

ILLUSTRATIVE ATTORNEY REPORT SAMPLE

ATTORNEY CASE BRIEF

Sepsis and Septic Shock Deterioration | SEPSIS-001

MATTER

Sepsis Screening / SEP-DEMO-001

PATIENT / CLAIMANT

Patient A, age 72 — fictional

PREPARED FOR

Prospective Attorney Clients

REPORT DATE

October 1, 2026



1. Matter Identification and Scope of Screen

This brief screens the emergency-department recognition, communication, escalation, and treatment response during Patient A's September 3, 2026 presentation. The patient subsequently required intensive care and died September 6. The allegation presented for screening is that delayed recognition and response to infection-associated deterioration contributed to shock and death. The allegation is treated as a question, not an established finding. [ED001–012; ICU001–018]

The fictional instruction is to determine whether the record supports further clinical investigation before counsel commissions a comprehensive review. The priority period is 07:45–16:15 on September 3. The ICU course is considered only to identify the subsequent outcome. Individual liability, damages valuation, and a final preventability opinion are outside this screen.

Screening assessment

Further investigation is supported. Abnormal findings accumulate before the documented physician assessment, antibiotic administration, and ICU transfer. The clearest issue is whether the evolving information prompted timely reassessment and action. The record supports investigating those intervals but does not establish that each interval represents an avoidable delay or that earlier treatment would have prevented death.

Record integrity is limited. The ordinary chart does not establish when the elevated lactate became available to the responsible clinician or when nursing concerns were acknowledged. A later physician entry and an earlier nursing notification entry do not resolve those questions. Causation remains qualified pending the missing records and specialty review.

2. Attorney Question(s) Presented

1. At what point did the information available to the treating team support recognition of possible sepsis and a need for escalation?
2. What is documented about reassessment, notification, antibiotic administration, and transfer during the evolving deterioration?
3. What limits a preliminary assessment of whether a different response could have changed the outcome?
4. Which records and clinical specialties are needed before a more definitive assessment is made?

Recommended decision at this stage

Obtain the communication and electronic timing records, reconcile the treatment sequence, and commission focused emergency-medicine or critical-care review. A comprehensive Clinical Intelligence Review may then be appropriate if the disputed response intervals remain supported. The present evidence does not justify either a definitive favorable causation opinion or dismissal of the clinical concern.

3. Materials Reviewed and Record Limitations

The demonstration record contains 120 fictional pages. The index below defines the universe used for this completed sample. References identify the supporting record category and page range; they do not refer to real medical records.

Source	Contents	Pages
Emergency department	Triage, nursing observations, physician note, escalation and transfer entries	ED001–032
Laboratory	Specimen and result entries, including lactate measurements	LAB001–010
Medication and fluids	Orders, administration entries, fluid documentation	MAR001–016
Radiology	Chest radiograph report and report metadata	RAD001–004
Intensive care	Admission, treatment course, death summary	ICU001–040
Prior care	Primary-care history and baseline function	PC001–012
Policy excerpt	Sepsis escalation and critical-result communication excerpt	POL001–006

Missing materials include the complete electronic audit trail, result acknowledgment history, full provider communication log, and complete fluid reassessment documentation. The policy effective-date page is absent. No original imaging files are included. These gaps directly affect interpretation of recognition, treatment response, and applicable local process.

4. Record Integrity Snapshot

Status: limited but usable for a qualified initial screen. The broad sequence is documented; the information and communication sequence is less secure. Event time, entry time, result availability, and clinician acknowledgment must be distinguished before assigning a precise recognition point.

