Exhibit 14

Begin forwarded message from Dr. Fisher:

I am not a member of the Children's Hospital medical staff and I have no relationship with Children's Hospital or its administration or staff that would affect my ability to provide an independent evaluation. I will require temporary hospital privileges for the evaluation.

My *curriculum vitae* is attached. I do not have any conflicts of interest here. In the spirit of fullest disclosure, as I mentioned on the telephone, I was chair of the American Academy of Pediatrics (AAP) Section on Neurology when the pediatric brain death guidelines were re-affirmed in 2011, so I am well familiar with the guidelines (attached) and saw several drafts prior to the final publication. I have also served as a medical expert witness in the past, either for defense or plaintiff. I have never been the subject of any lawsuit.

Should you need succinct data for my qualification to the judge, I am actively boarded and certified in Neurology, with Special Competence in Child Neurology. I am Professor of Neurology and Pediatrics at Stanford University, and Chief of Child Neurology at Lucile Packard Children's Hospital. Since completing training, I have performed between 50-100 brain death examinations.

For documentation of the exam on this child, I would suggest that I write a handwritten note immediately upon completion of the evaluation, and that note can then be incorporated in the medical record at Children's Hospital Oakland.

As far as compensation, I want to be utmost fair and thoughtful here. A new patient consultation charge at Stanford is about $850 these days, or for outside consultation my rate has been for years $450/hour (about $900 for two hours). I would suggest that a flat fee of $900 be the charge, and I would like that money to be split between two children's charities: Jack's Helping Hand (P.O. Box 14718, San Luis Obispo, CA 93406) and Jasper Ridge Farm (2995 Woodside Road, #620924, Woodside, CA 94062) in honor of Jahi McMath. That money could be paid directly to the two charities or routed through me--I have no preference, as long as such is done appropriately and in timely manner.

I would propose an evaluation time of 3 pm on Monday December 23. I could do something the morning of December 24, if necessary. Your team can advise how to proceed from here.

Finally, I consent to this email being shared with counsel for hospital or patient, as well as the judge.

Best regards,

Paul

Paul Graham Fisher, M.D. | Professor, Neurology and Pediatrics, and by courtesy, Neurosurgery and Human Biology | The Beirne Family Professor of Pediatric Neuro-Oncology | Chief, Division of Child Neurology| The Bing Director, Program in Human Biology | Stanford University and Lucile Packard Children's Hospital

Contact information: 750 Welch Road, Suite 317 | Palo Alto, CA 94304-1510 | Phone (650) 721-5889 | Fax (650) 723-7299 | Administrative assistant Gayla Weng gweng@stanford.edu

PAUL GRAHAM FISHER

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Program in Human Biology: 450 Serra Mall, Building 20, Room 22P • Stanford CA 94305-2160
Telephone (650) 725-0336 • Fax (650) 725-5451
E-mail pfisher@stanford.edu

EDUCATION

1985 B.A., With Distinction, Human Biology, STANFORD UNIVERSITY
1989 M.D., UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, SCHOOL OF MEDICINE
1996 M.H.S., Epidemiology, JOHNS HOPKINS UNIVERSITY SCHOOL OF HYGIENE AND PUBLIC HEALTH

POSTDOCTORAL TRAINING

1989 - 1991 Internship and Residency in Pediatrics, THE JOHNS HOPKINS HOSPITAL HARRIET LANE PEDIATRICS SERVICE
1991 - 1994 Residency in Neurology, THE JOHNS HOPKINS HOSPITAL, DEPARTMENT OF NEUROLOGY
1994 - 1995 Fellowship in Neuro-Oncology, THE CHILDREN'S HOSPITAL OF PHILADELPHIA AND THE JOHNS HOPKINS HOSPITAL

