decompensation. [PC005-012]

These baseline conditions remain part of the medical account. The later confusion, respiratory support needs and renal deterioration occurred in a patient with preexisting disease. The available record does not apportion the eventual outcome between that vulnerability, the severity of the acute illness and any potentially modifiable aspect of care. [PC001-012; ICU001-040]

4. Narrative of Relevant Care and Events

Onset of illness and transport

According to family history recorded by EMS and in the emergency department, Patient A developed cough, chills, reduced intake and increasing weakness on the evening of September 2, 2026. By the following morning, the family reported confusion and difficulty getting the patient out of bed. The supplied record contains no contemporaneous office or urgent-care assessment for that illness before the emergency call. The precise onset of hypotension or organ dysfunction is not established. [EMS001-004; ED003]

Cedar County EMS received the call at 06:52 on September 3 and documented arrival at 07:08. The patient was awake but gave an incorrect month and needed assistance transferring to the stretcher. The EMS narrative recorded blood pressure of 94/58 mmHg, pulse of 112/min and oxygen saturation of 91% on room air. Oxygen

and intravenous access were documented during transport. The extract described a small crystalloid infusion but did not establish a reliable delivered volume. [EMS001-006]

EMS recorded arrival at Northbridge at 07:38. The transport narrative described a verbal handoff addressing fever, cough and altered mental status. The extract did not include a timed acceptance signature from the receiving clinician. Hospital triage was recorded seven minutes later, at 07:45. Those times identify separate arrival and triage events rather than competing accounts of one event. [EMS007-008; ED001-004]

Emergency presentation and early findings

At triage, Patient A had a temperature of 39.1°C, pulse of 118/min, respiratory rate of 26/min, blood pressure of 92/54 mmHg and oxygen saturation of 90% on room air. Weakness and confusion were documented, and the family described the confusion as new. At 07:55, nursing recorded oxygen at 2 L/min with saturation of 94%. The patient followed simple commands but repeatedly asked the same questions. [ED001-005]

Laboratory specimens were collected at 08:05. The supplied results included white blood cell count of $18.2 \times 10^3/\mu\text{L}$ and creatinine of 2.1 mg/dL, compared with 1.4 mg/dL at the August office visit. The laboratory export listed lactate of 4.8 mmol/L at 08:20. That timestamp did not include a complete chain of verification, release, critical-result calling and clinician acknowledgment. It cannot establish by itself when a particular clinician knew the result. [LAB001-003; PC005-012]

At 08:15, nursing documented increasing confusion and a blood pressure of 88/50 mmHg. A 500 mL crystalloid bolus was recorded as started at 08:35, although a complete stop time and delivered-volume record were not supplied. At 09:00, blood pressure was 86/48 mmHg and the nursing entry stated that a provider had been notified. The entry did not identify the recipient, acknowledgment or subsequent instructions. [ED006-012; MAR001-002]

Imaging and physician assessment

A portable chest radiograph was acquired at 09:10. The 09:30 report described a right basilar opacity, with infection considered in the clinical setting, and no large pleural effusion. The sample contains the report, not the original images. It does not establish when the report was viewed or acknowledged by the treating team. These findings are reported as the radiologist's description and are not an independent image interpretation. [RAD001-002]

A physician note entered at 11:10 described a bedside assessment occurring at 10:15. The note addressed suspected pulmonary infection, hypotension and altered mental status and considered sepsis. It set out a plan for additional fluid and intravenous antibiotics. The later entry time is disclosed because the time of care and the time of documentation are different facts. The supplied materials do not establish that this was the first physician contact of any kind. [ED016-018]

Treatment and continuing deterioration

The order extract listed antibiotic orders at 10:30. A second 500 mL crystalloid bolus was recorded as started at 10:40. Neither the two bolus-start entries nor the EMS description establish a verified cumulative fluid volume. Complete infusion completion, interruption and reassessment records were not supplied. [MAR003-005; EMS005-006]

Blood-culture collection was recorded at 11:25. The first antibiotic administration entries supplied for the emergency course recorded ceftriaxone and azithromycin at 11:45. This places the documented culture collection before the documented antibiotic administration. The interval from the antibiotic order to administration was 1 hour 15 minutes. Pharmacy verification, dispensing, access-related events and the original administration edit history were not included, so the reason for that interval remains unresolved. [LAB004; MAR003-008]