A nursing entry at 09:00 records provider notification for persistent hypotension. A physician note entered at 11:10 describes an assessment at 10:15. The supplied chart does not establish the recipient, acknowledgment, or content of the earlier notification. These entries may describe separate events and should not be treated as proof of either fabrication or absent notification. [ED010–018]

The laboratory export lists a lactate result at 08:20 but does not include a complete verification-to-notification history. The MAR records antibiotic administration at 11:45; administration is distinguishable from ordering, although the unprovided edit history limits independent verification. [LAB002; MAR006–008]

5. Baseline and Relevant Clinical Context

Patient A, age 72, had diabetes, chronic heart failure, and chronic kidney disease. A prior-care visit describes living at home with family assistance for shopping and medications, walking with a cane, and no baseline confusion. These facts establish the documented functional starting point; they do not establish normal physiologic reserve. [PC001–008]

At arrival the record describes fever, weakness, and confusion. The chronic conditions may affect vulnerability and treatment decisions, particularly fluid assessment. Their presence does not independently explain the entire subsequent course or establish that the outcome was unavoidable. The expert review must compare acute changes with baseline and evaluate what options were reasonable at each point. [ED001–004; PC001–012]

6. High-Level Timeline of Material Events

September 3, 2026. Times are as documented; the clock and acknowledgment limitations in Section 4 apply.

Time	Record-supported event	Why it matters
07:45	ED arrival: fever, weakness, confusion, hypotension. [ED001–004]	Initial concerning presentation; complete context matters.
08:15	Increasing confusion recorded. [ED006]	Change requiring comparison with baseline.
08:20	Lactate 4.8 mmol/L listed in lab export. [LAB002]	Result availability and acknowledgment require reconciliation.
09:00	Persistent hypotension; provider notification entry. [ED010–012]	Recipient and acknowledgment remain unconfirmed.
09:30	Chest report describes a right basilar opacity; infection considered. [RAD001–004]	Report evidence only; no independent image interpretation.
10:15	Physician assessment described in later entry. [ED016–018]	Assessment time differs from 11:10 entry time.
11:45	Antibiotic administration recorded. [MAR006–008]	Establishes administration, not first recognition.
12:30	Repeat lactate 6.1 mmol/L. [LAB006]	Worsening laboratory trend warrants clinical correlation.
14:00–16:15	Further deterioration; rapid response 15:30; ICU transfer 16:15. [ED024–032]	Escalation sequence and level-of-care transition.
Sept 6	Death following ICU course documented. [ICU035–040]	Outcome does not by itself establish preventability.

7. Preliminary Clinical Issues and Documentation Signals

Recognition and communication

The record shows an accumulating pattern of hypotension, altered mental status, and an elevated lactate before the documented 10:15 assessment. The relevant inquiry is what information was available to each responsible clinician and what response followed. Retrospectively assembling every abnormal finding does not prove that all findings were known simultaneously. [ED001–018; LAB002]

Imaging Analysis

The chest radiograph report describes a right basilar opacity and considers infection in the clinical context. It is relevant to the search for an infectious source, but does not independently establish sepsis or the cause of shock. The report's distribution and acknowledgment are not shown. No prior comparison study is included. This analysis uses the radiologist's report and does not reinterpret the original image. [RAD001–004]

Treatment and reassessment

The MAR documents antibiotic administration at 11:45. The interval from the listed 08:20 lactate result is 3 hours 25 minutes; from the described 10:15 assessment it is 1 hour 30 minutes. These are record-based intervals, not automatic measures of negligent delay. The ordering sequence, clinical reasoning, access issues, and result-availability history are needed to interpret them. [LAB002; ED016–018; MAR006–008]

8. Preliminary Standard-of-Care Screening Observations

Recognition, escalation, treatment initiation, and reassessment warrant specialty review. No fixed treatment deadline or bundle violation is assigned in this screen. The applicable standard must be assessed against the contemporaneous circumstances, relevant guidance, and what the treating team reasonably knew.

Fluid management is a separate question. The sample MAR contains fluid entries but incomplete reassessment documentation. Heart failure and kidney disease make it particularly important to examine the actual findings, orders, response, and rationale. This brief does not infer inadequate resuscitation from an isolated volume or presume that unrestricted fluids would have been appropriate. [MAR001–016; PC001–012]

Regulatory and Compliance Overlay

The policy excerpt describes escalation and critical-result communication, but the effective version is unverified. Obtain the applicable policy and compare its requirements with the event sequence. A documentation gap does not establish a regulatory violation, and local policy is not treated as a substitute for a specialty standard-of-care opinion. [POL001–006]