ACADEMIC APPOINTMENTS

7/ 1/92 - 12/31/93 Chief Resident in Neurology, THE JOHNS HOPKINS HOSPITAL
7/ 1/95 - 9/30/96 Instructor in Neurology and Oncology, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
7/ 1/96 - 9/30/96 Instructor in Pediatrics, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
10/ 1/96 - 10/31/97 Assistant Professor, Neurology, Oncology, and Pediatrics, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
11/01/97 - 1/31/98 Acting Assistant Professor, Neurology and Neurological Sciences, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2/ 1/98 - 1/31/04 Assistant Professor, Neurology and Neurological Sciences and, by courtesy, Pediatrics, STANFORD UNIVERSITY SCHOOL OF MEDICINE
1/ 1/99 - 1/31/04 Assistant Professor, Pediatrics, STANFORD UNIVERSITY SCHOOL OF MEDICINE
6/ 1/01 - 1/31/04 Assistant Professor, by courtesy, Neurosurgery, STANFORD UNIVERSITY SCHOOL OF MEDICINE
7/ 9/03 - 10/12/09 The Beirne Family Medical Director of the Center for Children's Brain Tumors, LUCILE SALTER PACKARD CHILDREN'S HOSPITAL AT STANFORD
2/ 1/04 - 7/31/09 Associate Professor, Neurology and Neurological Sciences, Pediatrics, and by courtesy, Neurosurgery and Human Biology, STANFORD UNIVERSITY SCHOOL OF MEDICINE
4/25/07 - Member, STANFORD COMPREHENSIVE CANCER CENTER
9/ 1/08 - Chief, Division of Child Neurology, STANFORD UNIVERSITY SCHOOL OF MEDICINE

9/ 1/08 -	Director, The Center for Brain and Behavior, LUCILE PACKARD CHILDREN'S HOSPITAL AT STANFORD
8/ 1/09 -	Professor, Neurology and Neurological Sciences, Pediatrics, and by courtesy, Neurosurgery and Human Biology, STANFORD UNIVERSITY SCHOOL OF MEDICINE
10/13/09 -	The Beirne Family Professor of Pediatric Neuro-Oncology, STANFORD UNIVERSITY
9/ 1/12 - 2/11/13	Interim Director, Program in Human Biology, STANFORD UNIVERSITY
2/12/13 -	The Bing Director, Program in Human Biology, STANFORD UNIVERSITY

HOSPITAL APPOINTMENTS

1995 - 1997	Active Staff, THE JOHNS HOPKINS HOSPITAL, Baltimore, MD
1997	Consulting Medical Staff, THE KENNEDY-KRIEGER INSTITUTE, Baltimore, MD
1997 -	Active Staff, LUCILE SALTER PACKARD CHILDREN'S HOSPITAL, Palo Alto, CA
1997 -	Active Staff, STANFORD UNIVERSITY HOSPITAL AND STANFORD HEALTH SERVICES, Palo Alto, CA
1998 - 1999	Active Staff, DOMINICAN HOSPITAL, Santa Cruz, CA
2012 -	Active Staff, CALIFORNIA PACIFIC MEDICAL CENTER, San Francisco, CA

MEMBERSHIPS

1992 -	Active Member, AMERICAN ACADEMY OF NEUROLOGY
1992 -	Active Member, CHILD NEUROLOGY SOCIETY
1995 - 2000	Associate Member, PEDIATRIC ONCOLOGY GROUP
1996 -	Fellow, AMERICAN ACADEMY OF PEDIATRICS, no. 174921
1996 -	Active Member, AMERICAN SOCIETY OF CLINICAL ONCOLOGY, NO. 24657
1997	Member, MARYLAND NEUROLOGICAL SOCIETY
1998 -	Member, ASSOCIATION OF CALIFORNIA NEUROLOGISTS
1999 - 2003	Member, PEDIATRIC BRAIN TUMOR CONSORTIUM
1999 -	Member, Society FOR NEURO-ONCOLOGY
2000 -	Full Member, CHILDREN'S ONCOLOGY GROUP
2000 -	Affiliate Member, AMERICAN SOCIETY OF PEDIATRIC HEMATOLOGY-ONCOLOGY
2009 -	Member, PROFESSORS OF CHILD NEUROLOGY
2011 -	Active Member, AMERICAN ASSOCIATION FOR CANCER RESEARCH, no. 257956
2012 -	Member, PEDIATRIC BRAIN TUMOR CONSORTIUM

LICENSES

1994 - 2000	COMMONWEALTH OF PENNSYLVANIA, MD 052027 L
1995 - 1998	STATE OF MARYLAND, D47071
1997 -	STATE OF CALIFORNIA, G84211

