EXHIBIT 2

Texas Children's Hospital

MEMORANDUM OF TRANSFER

INSTRUCTIONS: SECTION A (WITH ATTACHMENTS REQUIRED BY SECTION 11-2.9, HOSPITAL LICENSING STANDARD) MUST BE FILLED OUT BY TRANSFERRING HOSPITAL. SECTION D MUST BE FILLED OUT BY RECEIVING HOSPITAL

For clarification on list of reconciled medications, or other information on the patient's treatment at TCH, please call 832-824-5550 to be connected to the Transferring Physician.

Section A *(Transferring Center Completion)*

1. Name and Address of Hospital: *Woodlands - 17600 I-45 South, The Woodlands, TX 77384 - (936) 267-5000*

2. Patient's Information (if known)

Patient's Name: [redacted]

[redacted]

Phone: *832-969-8254*

Sex: *M* | **Age:** *7 m.o.*

National Origin: *Hispanic [2]* | **Race:** *White [1]*

Religion: *No religion on file* | **Physical Handicap:** *n/a*

3. Next of Kin (if known)

Name: *TORRES,ANA*

Address:

Phone: | **Next of Kin Notified?**

4. Date of Arrival: *9/24/20* | **Time:** *10:08 PM*

5. Initial contact with receiving hospital

Date: *09/28/20* | **Time:** *1405*

Name of contact person at receiving hospital:

Dr. Erickson

6. Accepting physician secured by transferring physician

Date: *09/28/20* | **Time:** *1405*

Name of accepting Physician: *Dr. Thomas, James*

Address: *6621 Fannin St Houston Tx*

Phone: *832-824-5550*

7. Accepting hospital secured by transferring hospital:

Date: *09/28/20* | **Time:** *1406*

Name of accepting hospital administration person:

Zahid Raja

8. Transferring Hospital Administration Signature:

Melissa Muse

Date: *09/28/20* | **Time:** *1405*

Title: *RN* | **Phone:** *832-824-5550*

9. Facility transported to: *Texas Childrens Hospital MC*

Address: *6621 Fannin St houston Tx*

Phone: *832-824-5550*

10. Diagnosis: Cardiac arrest in pediatric patient

11. Reason for Transfer: *Higher Level of Care*

Section B *(Physician to Complete)*

PHYSICIAN CERTIFICATION: *Based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of the transfer to the patient and, in the case of labor, the unborn child.*

Summary of Benefits of Transfer: *higher level of care(Simultaneous filing. User may not have seen previous data.)*

Summary of Risks of Transfer: *MVA(Simultaneous filing. User may not have seen previous data.)*

Risks of the Individual If Not Transferred: *worseing condition(Simultaneous filing. User may not have seen previous data.)*

12. Transferring physician's name or name of hospital staff acting under physician's orders

Physician's Name: *C Erikson, MD(Simultaneous filing. User may not have seen previous data.)*

Physician's Signature: *C Erikson, MD(Simultaneous filing. User may not have seen previous data.)*

Name and Address of Hospital: *Woodlands - 17600 I-45 South, The Woodlands, TX 77384 - (936) 267-5000*

[redacted]

Patient (continued)

Documents (group 5 of 5) (continued)

Section C *(Sending Staff to Complete)*			
13. Type of vehicle and company used: *Kangaroo Crew*			
Equipment Needed: *PALS*			
Personnel Needed: *RN, RT*			
14. Included with MOT (Transfer Report)			
X-Ray: *Yes*	**MD Progress Notes:** *Yes*	**H&P:** *Yes*	**Medication Record:** *Yes*
Lab Reports: *Yes*	**Nurses Progress Notes:** *Yes*	**Other:**	**MAR/Home Medeist:** *Yes*
15. Condition of Discharge: *Stable for Transfer*			
PATIENT CONSENT TO TRANSFER: *I hereby consent to transfer to another medical facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made. I have considered these risks and benefits and consent to transfer.*			
Signature of Patient or Responsible Party: [signature]		**Date:** 9/28/20	**Time:** 1509
Witness: Melissa Muse RN			

Section D *(To Be Filled Out at Receiving Hospital)*			
1. Name of Hospital:		**4. Receiving physician assumed patient responsibility**	
Address:		**Physician Name:**	
Phone:		**Date:**	**Time:**
2. Date of Arrival:	**Time:**	**Receiving Physician's signature:**	
3. Hospital Administration Signature:			
Date:	**Time:**	**Address:**	
Title:		**Phone:**	
5. If response to transfer request was delayed beyond thirty (30) minutes, document the reason(s) for the delay, including any time extensions agreed to by transferring hospital. Use additional sheet it necessary.			

Once Sections A, B, and C are completed and the patient's signature has been obtained, please do the following:
Print the patient transfer report and make of copy of the MOT to send with the patient. Place the original MOT in the HIM basket.

[redacted]

Printed by TAYLOR MUSE, MELISSA [3172] at 9/28/2020 2:58:51 PM

09/29/2020 - Appointment in Nuclear Radiology Imaging at Legacy Tower

Visit Information

Appointment Information

09/29/2020 - Appointment in Nuclear Radiology Imaging at Legacy Tower (continued)

Visit Information (continued)

NM BRAIN IP **Arrived**
9/29/2020 2:15 PM

Time	Provider	Department	Length
2:15 PM	LT NM2	LT NUC RADIOLOGY	60 min

Arrival Time: 2:13 PM

History

Made On:	9/29/2020 2:12 PM	By:	Elliott, Ken M	ES
Checked In:	9/29/2020 2:13 PM	By:	Elliott, Ken M	ES

Medication List

Medication List

Cannot display patient medications because the patient has not yet been checked in.

Imaging

Imaging

NUC Brain Imaging Vascular Flow Only (Final result)

NUC Brain Imaging Vascular Flow Only Resulted: 09/29/20 1548, Result status: Final result

Ordering provider: Abelt, Mary R, APRN, NP 09/29/20 1411
Order status: Completed
Resulted by: Sher, Andrew C, MD
Filed by: Interfacei, Radrescvr 09/29/20 1550
Performed: 09/29/20 1413 - 09/29/20 1542
Accession number: 7001943
Resulting lab: INACTIVE
Narrative:
EXAM: NUC BRAIN IMAGING VASCULAR FLOW ONLY

CLINICAL HISTORY:
Reason for Exam: evaluate for brain death
Clinical Signs and Symptoms: first brain death exam showed no function. s/p drowning, fixed dilated pupils

TECHNIQUE: Following the injection of 2.4 mCi of Tc-99m Neurolite, two second per frame dynamic image acquisition began and was continued for one minute. Static planar images in the anterior, right lateral, and left lateral position were subsequently obtained.

COMPARISON: None

FINDINGS:

Dynamic imaging shows no intracranial perfusion.

Delayed static images do not demonstrate radiotracer uptake within the brain parenchyma. Radiotracer activity is increased in the nasal mucosa.

