Chronology with DepSum Facts Comparison

Facts Comparison - Highlight Legend
***Blue – Denotes details from deposition are matching corresponding details in the medical records**
***Red – Denotes details from deposition contradict details available in medical records**
***Green – Denotes new details that are observed from the deposition transcripts**

DATE	PROVIDER	OCCURRENCE/TREATMENT (MEDICAL RECORDS)	PDF REF	Facts Comparison *(Ref – Dep Transcript Page:Line)*	TRIVENT COMMENTS
12/23/YYYY	XXXX, M.D. ✔ Reordered 18:00 12/23/2016 [redacted] MD	**@1800 hours Order:** Lactated Ringers 1,000 ml, 125 ml per hour, IV Continuous for 1 day. Oxytocin 60 units in 1,000 ml of Lactated Ringer's, 1 milliunits per minute IV Continuous - titrate as per standard	1750	**Deponent # 1** Dr. XXXX stated that he did not know why his name was on this order. He mentioned that it was common for nurses to renew orders automatically and Dr. XXXX was the attending MD there at that time. *(REF: 14:19-15:11, 22:1-22:6)*	Medical Records mention Dr. XXXX.
12/23/YYYY	YYYY, RN	**@ 1922 hours Vitals:** SBP 89 DBP 69 MAP 75 RR 18 Temp 97.5 *Reviewer's Comment: No Documentation of BP and pulse between 1500 and 1922 hours.*	1782	**Deponent # 2** Ms. YYYY testified that as per the chart, there was no recording of blood pressure for 4 hours and 22 minutes, that is from 1500 hours until 1922 hours. Ms. YYYY stated that "for a patient who was being induced for labor that had their membranes ruptured, the patient who broke her water, they would take vitals every two hours. If the patient had an epidural, they would look at the blood pressure every 15 to 20 minutes." *(Ref: 30:11-31:23, 105:13-108:7)*	Medical records show no documentation of BP and pulse between 1500 and 1922 hours - confirmed in the deposition by Deponent # 2

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12/23/YYYY	ZZZZ, M.D. YYYY, RN	**@ 1940 hours Procedure report for vaginal delivery:** IOL for symptomatic polyhydramnios. **Drugs Administered (Prior to Time of Delivery**): Misoprostol, Oxytocin. On Epidural. **Vaginal Delivery: Membranes**: Artificial Rupture of Membranes (1551 12/23/YYYY) **Time from ROM to Delivery**: 3 Hours + 49 Minutes **Maternal delivery position**: Supine. Assessed cervical exam, VE was 10/0 station. **Interventions:** External fetal heart rate monitor, internal tocometer, Artificial Rupture of Membranes **Time of Delivery**: 1940, 12/23/YYYY **Sex**: Female. **Live Born**: Yes **Fetal Presentation**: Cephalic **Amniotic Fluid Color**: Clear Vacuum extraction was done. **Vacuum Type**: Mid vacuum. Cup Type: Kiwi **Vacuum Applications**: 2 **Number of pulls**: 2 **Number of pop offs**: 1 **Apgar: 1 minute** – 3. **5 minutes** – 8. **10 minutes** - 9	1670-1672	**Deponent # 3** Dr. ZZZZ stated she assessed the patient, and the patient was fully dilated. So, the most expeditious way to deliver her and save the baby was clearly with a vacuum. She remembered that the patient was being induced for polyhydramnios as the midwife informed her. Dr. ZZZZ knew that the patient was administered Pitocin and received an epidural. *(Ref: 51:24-52:23, 69:13-70:16, 110:17-112:6)*	Deposition statement of Dr. ZZZZ matches details in the medical records.

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12/23/YYYY	ZZZZ, M.D. WWWW, M.D.	**@1941 hours Obstetrical Hemorrhage Notes:** Assessed vaginal bleeding. Activated OB Code Team. Request for OR to be opened. Assess vital signs every 10 minutes. Initiated IV Bolus. Provided for patient safety/lower head of bed. Provided uterine massage. Requested hemorrhage pack/cervical exploration tray. Provided SBAR to first responder. Started 2nd large bore IV line as ordered. Administer medications as ordered: Pitocin, Methergine, Hemabate, Cytotec. **Notes:** @1945 patient transfer to OR2. **@ 1944 hours Anesthesia record:** Preoxygenated with 100% O2 via mask. The Anesthesia team arrived in the patient's room as soon as called. The patient was unresponsive on arrival. But still spontaneously breathing. Hyperventilated and assisted with Breathing with Ambu. The patient was not improving therefore was intubated.	1649	**Deponent # 3** Dr. ZZZZ stated that as soon as she entered the room patient was unresponsive and pulseless. It was a matter of minutes and a witnessed event. The Anesthesia Team was already there. *(Ref: 3:3-3:24, 136:4-137:25, 157:4-158:15)* **Deponent # 4** Dr. WWWW and his Anesthesiologists entered the room as part of a rapid response. He stated that when he walked into the room, the baby was already delivered. The pediatric ICU attendings were working on the baby on one side. And there was a cluster of doctors/medical professionals around the baby. The patient had no blood pressure monitor attached to her, no pulse oximetry, and no EKG monitor. The patient was not responsive. The patient was supposed to be monitored every three minutes or every five minutes for blood pressure and every second for pulse oximetry. Dr. WWWW stated that he did not write this entry and the chart notes were wrong as the patient was blue and not breathing at that time. *(Ref: 19:5-23:23, 49:5-51:21)*	Contradicting details in Deposition statement of Dr. ZZZZ. Records note OBGYN was in the room when Anesthesia Team entered. Contradicting details in Dr. WWWW deposition statement. Medical records mention patient was breathing.

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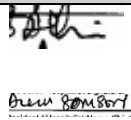
12/23/YYYY		**@ 1945 hours: Code Blue Records:** **Patient location:** Labor and Delivery **Clinical findings upon arrival at bedside:** **Pupils**: Reactive **Respirations:** Labored **Ventilator:** No **Pulse present**: Tachyarrhythmia Acute pulmonary edema Acute respiratory insufficiency **Post code assessment of cause**: Thrombosis, pulmonary **Post-Resuscitation assessment**: Patient with decreased responsiveness and respiratory distress intrapartum. Code called at approximately 1945 hours. Pulseless. CPR started. Resuscitated 9 units of Epi, bicarb. Central line placed. Massive transfusion protocol started. Transferred to OR. **Post-resuscitation status:** HR 128, BP 86/59, RR 18, SpO2 99% **Respiratory status:** Intubated **ECG:** ST Condition of patient: Unconscious	842-843	**Deponent # 4** Dr. WWWW stated that the chart mentioned tachyarrhythmia, but the patient did not have a pulse. So, he did not agree with that. He did not know the exact time for post-resuscitation status because the patient was intubated, and she did not have a pulse until they got her into the operating room. *(Ref: 31:6-31:24, 82:7-86:21)*	Medical records mention Tachyarrhythmia and patient pulseless post-resuscitation. Dr. WWW notes patient did not have a pulse and he does not agree with the Tachyarrhythmia pulse mentioned in the records.