BOARDING AND CERTIFICATION

1995	PEDIATRICS, certificate 055883
1998	NEUROLOGY, WITH SPECIAL QUALIFICATION IN CHILD NEUROLOGY, certificate 1114
2002	PEDIATRICS, certificate renewal 055883
2008	NEUROLOGY, WITH SPECIAL QUALIFICATION IN CHILD NEUROLOGY, certificate renewal 45490
2008	NEURO-ONCOLOGY, certificate NO00215-8

INTERNATIONAL, NATIONAL, AND REGIONAL COMMITTEES

1995 - 1997	Medical Advisory Board, THE CHILDREN'S CANCER FOUNDATION, Baltimore, MD
1996 - 1997	Medical Advisory Board, THE CHILDHOOD BRAIN TUMOR FOUNDATION, Woodbridge, VA
1996 - 1999	Neurosciences Subcommittee, PEDIATRIC ONCOLOGY GROUP
1997 -	Section on Neurology, AMERICAN ACADEMY OF PEDIATRICS
1998 - 1999	Subcommittee on Brainstem Gliomas, PEDIATRIC ONCOLOGY GROUP
1998 - 2001	Co-Investigator, POG 9879 Vincristine, Etoposide and Cyclosporine A in Concert with Standard Dose Radiation Therapy in Diffuse Intrinsic Brain Stem Glioma - A Phase I Study of Dose Escalation of Vincristine. A Pediatric Oncology Group Phase I Cooperative Agreement Study, PEDIATRIC ONCOLOGY GROUP
1999 - 2003	Co-Investigator, POG 9836 Treatment of Children with Diffuse Intrinsic Brain Stem Glioma with Standard Dose Irradiation and Vincristine Plus Oral VP-16 - A Pediatric Oncology Group Pilot Study
1999 -	Child Neurology Section, AMERICAN ACADEMY OF NEUROLOGY
2000	Abstract Review Committee and Symposium Moderator, AMERICAN PEDIATRIC SOCIETIES/SOCIETY FOR PEDIATRIC RESEARCH
2000 -	Neurology Discipline Subcommittee, CHILDREN'S ONCOLOGY GROUP
2000 - 2004	Subcommittee on Brainstem Gliomas, CHILDREN'S ONCOLOGY GROUP
2000 - 2005	Board of Directors, GREATER BAY AREA MAKE-A-WISH FOUNDATION
2000 - 2002	Question and Critique Writing Committee, Pediatrics Review and Education Program (PREP), AMERICAN ACADEMY OF PEDIATRICS
2001	Ad hoc reviewer, NATIONAL INSTITUTES OF HEALTH EDC-2 STUDY SECTION
2002 - 2004	Board Chair, GREATER BAY AREA MAKE-A-WISH FOUNDATION
2004	Scientific Review Committee, INTERNATIONAL SOCIETY FOR PEDIATRIC NEURO-ONCOLOGY
2004 - 2012	Executive Committee, Section on Neurology, AMERICAN ACADEMY OF PEDIATRICS
2004 - 2010	Chair, Long-Term Follow-up Task Force on Neurologic Complications, CHILDREN'S ONCOLOGY GROUP
2004 - 2009	Chair, Late Effects Subcommittee for Brain Tumors, CHILDREN'S ONCOLOGY GROUP
2004 - 2008	Member, Late Effects Steering Committee, CHILDREN'S ONCOLOGY GROUP
2004 - 2009	Co-Investigator, COG ACNS0122 A Phase II Study to Assess the Ability of Neoadjuvant Chemotherapy +/- Second Look Surgery To Eliminate All Measurable Disease Prior to Radiotherapy For Non-Germinomatous Germ Cell Tumors, CHILDREN'S ONCOLOGY GROUP
2004	Education Day Committee, SOCIETY FOR NEURO-ONCOLOGY
2004	Scientific Program Committee, SOCIETY FOR NEURO-ONCOLOGY
2005	Ad hoc reviewer, NATIONAL CANCER INSTITUTES SPECIAL EMPHASIS PANEL
2005 -	Advisory Board, GREATER BAY AREA MAKE-A-WISH FOUNDATION
2005 -	Member, BRAIN TUMOR EPIDEMIOLOGY CONSORTIUM
2006 - 2008	Board of Directors, NATIONAL BRAIN TUMOR FOUNDATION
2006 -	Study Co-Investigator, COG AALL06N1 A Study of Neurocognitive Function in Children Treated for Acute Lymphoblastic Leukemia, CHILDREN'S ONCOLOGY GROUP