Impression:
:

Images show no evidence of brain perfusion.

09/29/2020 - Appointment in Nuclear Radiology Imaging at Legacy Tower (continued)

Imaging (continued)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
105 - Unknown	INACTIVE	Unknown	Unknown	06/26/07 1615 - Present

NUC Brain Imaging Vascular Flow Only — Resulted: 09/29/20 1413, Result status: In process

Ordering provider: Abelt, Mary R, APRN, NP 09/29/20 1411
Resulted by: Sher, Andrew C, MD
Performed: 09/29/20 1413 - 09/29/20 1542

Order status: Completed
Filed by: Elliott, Ken M 09/29/20 1413
Accession number: 7001943

Signed

Electronically signed by Sher, Andrew C, MD on 9/29/20 at 1548 CDT

Medication Administrations

No documentation.

Visit Account Information

Hospital Account

Name	Acct ID	Class	Status	Primary Coverage
[redacted]	70641859	INPATIENT	Open	COMMUNITY HEALTH CHOICE MCD - COMMUNITY HC STAR MCD

Guarantor Account (for Hospital Account #70641859)

Name	Relation to Pt	Service Area	Active?	Acct Type
Torres, Ana Patricia	Mother	TCH	Yes	Personal/Family
Address	**Phone**			
[redacted]	832-969-8254(H)			

Coverage Information (for Hospital Account #70641859)

F/O Payor/Plan	Precert #
COMMUNITY HEALTH CHOICE MCD/COMMUNITY HC STAR MCD	20909321
Subscriber	**Subscriber #**
[redacted]	xxxxx4839
Address	**Phone**
PO BOX 301404 HOUSTON, TX 77230	713-295-2294

09/29/2020 - Appointment in X-Ray/Fluoroscopy Imaging 7 at Legacy Tower

Visit Information

09/26/2020 - Appointment in CT Imaging at The Woodlands (continued)

Medication List (continued)

Imaging

Imaging

CT Head without Contrast (Final result)

CT Head without Contrast — Resulted: 09/26/20 1609, Result status: Final result

Ordering provider: Nava, Bridgette M, PA-C 09/26/20 1413
Resulted by: Rauch, Ronald A, MD
Performed: 09/26/20 1454 - 09/26/20 1512
Resulting lab: INACTIVE
Order status: Completed
Filed by: Interfacei, Radrescvr 09/26/20 1611
Accession number: 6998166

Narrative:
EXAM: CT HEAD WITHOUT CONTRAST.

CLINICAL HISTORY: Brain death on examination, repeat CT

TECHNIQUE: Axial CT images were obtained through the brain without contrast. Multiplanar reformats were performed.

COMPARISON: Previous CT scan from the 24th 2020

FINDINGS:
Brain is markedly abnormal. There is generalized loss of gray-white junction loss sulci overlying the brain although the cerebellum and brainstem appear less hypodense. Ventricles are small, probably slightly smaller than seen before. There are small focal areas of high density seen overlying the brain which could represent minimal hemorrhage or possibly blood within cortical veins. No shift of midline is present.

3-dimensional images of the skull, show the cranial sutures are all somewhat split greater than was seen before suggesting of increased intracranial pressure.. Opacification of ethmoid air cells and circumferential mucosal thickening in maxillary sinuses and fluid within the mastoid air cells probably related to intubation.

Impression:
:

Markedly abnormal CT scan of brain showing loss of gray-white junction and loss of sulci overlying the brain and minimally smaller size of ventricles than before in a pattern that appears slightly progressively worse since the prior study from 40 hours ago suggestive of diffuse cerebral edema likely related to hypoxic ischemic insult to the brain.

In addition, cranial sutures appear more widely split than before suggestive of interval increase in intracranial pressure.

No acute hemorrhage or subdural collections or shift of midline is seen.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
105 - Unknown	INACTIVE	Unknown	Unknown	06/26/07 1615 - Present

CT Head without Contrast — Resulted: 09/26/20 1535, Result status: Preliminary result

Ordering provider: Nava, Bridgette M, PA-C 09/26/20 1413
Resulted by: Rauch, Ronald A, MD
Performed: 09/26/20 1454 - 09/26/20 1512
Resulting lab: INACTIVE
Order status: Completed
Filed by: Interfacei, Radrescvr 09/26/20 1535
Accession number: 6998166

Narrative:
EXAM: CT HEAD WITHOUT CONTRAST.

09/26/2020 - Appointment in CT Imaging at The Woodlands (continued)

Imaging (continued)

CLINICAL HISTORY: Brain death on examination, repeat CT

TECHNIQUE: Axial CT images were obtained through the brain without contrast. Multiplanar reformats were performed.

COMPARISON: Previous CT scan from the 24th 2020

FINDINGS:
Brain is markedly abnormal. There is generalized loss of gray-white junction loss sulci overlying the brain although with slightly more normal appearance to the cerebellum and brainstem. Ventricles are small, probably slightly smaller than seen before. The small focal areas of high density seen overlying the brain which could represent minimal hemorrhage or possibly blood within cortical veins. No shift of midline.

3-dimensional images of the skull, the cranial sutures are all somewhat split greater than was seen before suggesting of increased intracranial pressure. Is opacification of ethmoid air cells and circumferential mucosal thickening in maxillary sinuses and fluid within the mastoid air cells probably related to rotation.

Impression:
:

Markedly abnormal CT scan of brain showing loss of gray-white junction and loss of sulci overlying the brain and minimally smaller size of ventricles in a pattern that appears slightly progressively worse since the prior study from 40 hours ago suggestive of diffuse cerebral edema likely related to hypoxic ischemic insult to the brain.

In addition, cranial sutures appear more widely split than before suggestive of interval increase in intracranial pressure.

No acute hemorrhage or subdural collections or shift of midline is seen.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
105 - Unknown	INACTIVE	Unknown	Unknown	06/26/07 1615 - Present

CT Head without Contrast Resulted: 09/26/20 1454, Result status: In process

Ordering provider: Nava, Bridgette M, PA-C 09/26/20 1413
Resulted by: Rauch, Ronald A, MD
Performed: 09/26/20 1454 - 09/26/20 1512
Order status: Completed
Filed by: Diez, Lillian M 09/26/20 1454
Accession number: 6998166

Signed

Electronically signed by Rauch, Ronald A, MD on 9/26/20 at 1609 CDT

Medication Administrations

No documentation.