At 12:10, blood pressure was recorded as 90/52 mmHg, confusion persisted and oxygen remained in use. A repeat lactate was listed as 6.1 mmol/L at 12:30. The available records therefore describe continued illness after treatment began, rather than a documented sustained return to the patient's baseline. The sample does not contain all assessments needed to evaluate the adequacy of each fluid or medication decision. [ED019-021; LAB006]

At 14:00, nursing recorded blood pressure of 78/44 mmHg, respiratory rate of 32/min, an increasing oxygen requirement and reduced responsiveness to conversation. A physician note recorded a critical-care consultation request at 14:20. The supplied chart did not establish the time of consultant receipt, acceptance or bed assignment. A rapid response was documented at 15:30 for persistent hypotension and respiratory deterioration. [ED024-030]

Intensive care and organ support

Norepinephrine initiation was recorded at 15:45. The patient transferred to the ICU at 16:15, where the admission assessment listed septic shock, probable pulmonary source, acute respiratory failure and acute kidney injury. At 17:05, the patient was intubated and mechanical ventilation was begun for worsening respiratory failure. The 18:00 assessment described ongoing vasopressor and ventilator support, reduced urine output and continuing shock. [MAR009-011; ED031-032; ICU001-014]

On September 4, the laboratory record listed creatinine of 3.2 mg/dL and lactate of 5.4 mmol/L at 06:00. Although the lactate was lower than the previous listed value, the progress record continued to describe organ dysfunction and a need for intensive support. The 09:00 note referred to renal consultation, but the separate consultation was not provided. Its full assessment and recommendations cannot be supplied from that reference alone. [LAB007-008; ICU015-018]

A follow-up chest report at 10:20 described persistent right basilar opacity and interval bilateral interstitial opacities. The supplied record does not resolve the relative contribution of infection, edema or other processes to those reported findings. At 14:00, a preliminary culture entry reported gram-positive cocci. Final organism identification and susceptibility results were absent. An ICU entry at 16:00 recorded antimicrobial revision after reassessment, but the extracts did not supply the complete specialist rationale or every subsequent administration. [RAD003-004; LAB009; ICU019-022; MAR012-014]

Continued critical illness and death

On September 5, the ICU progress note recorded persistent shock, renal dysfunction and ventilator dependence. The patient remained sedated for ongoing mechanical ventilation. No return to baseline conversation or mobility was documented. Sedation limits what can be inferred about cognition, awareness and subjective distress during that period. A 15:00 family conference addressed the seriousness of the illness and uncertain prognosis; continued intensive treatment was documented at that time. [ICU023-032]

On September 6 at 08:00, the progress record described worsening shock and multiorgan dysfunction despite ongoing support. A separate 10:30 family discussion and treating-team entry documented a transition to

comfort-focused care. The supplied narrative shows that decision, although the complete standalone goals-of-care order history was not included. Withdrawal of ventilatory support was documented at 12:10, with comfort medication described in the available extract. [ICU033-038; MAR015-016]

Death was pronounced at 12:42 on September 6. The death summary described septic shock, respiratory failure and kidney injury during the admission. A certified death certificate and any postmortem report were not supplied. The sequence establishes the documented treatment course and outcome; it does not, by itself, establish that a particular response interval caused the death or that an earlier intervention would have prevented it. [ICU039-040]

5. Material Interventions, Transitions, and Outcome

Intervention or transition	Documented course	Material qualification
Oxygen and fluids	Prehospital oxygen; ED oxygen at 07:55; bolus starts at 08:35 and 10:40.	Delivered fluid totals and complete reassessments remain unverified. [EMS005-006; ED005; MAR001-005]
Antimicrobial treatment	10:30 orders; 11:45 initial administration; ICU revision September 4.	Full pharmacy sequence, final cultures and consultant rationale missing. [MAR003-008, 012-014; LAB009]
Organ support	15:45 norepinephrine; 16:15 ICU transfer; 17:05 intubation on September 3.	Complete titration, respiratory and hourly nursing records absent. [MAR009-011; ICU001-014]
Goals of care and outcome	Continued care September 5; comfort transition September 6; death 12:42.	Narrative decision and pronouncement documented; full order history and certified death record absent. [ICU029-040]

6. Documentation Issues and Information Gaps

The most consequential timing gaps concern the 08:20 lactate and 09:00 provider notification. The record shows that a result and notification entry exist, but not the complete receipt-and-response sequence. The 10:15 assessment described in the 11:10 note should remain identified as a later-entered account until audit information clarifies its history. Requests G01 and G02 address these questions. [LAB002; ED010-018]

The fluid and medication extracts provide discrete start and administration entries without a complete delivery history. The narrative therefore does not state that every ordered milliliter was received or that every minute between ordering and administration was avoidable. Request G03 seeks the records needed to clarify actual treatment and contemporaneous reassessment. [MAR001-016]

The hospital transition and ICU record gaps affect the account after deterioration. Requests G04 and G05 seek consultation records, bed and transfer events, renal assessment, respiratory records and complete treatment documentation. Requests G06-G08 address baseline corroboration, applicable policy versions and certified outcome documentation. None of these outstanding requests permits an adverse factual assumption.