2007 -	Study Vice Chair, COG ALTE07C1 Neuropsychological, Social, Emotional, and Behavioral Outcomes in Children with Cancer, CHILDREN'S ONCOLOGY GROUP
2007 -	Investigator, COLLABORATIVE EPENDYMOMA RESEARCH NETWORK
2008 -	Medical Advisory Board, THE CHILDHOOD BRAIN TUMOR FOUNDATION, Woodbridge, VA
2008 - 2013	National Conference and Exhibition Planning Group, AMERICAN ACADEMY OF PEDIATRICS
2008	Scientific Review Committee and Symposium Moderator, INTERNATIONAL SOCIETY FOR PEDIATRIC NEURO-ONCOLOGY
2008	Neurology Working Group, CHILDHOOD CANCER SURVIVOR STUDY
2008 -	Member, Council on Children with Disabilities, AMERICAN ACADEMY OF PEDIATRICS
2008 - 2012	Chairperson, Executive Committee, Section on Neurology, AMERICAN ACADEMY OF PEDIATRICS
2008 - 2012	Board of Directors, NATIONAL BRAIN TUMOR SOCIETY
2008 - 2009	Board of Directors, ANIMAL-ASSISTED HAPPINESS, Los Altos, CA
2009 - 2010	Medical Advisory Council, MAKE-A-WISH FOUNDATION OF AMERICA
2009 - 2013	Board of Directors, RILEY'S PLACE, Woodside, CA
2009 -	Research Committee, CHILD NEUROLOGY SOCIETY
2009 -	Advisory Board, CAMP OKIZU FOUNDATION, Novato, CA
2010 -	Member, Long-Term Follow-up Guideline Core Working Group, CHILDREN'S ONCOLOGY GROUP
2010	Nominator, MACARTHUR FELLOWS PROGRAM, Chicago, IL
2010	Symposium Moderator, INTERNATIONAL SOCIETY FOR PEDIATRIC NEURO-ONCOLOGY
2010	Chair, Site Visit, DEPARTMENT OF DEFENSE, to UNIVERSITY OF PENNSYLVANIA ROBERTS PROTON THERAPY CENTER, Philadelphia, PA
2011 -	Cancer Prevention Committee, AMERICAN SOCIETY OF CLINICAL ONCOLOGY
2011	Ad Hoc Reviewer, CHILDREN WITH CANCER UK, London, England
2011	Ad Hoc Reviewer, CHILDREN'S CANCER RESEARCH FUND, Los Angeles, CA
2011	Workshops Reviewer, PEDIATRIC ACADEMIC SOCIETIES
2011 - 2012	Board Secretary and Executive Committee, NATIONAL BRAIN TUMOR SOCIETY
2012	Nominator, NOBEL PRIZE IN PHYSIOLOGY OR MEDICINE, Stockholm, Sweden
2012	Ad Hoc Reviewer, DEPARTMENT OF DEFENSE MEDICAL RESEARCH PROGRAMS, Bethesda, MD
2012	Scientific Review Committee, INTERNATIONAL SOCIETY FOR PEDIATRIC NEURO-ONCOLOGY
2012 -	Site Principal Investigator, PEDIATRIC BRAIN TUMOR CONSORTIUM
2012	Scientific Advisory Board, Division of Neuro-Oncology, ST. JUDE CHILDREN'S RESEARCH HOSPITAL, Memphis, TN
2012 -	Ad Hoc Reviewer, ST. BALDRICK'S FOUNDATION, Monrovia, CA
2012	Ad Hoc Reviewer, THRASHER RESEARCH FUND, Salt Lake City, UT
2012 -	Central Nervous System Tumor Committee, CHILDREN'S ONCOLOGY GROUP
2012 -	Secretary, BRAIN TUMOR EPIDEMIOLOGY CONSORTIUM
2012 -	Medical Advisory Board, NATIONAL BRAIN TUMOR SOCIETY