Referral

Radiology Services #15518103

Reason: Specialty Services Required
Priority: Routine

09/24/2020 - ED to Hosp-Admission (Current) in Pediatric Intensive Care Unit 9 at Legacy Tower (continued)

H&P (continued)

Patient examined at ***
Physical Exam

Labs/Imaging Reviewed: {Yes/No:304052370}

***Impressions**

Patient is {Assessment:304063313} and has the following active issues:
Principal Problem:
Cardiac arrest in pediatric patient
Active Problems:
Cardiopulmonary arrest
Acute respiratory failure with hypoxia and hypercapnia
Submersion injury
Cerebral edema due to anoxia
On mechanically assisted ventilation
Diabetes insipidus
AKI (acute kidney injury)
Coagulopathy
Lactic acidosis
Shock liver
Hypophosphatemia
Hypokalemia
Severe hypoxic ischemic encephalopathy (HIE)

***

***Plan**

Admit to PICU
Place on continuous cardiopulmonary monitoring
Continue vasopressin
Notify neurology consult
Order perfusion exam
Continue Keppra Q12
Continue famotidine
Notify life gift

Supervising Critical Care Physician: Dr. Arikan
Signature: ***

H&P by Sigdel, Binayak, MD at 9/24/2020 11:13 PM

I have reviewed the history of this patient and examined physically and reviewed the lab and pertaining images.

H&P (continued)

The patient is critically ill with acute hypoxemic respiratory failure due to submersion injury, now with multiorgan failure with significant cerebral edema, cardiogenic shock requiring high dose epinephrine, coagulopathy..

As per the mother the baby was atetnded by the 15 yr old brother in a room upstairs, who found the child was vomiting, who then took baby to the bathtub to clean and " left the baby there in the tub with faucet open" and came back in to check to find baby floating, he scooped baby and brought to the parents downstairs, father started CPR, mother continued CPR till EMS came(approx 5 min) and they intubated the child and continued CPR and brought child to our EC at TCH WOO. enroute they gave some fluid bolus, and gave 11 rounds of epinephrine, EC gave 3 rounds of Epi, and achieved ROSC. His presenting ph was <6.8 and lactate >19.9, He also received 40/kg fluid bolus, got head CT and brought the pt tot he PICu.

I briefly saw the patient at the EC, gone there to respond to a code page on this patient, which turned out to be a false alarm.

I have talked to the investigating detective and their account is almost the same, they found baby's vomitus in the house, they have communicated that they will continue to be in touch with us.

In our PICU we have given 40/kg of fluid bolus, 5% albumin, cryo and FFp and 2 meq/kg of sodium bicarbonate.After our failed CVl placement attempt, IR was called who put in a 4fr DL central left femoral venous line.

Exam time: 2325

Physical exam:
2 IO in situ, and a piv, no obvious signs of injury in body or extermities, no obvious fractures
CVs:s1s2m0
Rs: b/l VBS, occassional crackle
CNs: pupil 4 mm and not reactive to light, no cough or gag reflex
Abd: soft and non tender

Plan:
CNS: keppra, watch for seizure, not on any sedative medication, neuro consult am for formal evaluation, keep head end elevated, significant cerebral edema, can progress to brainstem dysfunction and death
Rs: titrate mechanical ventilation to keep adequately Oxygenated and ventilated, VBG q1hr
CVs: monitor hemdoynamics closely, titrate epi to keep map in 45, SBP in 70s, serial lactates
Fen/Gi: NPo and IVf with sodium acetate, till ph improves to >7.25, at risk of renal failure
Id: Iv ceftriaxone for presumed aspiration
Heme: coagulopathic, give FFP and cryo, CMp q12hr, coags q8hr, cbc q12hr, chem q6hr
Social: updated family on plan of care.

I have updated the family about the critical condition of [redacted], family is appropriately tearful. I have discussed with them that he is very sick and can arrest again in hospital ,His next 12-24 hrs are going to be crucial. He has significant brain injury and that this brain injury will get worse in next 24-48 hrs, there is a significant possibility that he develops brainstem dysfunction progressing to brain death.

Sw consult asked for.
Chaplain service requested as well.

Binayak Sigdel
PCCM attending
Voltae:37707
Critical care time 120 min

Critical Care Service
History & Physical

***Chief Complaint:**

History received from: mother
Patient's primary language: English

Chief Complaint: submersion injury

***History of Present Illness**

[redacted] is a 7 month old male with no PMH who presented to the WL EC after suspected submersion injury. Mother reports that her 16 year old son took [redacted] into the other room and Mother and Father remained in their bedroom. Mother states "all I know is that my 16 year old son came running to me with [redacted] in his arms" and stated that he vomited when she took him from her 16 year old's arms. Mother stated that she is unsure exactly what happened but says that [redacted] vomited and her 16 year old son was cleaning him with water. I asked if he was left alone in he bath tub or had water running over him and Mother stated that she did not know.
Mother then stated that Father performed CPR and 911 was called. It was reported he received Epinephrine x 11 via EMS and x3 in WL EC.. Arrived tto EC CPR in progress and was able to obtain ROSC and started on Epinephrne gtt. Initial blood gas: pH <6.80, lactate >19.9. Head CT obtained and transported to WL PICU.

Of note, police officer and EC nursing staff have reported that Mother stated the 16 year old brother was caring for [redacted] and he vomited. 16 year old brother took [redacted] to the bathtub to rinse off and left the [redacted] in the bathtub with running water for an unknown reason and unknown amount of time. Upon brother's return to bathroom, [redacted] was noted to be floating in the water.

No known sick contacts
No known COVID exposure
No known allergies to food or medication
No previous surgeries
Takes no medications daily
Born full term by repeat c/s

***Review of Systems**

H&P (continued)

Review of Systems
Constitutional: Positive for activity change.
Hypothermia
HENT: Negative.
Eyes: Negative.
Respiratory: Positive for apnea.
Cardiovascular:
Arrived CPR in progress, ROSC in EC
Gastrointestinal: Negative.
Genitourinary: Negative.
Musculoskeletal: Negative.
Skin: Positive for pallor.
Allergic/Immunologic: Negative.
Neurological: Negative.
Hematological: Negative.

Past Medical/Surgical History

No past medical history on file.
No past surgical history on file.

Family History

Reviewed
No family history on file.

Social History

Reviewed
Social History

Lifestyle
- Physical activity
  - Days per week: Not on file
  - Minutes per session: Not on file
- Stress: Not on file

Relationships
- Social connections
  - Talks on phone: Not on file
  - Gets together: Not on file
  - Attends religious service: Not on file
  - Active member of club or organization: Not on file
  - Attends meetings of clubs or organizations: Not on file
  - Relationship status: Not on file
- Intimate partner violence
  - Fear of current or ex partner: Not on file

Emotionally abused:	Not on file
Physically abused:	Not on file
Forced sexual activity:	Not on file

Other Topics	Concern

- Not on file

Social History Narrative

Lives with Mom and Dad and 4 siblings. One outside dog. No exposure to smoke of any kind

Other History

*Allergies

No Known Drug or Food Allergies

Immunizations

Up to date

Medications Prior to Admission

None

*Physical Exam

Temp: **(!) 93 °F (33.9 °C)**	Pulse: 143
Temp src: Rectal	Resp: 34
BP: **(!) 72/35**	Weight: 7 kg (15 lb 6.9 oz)
SpO2: 100 %	

Artificial Airway Type: ETT or trach: ETT ETT 3.5 cuffed
Conventional Vent: Vent Mode: VC-SIMV (AutoFlow)
Set Rate (/min): 30
Ti (s): 0.8
PIP (cm H2O): 19 cm H2O
Vt Set (ml): 75 ml
PEEP (cm H2O): 5 cm H20
Vent FiO2 (%): 100 %
PS (cm H2O): 10 cm H2O
Paw (cm H2O): 13
SIMV- VC

Patient examined at 2322

Physical Exam

Constitutional:

Appearance: He is well-developed and normal weight. He is toxic-appearing.