7. Key Clinical Questions Identified for Further Review

Recognition and communication: What findings were available to each responsible clinician, when were they acknowledged, and what assessment or action followed? The early nursing findings and later note are not sufficient to assign a single defensible recognition time. [ED001–018; LAB002; RAD001–002]

Treatment response: What were the actual fluid volumes, bedside reassessments and reasons for medication timing? Heart failure and chronic kidney disease make the contemporaneous reasoning relevant. The report does not supply a fluid target or judge treatment from two bolus-start entries. [PC005–012; MAR001–008]

Escalation and outcome: What happened between the documented 14:20 consultation request and 16:15 transfer? Did additional records establish earlier critical-care involvement? Which aspects of the illness reflected its severity at presentation, and which, if any, were affected by subsequent management? These require patient-specific specialty review. [ED024–032; ICU001–040]

8. Limitations and Source Reference Appendix

This narrative summary organizes the reviewed record and does not provide legal advice, legal conclusions, final standard-of-care determination, legal causation conclusion, or expert opinion.

Section 4 is medical source material for counsel's review and adaptation. It is not a completed demand letter. References and material qualifications should remain traceable when counsel incorporates the account into another document. The sample does not supply economic losses, a damages valuation, future-care costs, or an assessment of the patient's conscious pain and suffering.

Appendix A — Source reference map

Baseline and medications: PC001–012. Symptom history and transport: EMS001–008 and ED003. Emergency course: ED001–032. Laboratory trend and cultures: LAB001–010. Orders, medications and fluids: MAR001–016. Reported imaging findings: RAD001–004. Intensive care, family discussions and outcome: ICU001–040. Unverified policy excerpts: POL001–006. Full inventory and limitations appear in Section 2.

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Appendix B — Demand Letter Medical Support

Completed clinical support companion for the same fictional matter. The numbered headings below follow the retrieved Demand Letter Medical Support structure. This appendix supplements the narrative without converting it into a legal demand or representing an operational release approval.

1. Executive Injury Summary

The documented course progressed from community living with assistance to acute confusion, hypotension, respiratory failure, ICU organ support and death. Treating ICU diagnoses include septic shock, probable pulmonary source and acute kidney injury. The central factual issue is the response to evolving deterioration

before ICU transfer. The available evidence establishes the progression but leaves important acknowledgment, treatment and consultation steps unresolved. [PC001-012; ED001-032; ICU001-040]

2. Clinical Injury Overview

The acute clinical picture includes fever, hypotension, confusion and respiratory impairment at presentation, followed by increasing support requirements. Creatinine rose from the August baseline of 1.4 mg/dL to 2.1 mg/dL on September 3 and 3.2 mg/dL on September 4. The ICU record labels the renal condition acute kidney injury. These findings are reported as documented observations and treating diagnoses, without assigning a separate mechanism of injury or excluding competing contributors. [PC005-012; LAB001-008; ICU001-018]

3. Treatment Course Summary

Treatment included oxygen, recorded crystalloid bolus starts, antibiotics, vasopressor support and mechanical ventilation. The treatment course continued after the September 5 family meeting. Comfort-focused treatment followed a separately documented September 6 decision. The detailed narrative in Section 4 supplies the date-by-date account, while the chronology provides each event and its timing limitation. [EMS005-006; MAR001-016; ICU001-040]

4. Functional Impact Review

At baseline the patient walked with a cane and received help with shopping and medications. At emergency presentation the patient was confused and needed assistance with movement. By September 3 at 17:05 the patient required mechanical ventilation; subsequent ICU records describe sedation and continued organ support. No return to the documented baseline occurred before death. This account does not infer unrecorded daily-living limitations, duration of awareness, or subjective suffering from diagnoses or procedures alone. [PC001-004; EMS003-004; ED001-008; ICU007-040]