UNIVERSITY COMMITTEES

1998 - 2000	Admissions Panel, STANFORD UNIVERSITY SCHOOL OF MEDICINE
1999	Chair, Child Neurology Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2000 - 2003	Admissions Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2001	Child Neurology Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2002	Pediatric Neurosurgery Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2002	Neuro-Oncology Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2002	Faculty Advisory Board for the Undergraduate Advising Center, STANFORD UNIVERSITY
2003 - 2005	Admissions Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2003 - 2012	Continuing Medical Education Committee, LUCILE SALTER PACKARD CHILDREN'S HOSPITAL AT STANFORD
2003 -	Education Committee, Department of Neurology, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2003 - 2005	Medical School Faculty Senate, Senator-At-Large Alternate, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2004 -	Honors Committee, Program in Human Biology, STANFORD UNIVERSITY
2005 -	Executive Committee, Program in Human Biology, STANFORD UNIVERSITY
2006	Neurology Dementia Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2007 -	Henzl-Gabor Young Women in Science Fund Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2007 - 2008	Chair, Pediatric Neuro-Oncology Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2007 - 2008	Child Neurology Division Chief Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2007 - 2008	Neuro-Pathology Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2008 - 2012	Appointments and Promotions Committee, Department of Pediatrics, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2008 - 2012	Continuing Medical Education Faculty Advisory Council, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2009	Child Psychiatry Affective Disorders Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2009 -	Awards Committee, Program in Human Biology, STANFORD UNIVERSITY
2010 - 2011	Pediatrics Hematology-Oncology Stem Cell Division Chief Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2010	Radiation Oncology Chair Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2010	Neurosurgery Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2010 - 2012	Institutional Review Board, STANFORD UNIVERSITY

2011 - 2012	Chair, Developmental and Behavioral Pediatrics Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2011 - 2012	Genetics (Pediatrics) Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2012	Pediatric Neurosurgery Division Chief Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2012	Radiation Oncology (Neuro-Oncology) Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2012 - 2013	Chair, Pediatric Cardiology/Cardiovascular Intensive Care Unit Director Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2012 -	Child Psychiatry Division Chief Faculty Search Committee, STANFORD UNIVERSITY SCHOOL OF MEDICINE

HOSPITAL COMMITTEES

1992 - 1997	Quality Assurance/Performance Improvement Committee, Departments of Neurology and Neurosurgery, THE JOHNS HOPKINS HOSPITAL
2008 - 2011	Care Improvement Committee, LUCILE PACKARD CHILDREN'S HOSPITAL
2008-	Medical Executive Committee, LUCILE PACKARD CHILDREN'S HOSPITAL
2008-	Pediatrics/Obstetrics Faculty Practice Organization Management Committee, LUCILE PACKARD CHILDREN'S HOSPITAL

AWARDS

1998	Lysia Forno Award for Teaching Excellence, DEPARTMENT OF NEUROLOGY, STANFORD UNIVERSITY SCHOOL OF MEDICINE
1999 - 2000	Joseph and Helen Luetje-Stubbs Faculty Scholar, STANFORD UNIVERSITY SCHOOL OF MEDICINE, for cancer research and teaching
2002	Outstanding Undergraduate Faculty Advisor, STANFORD UNIVERSITY
2005	Neurology Clerkship Teaching Award, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2006	Neurology Clerkship Teaching Award, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2006	Human Biology Award for Excellence in Faculty Advising, STANFORD UNIVERSITY
2007	Neurology Clerkship Teaching Award, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2007	44TH Annual Arthur L. Bloomfield Award, STANFORD UNIVERSITY SCHOOL OF MEDICINE, for excellence in the teaching of clinical medicine
2007	39th Annual Henry J. Kaiser Family Foundation Award for Excellence in Clinical Teaching, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2008	Neurology Clerkship Teaching Award, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2009	Neurology Clerkship Teaching Award, STANFORD UNIVERSITY SCHOOL OF MEDICINE
2011	Neurology Clerkship Teaching Award, STANFORD UNIVERSITY SCHOOL OF MEDICINE

EXTRAMURAL SUPPORT

NIH/NINDS Neurological Sciences Academic Development Award K12 NSO1692-05, 1994-1997, 1999-2001, institutional-based investigator development grant

Children's Cancer Foundation Neuro-Oncology Development Grant, 1994-1997, principal investigator, total direct costs $255,000

Children's Miracle Network Telethon institutional grant, 1996, principal investigator, total direct costs $2,500

Children's Cancer Foundation, Neuro-Oncology Clinical Research Grant, 1996, principal investigator, total direct costs $85,794

American Brain Tumor Association, Medical Student Summer Fellowship Program, 1999, total directs costs $2500