H&P (continued)

Interventions: He is intubated.
Comments: **No response to sternal rub**

HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: Nose normal.
Comments: **Salem sump to left nare with greenish-brown drainage and**
Mouth/Throat:
Lips: Pink.
Mouth: Mucous membranes are moist.
Comments: **Lips mildly dry**

Eyes:
General: Lids are normal.
Comments: **Bilateral conjunctivae/sclerae mildly injected. Bilateral pupils 4mm, nonreactive**

Neck:
Musculoskeletal: Neck supple.

Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Pulses are weak.
Heart sounds: Normal heart sounds, S1 normal and S2 normal. No friction rub. No gallop.
Comments: **Weak peripheral pulses, normal central pulses**

Pulmonary:
Effort: No respiratory distress. He is intubated.
Breath sounds: Normal breath sounds.
Comments: **On ventilator, PIPs 20**

Abdominal:
General: Bowel sounds are normal.
Palpations: Abdomen is soft. There is hepatomegaly.
Comments: **Mild distention**

Genitourinary:
Penis: Normal and circumcised.

Musculoskeletal:
Comments: **Does not move extremities**

Skin:
Capillary Refill: Capillary refill takes more than 3 seconds.
Findings: No rash.
Comments: **On warming blanket, warm extremities. Head is cool to touch.**

Neurological:
Comments: **Intubated, no sedation, no response to painful stimuli, does not move extremities.**

Labs/Imaging Reviewed: Yes

09/24/2020 - ED to Hosp-Admission (Current) in Pediatric Intensive Care Unit 9 at Legacy Tower (continued)

H&P (continued)

Recent Labs

	09/24/20 2340
WBC	**19.37***
HGB	11.7
HCT	**39.7***
PL	223
MCV	**93.2***
SEG	**8.9***
BAND	4.8
LYMP	**82.3***
MONOS	**2.4***
EOS	0.8

No results for input(s): LDH, ABORH in the last 72 hours.

Recent Labs

	09/24/20 2227	09/24/20 2239	09/24/20 2338	09/25/20 0033
NA	--	137	--	--
K	--	**5.7***	--	--
CL	--	**106***	--	--
CO2	--	**5***	--	--
GLUC	--	**282***	--	--
BUN	--	7	--	--
CREAT	--	**0.62***	--	--
CA	--	**11.0***	--	--
IONCA	**1.74***	--	**1.49***	1.23
MG	--	**3.3***	--	--
PHOS	--	**10.4***	--	--

Recent Labs

	09/24/20 2227	09/24/20 2338	09/25/20 0033
PHV	**<6.80***	--	--
ABE	--	-28.3	-25.3
BICARB	--	4	4

Impressions

Patient is critically ill and requires intensive evaluation and monitoring and has the following active issues:
Principal Problem:
Acute respiratory failure with hypoxia and hypercapnia
Active Problems:

Cardiopulmonary arrest
Hypothermia
Submersion injury
Cerebral edema due to anoxia

[redacted] is a 7 month old male with no PMH admitted with acute respiratory failure with hypoxia and hypercapnia secondary to submersion injury with cardiopulmonary arrest requiring intensive monitoring of hemodynamics and perfusion.

***Plan**

Respiratory:
- Close monitoring of respiratory status
- Continue full ventilatory support, currently on SIMV-VC, titrate to optimize oxygenation and ventilation/continue to monitor for respiratory distress
  - PS 10 PEEP 8 R 34 TV 60 Ti 0.6
- Wean oxygen supplementation as tolerated to maintain saturations > 90%
- CXR and blood gas daily while intubated
- VAP prevention with HOB elevated, in-line suctioning PRN, oral care Q4hrs
- Airway Clearance: inline suction prn

Cardiovascular: S/p 30ml/kg NS bolus
Monitor hemodynamics and perfusion
Continue Epinephrine gtt and titrate to keep MAPs above 45
Give 20ml/kg NS now

CNS:
Monitor neuro VS hourly
Keppra 30mg/kg once now
Consult Neurlogy
Continue Sedation/Analgesia for comfort/pain management:
Fentanyl Step 1
Versed Step A
Goal SBS -1
Tylenol/Ibuprofen per protocol

FEN/GI:
Nutrition: NPO on mIVF D5NS @ 28ml/hr
GI prophylaxis: Famotidine q12h
Give 2mEq NaHCO3 now

Renal:
Strict I/Os via Foley

Heme:
Send CBC now

ID:
Monitor temperature curve and for s/sx infection
Follow pending cultures:

Antimicrobial Bundle	
Infection	pna
Antimicrobial	Ceftriaxone (day#1)
Culture, pending or resulted/Date Collected	BAL 9/24: pending COVID: pending
Planned length of therapy	TBD pending clinical course and cultures

Lines/Drains:
All lines/drains reviewed and necessary: ETT, salem sump, Foley, PIVs, IO x2
Consult IR for central access

Lab Schedule:
Chem 10 Q6H
CBC Q12H
DIC panel Q8H
Blood gas Q1H

Social:
Parents at bedside and updated on plan of care during multidisciplinary rounding. All questions and concerns have been fully addressed.

Disposition:
Admit to PICU

Anticipated date of discharge: TBD

Supervising Critical Care Physician: Sigdel

Signature:
Kimberly Deese, MSN, APRN, CPNP-AC
Pediatric Critical Care Medicine
Texas Children's Hospital
Baylor College of Medicine
Voalte: 37709 / 37710

The patient's assessment and plan of care as outlined above was discussed with my attending, consulting services and other team members on rounds/admission.