5. Standard of Care Screening Considerations

The sample identifies recognition, communication, reassessment, treatment processing and escalation as questions for appropriately scoped specialty review. It does not determine breach. The combination of repeated abnormalities and unresolved response metadata warrants examination of what information was available at each stage, rather than retrospective assembly of all findings as if simultaneously known. Applicable guidance and complete local policies have not been evaluated in this fictional report. [ED001-032; LAB002-006; POL001-006]

6. Clinical Causation Considerations

Infection-associated deterioration is the documented treating framework, with a probable pulmonary source recorded in the ICU. Severe illness was already present at arrival; chronic heart and kidney disease are relevant competing contributors to vulnerability and treatment choices. The source set does not establish whether a different response would probably have changed the outcome, or which portion of the progression was modifiable. The later comfort-care decision is part of the terminal course and does not resolve the clinical effect of earlier events. [PC001-012; ED001-004; ICU001-040]

7. Delay / Escalation Impact

The listed 08:20 lactate precedes the 11:45 antibiotic administration by 3 hours 25 minutes. The 10:30 antibiotic order precedes that administration by 1 hour 15 minutes. The 14:20 consultation request precedes 16:15 ICU transfer by 1 hour 55 minutes. Deterioration is documented during the emergency course, but these intervals are not findings that all elapsed time was avoidable or that an interval caused the outcome. Result receipt, treatment processing and consultation milestones must be reconciled before assigning clinical significance. [LAB002; MAR003-008; ED024-032]

8. Documentation Support

The best-defined observations are triage findings, serial nursing deterioration entries, the listed laboratory trend, first supplied antibiotic administration, ICU transfer, intubation and death pronouncement. The thinner parts of the record are acknowledgment and communication, cumulative fluids, complete medication history, consultation receipt and final microbiology. Counsel can cite the documented events while preserving the unresolved questions. The companion Record Gap List maps them to requests G01-G08. [ED001-032; LAB001-010; MAR001-016; ICU001-040]

9. Future Care Considerations

No future patient care is identified because this fictional patient died on September 6. The sample does not generate projected treatment, rehabilitation needs, care quantities or costs. Before death the record described ongoing intensive care and subsequently comfort-focused care; those are historical treatment facts, not future-care projections. [ICU029-040]

10. Defense Counterpoint Considerations

The patient arrived already seriously ill and had chronic heart failure, chronic kidney disease and diabetes. Treatment did occur, including fluids, antibiotics, vasopressor support and ventilation. The incomplete export may omit assessments or communications. A later-entered note is not itself proof of fabrication, and worsening after treatment does not establish that treatment was inadequate. These points must remain in a balanced medical account even when counsel investigates possible response gaps. [PC001-012; ED016-018; MAR001-016; ICU001-040]

11. Strategic Demand Support Observations

The medical narrative is most firmly supported when it describes the change from baseline, the serial abnormalities, the documented treatment sequence and the ICU outcome with their source references. It is less complete when addressing who knew which finding at which time or why a particular interval occurred. Additional records could strengthen, narrow or remove an apparent response concern. These are neutral observations about evidentiary completeness, not advocacy, case valuation or a recommendation about demand posture. [PC001-012; ED001-032; ICU001-040]

12. Recommended Expert or Specialty Support

For counsel's consideration, emergency-medicine review may address the recognition, treatment and escalation sequence; critical-care review may address the ICU course and patient-specific opportunity for a different outcome. Nursing review may clarify assessment and notification responsibilities. Infectious-disease or renal

input may be appropriate if final culture, antimicrobial selection or renal management remains disputed after records are complete. These are issue-based referral options, not completed expert opinions or automatic assignments.

13. Scope, Limitations, and Human Review

This report is record-based clinical support for a demand. It is not a demand letter, does not make a demand, does not state or imply a demand figure or claim value, does not provide legal advice, does not determine legal liability or causation, and does not substitute for retained expert testimony. The attorney retains all legal drafting, valuation, strategy, and review. Conclusions are limited to the reviewed materials and stated scope. This fictional demonstration has not undergone actual case-specific clinical or specialty review and is not labeled QA approved.

14. Source Reference Appendix

The inventory in Narrative Summary Section 2 and reference map in Section 8 govern this appendix. No additional records are represented as reviewed. Every source identifier is part of the same 128-page fictional inventory. The associated Medical Chronology contains the detailed event sequence; Record Gap List requests G01–G08 identify outstanding evidence categories. Supplemental records would require a new source-set version and a controlled revision in a real matter.