9. Preliminary Causation Considerations

A plausible pathway for expert evaluation is progressive infection-associated deterioration during a period when earlier recognition and treatment may have offered an opportunity to limit shock and organ dysfunction. The record supports a worsening sequence; it does not establish the size of that opportunity or the probable effect of a different intervention. [ED001–032; LAB002–006; ICU001–018]

The ICU record identifies septic shock and subsequent organ dysfunction. The preliminary concern is whether a modifiable response interval materially affected that course. An expert must separate the severity of infection at presentation from any additional harm associated with delayed or insufficient treatment. The later diagnosis cannot be used to assume that a specific earlier intervention would have prevented death. [ICU001–018, ICU035–040]

Competing considerations include severe illness already present at arrival, reduced reserve associated with chronic heart and kidney disease, and potential progression despite appropriate treatment. The response to actual treatment and any evidence of mixed causes of shock require examination. No survival probability, legal causation finding, or damages opinion is offered.

10. Strengths, Vulnerabilities, and Information Gaps

Finding	Strength or concern	Limit or needed evidence
Acute change from baseline	Confusion differs from prior-care description. [PC001–008; ED006]	Baseline documentation is limited to the supplied visit.
Repeated abnormalities	Persistent hypotension and rising lactate support a deterioration trend. [ED010–012; LAB002–006]	Do not establish a single cause or exact recognition deadline.
Documented treatment interval	Administration and assessment times permit focused review. [ED016–018; MAR006–008]	Need order history, result availability, clinical rationale.
Notification uncertainty	The 09:00 entry identifies a traceable communication question. [ED010–012]	Need recipient, acknowledgment, and response records.
Serious outcome	ICU admission and death are documented. [ICU001–040]	Severity alone does not establish avoidability or causal contribution.

Evidence that could change the assessment

Earlier acknowledgment and appropriately documented treatment could weaken the delayed-response concern. Verified unaddressed deterioration could strengthen it. Either finding still requires a separate patient-specific assessment of whether different care probably would have changed the outcome. The current gaps support further investigation rather than an assumption in either direction.

11. Recommended Next Review Path

Priority	Next action	Purpose
First	Obtain result verification and acknowledgment history, communication logs, audit trail, and original order/MAR history.	Reconcile knowledge, notification, ordering, and administration.
First	Obtain full fluid, monitoring, and reassessment records and applicable policy version.	Assess response to treatment and the contemporaneous care process.
Next	Focused emergency-medicine or critical-care review of the September 3 course.	Evaluate recognition, escalation, treatment decisions, and opportunity to alter progression.
If needed	Nursing review of monitoring and communication; infectious-disease input if treatment selection or source is disputed.	Resolve discipline-specific questions without extending beyond the screen.
Then	Consider a comprehensive Clinical Intelligence Review with counsel's authorization.	Integrate confirmed facts, competing explanations, and expert-dependent questions.

The preferred next path is record completion followed by focused specialty review. If the reconstructed course shows a material response gap with clinically supported outcome implications, a deeper integrated review is warranted. If additional records establish an appropriate response or remove the alleged interval, the concern should be narrowed or reconsidered. Counsel retains all legal and case-selection decisions.

12. Limitations and Source Reference Appendix

This is an initial screening report based only on the materials identified as reviewed. It does not state legal conclusions, assign liability, determine legal causation, provide expert opinion, or replace comprehensive clinical, specialty, or legal review.

Source map: ED001–012 supports presentation and early nursing observations; ED016–018 supports the later-entered physician assessment; ED024–032 supports escalation and transfer. LAB002 and LAB006 support serial lactate values. MAR001–016 supports documented treatment. RAD001–004 supports reported chest findings. ICU001–018 and ICU035–040 support the ICU diagnosis, course, and outcome. PC001–012 supports baseline. POL001–006 supports the supplied policy excerpt only.

The complete source inventory appears in Section 3. All identifiers and clinical content are fictional and created solely for this example. No actual clinical review, specialty approval, numerical score confirmation, or QA release is represented. In a real matter, the final report requires the applicable clinical and quality approvals before delivery.