Electronically signed by Sigdel, Binayak, MD at 09/25/20 0248

Consult Notes (continued)

Consults by King, Staci D, MD at 9/26/2020 5:50 PM

Consult Orders
1. IP Consult to Neurology [258897050] ordered by Nava, Bridgette M, PA-C at 09/25/20 1133

PEDIATRIC NEUROLOGY CONSULTATION NOTE
Texas Children's Hospital The Woodlands

Name: [redacted]
Date of Birth: [redacted]
Date: 09/26/2020
History obtained by: mom, dad, chart review
Interpreter: none

Chief Complaint: Cardiac arrest (Arrives via CCEMS with report of patient being found in bath tub, reportedly being wtched by little brother who reported to parents that the patient vomited. EMS report epinephrine x 11 PTA)

History of Present Illness: [redacted] is a 7 m.o. male who presents with cardiac arrest. Per chart review:
As per the mother the baby was attended by the 15 yr old brother in a room upstairs, who found the child was vomiting, who then took baby to the bathtub to clean and " left the baby there in the tub with faucet open" and came back in to check to find baby floating, he scooped baby and brought to the parents downstairs, father started CPR, mother continued CPR till EMS came(approx 5 min) and they intubated the child and continued CPR and brought child to our EC at TCH WOO. enroute they gave some fluid bolus, and gave 11 rounds of epinephrine, EC gave 3 rounds of Epi, and achieved ROSC. His presenting ph was <6.8 and lactate >19.9, He also received 40/kg fluid bolus, got head CT and brought the pt to the PICU.

Review of Systems:
CONSTITUTIONAL: Reports no specific concern
EYES: Reports no specific concern
EARS, NOSE, THROAT: Reports no specific concern
CARDIOVASCULAR: Reports no specific concern
RESPIRATORY: Reports no specific concern
GASTROINTESTINAL: Reports no specific concern
GENITOURINARY: Reports no specific concern
NEUROLOGIC: see HPI
ENDOCRINE: Reports no specific concern
SKIN: Reports no specific concern
MUSCULOSKELETAL: Reports no specific concern
HEME/LYMPHATIC: Reports no specific concern
ALLERGIC/IMMUNOLOGIC: Reports no specific concern
PSYCHIATRIC: Reports no specific concern

History: *I have reviewed past medical history, family history, social history, medications and allergies as documented in the patient's electronic medical record. See below for further pertinent details.*

Past Medical: None

Family Medical: No pertinent family history.

Social: Lives with parents

Medications:
Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
dextrose 5% -	1,600	Intravenous	CONTINUO	Nava, Bridgette	32.67	1,600

09/24/2020 - ED to Hosp-Admission (Current) in Pediatric Intensive Care Unit 9 at Legacy Tower (continued)

Consult Notes (continued)

lactated ringers (D5-LR) with potassium CHLORide 4 mEq/100 mL IV Infusion	mL/m2/day (Dosing Weight)		US	M, PA-C	mL/hr at 09/26/20 1418	mL/m2/day at 09/26/20 1418
• sodium CHLORide 0.9% (NS) Prime Bag		See Administration Instructions	PRN	Deese, Kimberly H, APRN, CPNP		
• sodium CHLORide 0.9% (NS) Injection Flush		Intravenous	PRN	Deese, Kimberly H, APRN, CPNP		
• heparin Injection 10 units/mL (flush)	30 Units	Intravenous	PRN	Deese, Kimberly H, APRN, CPNP		
• heparin in NS (PF) Injection 1 unit/mL (50 mL) Flush - CVP LINE		Intravenous	CONTINUOUS	Deese, Kimberly H, APRN, CPNP		Stopped at 09/26/20 1100
• papaverine/heparin in NS Continuous Infusion 0.12 mg/mL-1 unit/mL		Intra-arterial	CONTINUOUS	Deese, Kimberly H, APRN, CPNP	2 mL/hr at 09/26/20 0700	2 mL/hr at 09/26/20 0700
• leveTIRAcetam (KEPPRA) INJ 330 mg	30 mg/kg	Intravenous	Q12	Sigdel, Binayak, MD		330 mg at 09/26/20 0814
• vasopressin Continuous Infusion 0.05 units/mL	0.006 Units/kg/hr (Dosing Weight)	Intravenous	CONTINUOUS	Nava, Bridgette M, PA-C	1.32 mL/hr at 09/26/20 1712	0.006 Units/kg/hr at 09/26/20 1712
• acetaminophen (Ofirmev) INJ 110 mg	10 mg/kg (Dosing Weight)	Intravenous	Q6	Nava, Bridgette M, PA-C		110 mg at 09/26/20 1422
• sodium CHLORide 0.9% (NS) Carrier IV Infusion	50 mL	Intravenous	CONTINUOUS	Nava, Bridgette M, PA-C	2 mL/hr at 09/26/20 0700	
• famotidine (PEPCID) IV INJ 2.8 mg	0.25 mg/kg (Dosing Weight)	Intravenous	Q12	Deese, Kimberly H, APRN, CPNP		2.8 mg at 09/26/20 0839
• cefepime INJ 560 mg	50 mg/kg (Dosing Weight)	Intravenous	Q8	Riccioni, Mark J, APRN, CPNP		560 mg at 09/26/20 1135
• lactated ringers (LR) Bolus Injection	200 mL	Intravenous	PRN	Pymento, Craig F, MD	999 mL/hr at 09/26/20 0614	
• sodium CHLORide 0.9% (NS) Carrier IV Infusion		Intravenous	CONTINUOUS	Pymento, Craig F, MD		Stopped at 09/26/2

Consult Notes (continued)

					0 0500
• ocular lubricant ((LACRI-LUBE)) OPHTH OINT		Both Eyes	Q4	Gutierrez, Efren Jr., MD	Stopped at 09/26/20 0800
• bisacodyl RECTAL SUPP 5 mg	5 mg	Rectal	DAILY PRN	Deese, Kimberly H, APRN, CPNP	

Allergies: No Known Drug or Food Allergies

Physical Exam:
Vital Signs: Blood pressure **(!) 129/90**, pulse 117, temperature **(!) 96.4 °F (35.8 °C)**, temperature source Rectal, resp. rate 14, height 77.5 cm (2' 6.5"), weight (S) 11 kg (24 lb 4 oz), head circumference 40 cm (15.75"), SpO2 100 %. >99 %ile (Z= 2.56) based on WHO (Boys, 0-2 years) weight-for-age data using vitals from 9/25/2020. <1 %ile (Z= -3.31) based on WHO (Boys, 0-2 years) head circumference-for-age based on Head Circumference recorded on 9/25/2020.

General Appearance: Not responsive.
Head: Normocephalic, no craniofacial dysmorphology. Anterior fontanelle open and full.
Cardiovascular: Regular rate.
Respiratory: Ventilated.
Abdominal: Soft, non-protuberant.
Extremities: Normal digits, no evidence of hemiatrophy or hemihypertrophy.
Musculoskeletal: No deformities.
Skin: No abnormal cutaneous lesions.

Neurologic:
Mental Status: No response to painful stimuli.
Cranial Nerves:
II: Pupils non-reactive.
III/IV/VI: Pupils non-reactive.
V: Corneal reflex absent bilaterally.
VII: Corneal reflex absent bilaterally.
VIII: VOR absent.
IX: No gag.
X: No gag or cough.
XI: Absent neck rotation.
XII: Unable to assess due to intubation.
Motor: No response to central or peripheral deep painful stimuli.
Reflexes: Did not assess.
Coordination: Unable to assess.
Sensation: No response to central or peripheral deep painful stimuli.
Gait/Station: Unable to assess.

Diagnostics:
I have personally reviewed the images and reports for:
CT head w/o contrast (9/24/2020):
IMPRESSION
CT findings consistent with global hypoxic ischemic injury as detailed Above.

Routine EEG (9/26/2020):
IMPRESSION:
Abnormal EEG in the unresponsive state due to:
Severely depressed background
Lack of reactivity

Consult Notes (continued)

==========

Assessment
[redacted] is a 7 m.o. male with profound hypoxic ischemic injury after cardiac arrest from drowning. His brainstem responses are completely absent with absent brainwaves on EEG, concerning for brain death.

- Repeat CT head w/o contrast
- Formal brain death exam on 9/27/2020
- Neurology will continue to follow

Family agrees with plan and all questions answered.

I have spent a total of 100 minutes with [redacted] and family, >50% of which involved education, counseling, and coordination of care. Specifically, we discussed the diagnosis, differential for etiologies, plan of workup, and plan of management.

Staci D. King, MD | Assistant Professor
Pediatric Neurology | Baylor College of Medicine
Texas Children's Hospital - The Woodlands
Available via SPOK

Electronically signed by King, Staci D, MD at 09/26/20 1801

Consults by Malave, Maricarmen Nazario, MD at 9/25/2020 2:15 AM

Consult Orders
1. IP Consult to IR for Vascular Access [258869319] ordered by Deese, Kimberly H, APRN, CPNP at 09/25/20 0023

Interventional Radiology Consult

Date: 9/25/2020
Time: 2:15 AM

I was asked to see [redacted] in consultation to evaluate the need for vascular access at the request of Kimberly Deese, APRN, CPNP (ordering provider).

Subjective

Chief Complaint: Limited vascular access

HPI (Reason for line placement): [redacted] is a 7 m.o. male with no PMH who presented to the WL EC after suspected submersion injury. As per police officer and EC nursing staff have reported that Mother stated the 16 year old brother was caring for [redacted] and he vomited. 16 year old brother took [redacted] to the bathtub to rinse off and left the [redacted] in the bathtub with running water for an unknown reason and unknown amount of time. Upon brother's return to bathroom, [redacted] was noted to be floating in the water. Father performed CPR and 911 was called. It was reported he received Epinephrine x 11 via EMS and x3 in WL EC. Arrived to EC CPR in progress and was able to obtain ROSC and started on Epinephrne gtt. Initial blood gas: pH <6.80, lactate >19.9. Head CT obtained and transported to WL PICU. Attempts at central venous access were unsuccessful and I was consulted to place a central venous catheter.

Consult Notes (continued)

Pediatric Interventional Radiology
Pager # 5889

Electronically signed by Malave, Maricarmen Nazario, MD at 09/25/20 0223

Progress Notes

MD Progress Note by Musick, Matthew A, MD at 9/30/2020 1:56 PM

Brain Death Note

Date of Admission: 9/24/2020
Etiology of Brian Injury: Anoxic brain injury
This is the second exam and 72 hours has elapsed since first exam

Temp: 97.7 °F (36.5 °C)
BP: **(!) 116/76**
Pulse: 106

Sedative/analgesic drug effect has been excluded as a contributing factor: Yes
Metabolic intoxications excluded as a contributing factor: Yes
Neuromuscular blockade has been excluded as a contributing factor: Yes

Current Medications

Active Continuous Drips
vasopressin Continuous Infusion 0.05 units/mL Last Rate: 0.005 Units/kg/hr (09/30/20 0700)
dextrose 5% - lactated ringers (D5-LR) + additives Continuous Infusion Last Rate: 1,600 mL/m2/day (09/30/20 0700)
papaverine/heparin in NS Last Rate: 2 mL/hr (09/30/20 0700)
Sodium CHLORide 0.9% (NS) Last Rate: 2 mL/hr at 09/30/20 0700

Active Scheduled Medications
famotidine, 0.25 mg/kg (Dosing Weight), Q12
ocular lubricant, , Q4

Active PRN Medications
Sodium CHLORide 0.9% (NS), , PRN
Sodium CHLORide, , PRN
heparin, 30 Units, PRN
bisacodyl, 5 mg, DAILY PRN

Progress Notes (continued)

Physical Exam

Flaccid tone is present and patient is unresponsive to deep painful or auditory stimuli: Yes
Pupils are midposition or fully dilated and light reflexes are absent in both eyes: Yes
Corneal reflexes are absent bilaterally: Yes
Cough reflex is absent: Yes
Gag reflex is absent: Yes
In neonates and infants, sucking and rooting reflexes are absent: Yes
Oculovestibular reflexes (Cold Calorics) are absent bilaterally: Yes
Spontaneous Respirations while on ventilator are absent: Yes
Apnea test was performed: Yes
Apnea test start time: 13:24
ABG at start: 7.32/42
Apnea test end time: 13:31
ABG at end: 7.14/61
Time off ventilator: 7 minutes

We were forced to cease the apnea test at 7 minutes because the patient was becoming hypoxic and hypotensive (despite 100% FiO2 blow by via T-piece and PEEP valve).

Ancillary test, was already performed 9/29/20 at 15:42
I certify that my examination is consistent with cessation of function of the brain and brainstem.
The ancillary study and all components or the second neurologic exam that could be performed confirms the irreversible cessation of function of the brain and brainstem and the child is declared brain dead at 13:31.
The following were notified of the above findings: Mother, Father, Grandparents, Other family members, Medical Examiner's Office, Life Gift

Labs

Recent Labs

	09/29/20 0625
NA	141
K	4.1
CL	**117***
CO2	22
GLUC	**129***
BUN	6
CREAT	0.16
CA	8.8
MG	**1.5***
PHOS	**3.0***

The patient has been declared brain dead. However, the legal proceedings that are happening mandate that we continue the ventilator. We will also continue vasopressin infusion for DI. Final discontinuation of ventilator will be dependent upon family decision re: organ donation and the legal process.

Signature: Matthew Musick, MD

Progress Notes (continued)

Voalte 39934

Electronically signed by Arikan, Ayse, MD at 09/30/20 0830

MD Progress Note by Thomas, James A, MD at 9/28/2020 4:05 PM

Transport Note

Called for transport of this patient from WL PICU.
Preliminary Diagnosis/Complaint: severe HIE, cardiac arrest, acute respiratory failure, CDI
Brief hx: 7 month old with severe submersion injury 5 days ago. Yest brain death exam c/w brain death and parents now refusing second exam. Internal discussions le to decision to transfer patient to MC for further care, inlcuding ethics consultation and Technetium flow study.

Reported VS are: Temp 99.9 Pulse 132 RR 14 BP 106/59 Sat 99 % Reported wt:11 kg
Exam described as:
Intubated, unresponsive, no spontt movement or respirations
HEENT: ETT in place, puils nonreactive
Chest; symm rise, good a/e
Cor; RRR no murmur
Abd: benign
Ext: warm

I have directed the following interventions: Continue current LST and transfer patient to MC for further evaluation and next steps

Concerns: None for transfer

Patient is critically ill with acute respiratory failure with hypoxemia, severe HIE, CDI, h/o cardiac arrest.
Will admit patient to LT Neuro ICU.

I have been in direct contact with transport personnel/ Kangaroo Crew and have reviewed the pertinent history. I supervised the entire inter-facility transport to Texas Children's Hospital. I have been immediately available when not on the telephone with the team. I have contacted Dr. Arikan attending on call to notify her about this incoming patient.

Signature:
James A. Thomas, MD
Pediatric Critical Care

CCM time: 45 minutes

Electronically signed by Thomas, James A, MD at 09/28/20 1638

Progress Notes (continued)

Lab Results: see Epic

Imaging Results:

CT head w/o contrast 9/24
IMPRESSION
CT findings consistent with global hypoxic ischemic injury as detailed above. Findings discussed with a member of the team via phone at the time of dictation.

CT head w/o contrast 9/26
IMPRESSION
Markedly abnormal CT scan of brain showing loss of gray-white junction and loss of sulci overlying the brain and minimally smaller size of ventricles than before in a pattern that appears slightly progressively worse since the prior study from 40 hours ago suggestive of diffuse cerebral edema likely related to hypoxic ischemic insult to the brain.

In addition, cranial sutures appear more widely split than before suggestive of interval increase in intracranial pressure.

No acute hemorrhage or subdural collections or shift of midline is seen.

Echo 9/25
Summary:

1. No structural heart disease detected.
2. Low normal left ventricle systolic function (55-57%). No focal wall motion abnormalities.
3. Normal right ventricular size and systolic function.
4. No pericardial effusion.

EEG 9/26
Abnormal EEG in the unresponsive state due to:
Severely suppressed background
Lack of reactivity

CLINICAL CORRELATION:
The above findings are indicative of a severe encephalopathy of a non-specific etiology. No epileptiform activity was observed. No clinical or electrographic seizures were recorded. Clinical correlation is recommended. No prior study is available for comparison. These findings were discussed with the neurologist on call.

Summary of Hospital Course (If no problems in any system, write: No issues)

Per H&P: [redacted] is a 7 month (10 month, Epic DOB is incorrect) old male with no PMH who presented to the WL EC after suspected submersion injury. Mother reports that her 16 year old son took [redacted] into the other room and Mother and Father remained in their bedroom. Mother states "all I know is that my 16 year old son came running to me with [redacted] in his arms" and stated that he vomited when she took him from her 16 year old's arms. Mother stated that she is unsure exactly what happened but says that [redacted] vomited and her 16 year old son was cleaning him with water. I asked if he was left alone in he bath tub or had water running over him and Mother stated that she did not know. Mother then stated that Father performed CPR and 911 was called. It was reported he received Epinephrine x 11 via EMS and x3 in WL EC.. Arrived to EC CPR in progress and was able to obtain ROSC and started on Epinephrne gtt. Initial blood gas: pH <6.80, lactate >19.9. Head CT obtained and transported to WL PICU.

Of note, police officer and EC nursing staff have reported that Mother stated the 16 year old brother was caring for [redacted] and he vomited. 16 year old brother took [redacted] to the bathtub to rinse off and left the [redacted] in the bathtub with running water for an unknown reason and unknown amount of time. Upon brother's return to bathroom, [redacted] was noted to be floating in the water.

No known sick contacts
No known COVID exposure
No known allergies to food or medication
No previous surgeries
Takes no medications daily
Born full term by repeat c/s

Airway and Breathing:
[redacted] was initially apneic when found. EMS intubated with 3.5 ETT in route to EC. Initial gas 6.91/17/4, placed on SIMV-VC on arrival to EC with modest ventilator settings. [redacted] has made no efforts of spontaneous respirations. Rate decreased to improve CO2, Initial apnea test delayed due to water in ventilator filter cause what appeared to be spontaneous respirations. First apnea test on 9/27 was positive with a 34 mmHg increase in CO2 after 10 minutes and no spontaneous respiratory effort.
Medications:
Issues Pending: 2nd apnea test/breath death exam

Cardiovascular:
Prior to admission, CPR given with 14x epinephrine given to obtain ROSC. Initially given 30mL/kg in NS bolus and started on epinephrine gtt. Epinephrine gtt discontinued within 24hrs due to increasing hypertension, also on vasopressin for DI which was titrated down for MAP >100. Echocardiogram on 9/24 shows low normal left ventricle function. Fluid replacement initially started with 1:1 but then discontinued due to electrolyte derangements. He continues to be stable from a cardiovascular perspective.
Medications: Vasopressin
Issues Pending:

Central Nervous System:
Brain death by physical exam has been present since ROSC, absent respirations, pupils fixed and dilated, absent corneal reflex, absent gag reflex, no response to painful or noxious stimuli. [redacted] has not required sedation. Initial head CT with global hypoxic ischemic injury with repeat CT per family's request with worsening insult and widened sutures. EEG performed with lack of reactivity and severely suppressed background. Neurology came in 9/27 for first brain

SW will remain available as needed.

Interventions and Referrals
Interventions: Case management
Referrals: No needs for referrals identified at this time
Plan: Continue to follow
Verbalized understanding and agreement with plan: Unrelated caretaker
Social Worker contact information provided to: CPS case worker

ASHLEY E ROWLAND, LMSW
Evening Social Worker
Texas Children's Hospital – The Woodlands
Phone: 936-267-5071 | Voalte: 38526

Electronically signed by Rowland, Ashley E, LMSW at 09/27/20 1813

Procedure Report by King, Staci D, MD at 9/27/2020 1:07 PM

Brain Death Exam:
-Flaccid tone is present and patient is unresponsive to deep painful or auditory stimuli: Yes
-Pupils are midposition or fully dilated and light reflexes are absent in both eyes: Yes
-Corneal reflexes are absent bilaterally: Yes
-Cough reflex is absent: Yes
-Gag reflex is absent: Yes
-Oculovestibular reflexes (Cold Calorics) are absent bilaterally: Yes
-Spontaneous Respirations while on ventilator are absent: Yes
-Apnea test was performed: Yes
-Apnea test start time: 1249
-ABG at start: 7.32/36/-7
-Apnea test end time: 1259
-ABG at end: 7.07/72/-8.8
-Time off ventilator: 10 minutes
-Ancillary test: EEG (9/26/2020) - The EEG background appears diffusely suppressed with no definite cerebral activity >10 microvolts. No spontaneous variability or reactivity to noxious stimulation is observed.

I certify that my examination is consistent with cessation of function of the brain and brainstem.

Confirmatory exam to follow in 12 hours

The following were notified of the above findings: Dr. Erikson

Staci D. King, MD | Assistant Professor
Pediatric Neurology | Baylor College of Medicine

Other Notes (group 2 of 3) (continued)

Texas Children's Hospital - The Woodlands

Electronically signed by King, Staci D, MD at 09/27/20 1313

Nsg/Anc Progress Note by Carr, Lisa A, RN at 9/27/2020 9:39 AM

Nursing Narrative Note

0800--Patient with bairhugger in place at 43. Pupils remain 6.0 nonreactive bilaterally. B. Nava, PA at bedside to examine patient also. Patient without corneal reflex, cough, gag or any movement to noxious stimuli. No sedatives have been given to patient. Breath sounds course, ETT suction with thick, beige secretions returned. PIP 27-29 after suctioning. Foley with very pale, yellow, clear urine returned. Mom and dad remain at bedside. Updated on plan of care, questions answered. Both parents appropriately tearful.

0930--Patient rounds done. Labs to be drawn at 1000. Brain death testing pending electrolyte results.

1010--Na 134, will recheck at 1200.

1030--Dr. Erikson at bedside to talk with family and update on plan of care. LifeGift updated on plan.

1240--Dr. King and Dr. Erikson at bedside, talked with mom and dad about performing neuro exam and apnea test. Parents state they do not want to be in the room and will leave to go get something to eat.

1249--ABG obtained, apnea test started.

1254--5 minute ABG obtained.

1259--ABG obtained, apnea test completed. Patient placed back on ventilator.

1315--Mom and dad back at bedside.

1340--Asked mom and dad if they were ready to have Dr. Erikson or Dr. King come talk with them. Dad states "I know what they are going to say and I don't want to hear it." When asked if they would like to discuss what the plan of care is after the apnea test, dad states "Not today". Dr. Erikson aware. LifeGift updated of results of brain death exam #1 and of parents response to results. LifeGift updated that exam #2 anticipated for tomorrow AM.

1500--Asked mom and dad if they would like to have patient moved into an adult bed so that they may lay in bed with him, both parents said yes. Asked parents if they would like to help bathe patients, both stating no.

1530--Patient bathed, hair shampooed. Patient moved to an adult bed with all lines and tubings on patient's right side so that parents may lay with patient from his left side.

1700--Mom laying in bed with patient. Denies any needs at this time

1800--Dad laying in bed with patient.

LISA A CARR, RN
09/27/2020

Other Notes (group 2 of 3) (continued)

Evening Social Worker
Texas Children's Hospital – The Woodlands
Phone: 936-267-5071 | Voalte: 38526

Electronically signed by Rowland, Ashley E, LMSW at 09/26/20 1633

Nsg/Anc Progress Note by Hummel, Ashlee B, RT at 9/26/2020 3:10 PM

Transport to CT and back to Picu 419 on drager. VT65, Ti 0.6, RR 14, Peep 7, PS 10, Fio2 40%, pt tolerated well. ASHLEE B HUMMEL, RT

Electronically signed by Hummel, Ashlee B, RT at 09/26/20 1608

Procedures by Sen, Sonali T, MD at 9/26/2020 1:23 PM

Procedure Orders
1. EEG [258955205] ordered by Riccioni, Mark J, APRN, CPNP at 09/26/20 0952

Texas Children's Hospital
Neurophysiology Department
EEG Report

Date of Examination: 09/26/2020

EEG Number:

[redacted]

Patient's Age: 7 m.o.

Referring Provider: King,Staci MD

EEG TECHNOLOGIST HISTORY:

Pertinent medical history:	Per note, patient is a 10 month old previously healthy boy who was attended by his 15 yr old brother in a room upstairs. He found the child was vomiting, and then took baby to the bathtub to be cleaned. He left him unattended with water running for unknown amount of time and came back in to check on baby and found him floating in the bath tub
Level of consciousness:	Comatose
Reason for EEG:	Submersion Injury
Description of event:	N/A
Frequency of events:	Ongoing

Length of episode:	Ongoing
Preceding symptoms?	No
Behavior after event is over:	N/A
Date/Time of last event:	N/A
Pertinent Medications	Keppra
Previous EEG?	No

TECHNICAL SUMMARY: Electrodes are applied by an EEG technologist according to the 10-20 electrode placement system with at least 16 recording electrodes. Ocular leads and a single electrocardiogram channel are also recorded. The electroencephalogram is recorded simultaneously with video throughout the designated time period. Monitoring is maintained and continuously attended by the neurophysiology technical staff.

A description of the terms used to quantify spikes includes:
Rare: a spike-wave index of less than 1%.
Occasional: a spike-wave index of 1-10%.
Frequent: a spike-wave index of 10-50%.
Abundant: a spike-wave index of 50-90%.
Continuous: a spike-wave index of greater than 90%.

A description of the terms used to quantify voltage includes:
Low: <20 uV
Medium or Moderate: 20-70 uV
High: >70uV

EEG DESCRIPTION:
There is no posterior dominant rhythm, anterior to posterior voltage/frequency gradient, or central rhythm observed during this study. The EEG background appears diffusely suppressed with no definite cerebral activity >10 microvolts. There is superimposed pulse, electrode, and sweat artifact. Movement artifact from medical professionals examining the patient are also seen. No spontaneous variability or reactivity to noxious stimulation is observed.

Epileptiform Abnormalities:

None

Seizures or patient events:

None

Activation Procedures:

Hyperventilation is not performed.

Photic stimulation is associated with photoelectric artifact.

ECG:

No obvious dysrhythmia

IMPRESSION:

Abnormal EEG in the unresponsive state due to:

- Severely suppressed background
- Lack of reactivity

CLINICAL CORRELATION:
The above findings are indicative of a severe encephalopathy of a non-specific etiology. No epileptiform activity was observed. No clinical or electrographic seizures were recorded. Clinical correlation is recommended. No prior study is available for comparison. These findings were discussed with the neurologist on call.

SONALI T SEN, MD
Department of Pediatrics and Neurology
Epilepsy and Neurophysiology
Baylor College of Medicine
Texas Childrens Hospital

Start Time: 1205
End Time: 1235

ICD10 Code: !46.9 Cardiac arrest

Electronically signed by Sen, Sonali T, MD at 09/26/20 2253

I, Marilyn Burgess, District Clerk of Harris County, Texas certify that this is a true and correct copy of the original record filed and or recorded in my office, electronically or hard copy, as it appears on this date.
Witness my official hand and seal of office this October 3, 2020

Certified Document Number: 92429351 Total Pages: 30

Marilyn Burgess, DISTRICT CLERK
HARRIS COUNTY, TEXAS

In accordance with Texas Government Code 406.013 electronically transmitted authenticated documents are valid. If there is a question regarding the validity of this document and or seal please e-mail support@hcdistrictclerk.com