SmithKline Beecham, 1999-2001, A Phase II Evaluation of the Efficacy of Oral Topotecan for the Treatment of Recurrent Brain Tumors in Children, site investigator, total direct costs $4,550

Schering Oncology, 2000-2002, A Phase I Trial of Temodar for children with Recurrent or Progressive Brain Tumors, site investigator, total direct costs $3,000

National Brain Tumor Foundation, Pediatric Brain Tumor Grant, 2001, principal investigator, total direct costs $15,000

Schering Oncology, 2002-2004, Phase II Trial of Temozolomide in Patients with Newly Diagnosed Anaplastic Oligodendroglioma and Mixed Oligoastrocytoma, site investigator, total direct costs $10,400

National Childhood Cancer Foundation, Children's Oncology Group, 2005-2013, Methotrexate BPCA Chair's Grant, subcontract 14667, 15638 under grant U10 CA98543-03, -04, -05, -06, -07S2, -08S2, -09S2, co-investigator, total direct costs $381,728

Genentech, 2007, A Phase I Study of the Systemic Hedgehog Pathway Antagonist GDC-0449 for Recurrent Medulloblastoma Refractory to Standard Therapy, principal investigator, total direct costs $22,424

The Sence Foundation, 2007 and 2009, Molecular and Cellular Dynamics in Brainstem Tumors, principal investigator, total direct costs $13,500

Timmy's Rainbow of Hope, 2008, Molecular and Cellular Dynamics in Brainstem Tumors, principal investigator, total direct costs $10,000

Centers for Disease Control, 2008-2010, Childhood Cancers among Children with Birth Defects in California, principal investigator, total direct costs $216,080

NIH/NINDS Neurological Sciences Academic Development Award K12 NS049648-05, 2009-2011, principal investigator

NIH/NCI GO Grant 1RC2CA148491-01, 2009-2013, A Phase I Study of EGFRvIII Peptide Vaccination (CDX-110) after Conventional Radiation in Children with Diffuse Intrinsic Pontine Gliomas, principal investigator, total direct costs $1,176,368

NCI 5 U01CA081457-14, 2012-2016, Pediatric Brain Tumor Consortium, site principal investigator, $43,932 annually

TEACHING

Lecturer for Pediatrics Core Clerkship, the Johns Hopkins University School of Medicine Year 3/4, 1992 - 1997

Lecturer for Pediatrics residents, Neurology residents, Pediatric Oncology fellows, and Emergency Medicine residents' didactic conference series, the Johns Hopkins Hospital, 1994 - 1997

Section leader in Neurology/Neuropathology course and Neurology Clinical Skills course, the Johns Hopkins University School of Medicine Year 2 classes, 1994 - 1997

Attending physician for Pediatric Neurology and General Pediatrics services, the Johns Hopkins Hospital, 1995 - 1997

Instructor in Johns Hopkins University School of Medicine Year 1 class "Physician and Society," 1996 - 1997

Attending physician for Child Neurology service, Lucile Salter Packard Children's Hospital, 1997 -

Lecturer for Neurology residents, Pediatrics residents, Neurosurgery, and Emergency Medicine residents' didactic conference series, Stanford University Medical Center, 1997 -

Lecturer for Neurology 205, "Clinical Neuroscience," Stanford University School of Medicine, 1998 - 1999

Course Director for Medicine 208C, "Introduction to Clinical Problem Solving/Skills Training - Neurology," Stanford University School of Medicine, 1998 - 2004

Child Neurology Residency Director, Stanford University School of Medicine, 1998 - 2000, 2008 -

Freshman and Undergraduate Advisor, Stanford University, 1999 - 2005

Stanford Medical Youth Science Program, College and Health Options: Ideas Creating Excellence - high-school student workshop, 2002

Instructor in Medicine 208B, "End-of-Life Care Module," and "Introduction to Neurologic Exam," Stanford University School of Medicine, 2002

Faculty coordinator, "Club Neuro," Stanford University Student Interest Group in Neurology (SIGN, medical students) and Co-SIGN (undergraduates), 2002 - 2004

Lecturer for Public Health 258, "Cancer Epidemiology," University of California, Berkeley, 2003 - 2005

Course Director for Human Biology 154, "Cancer Epidemiology," Stanford University, 2004 -

Undergraduate Major Advisor, Human Biology, Stanford University, 2004 -

Neurology Core Clerkship Director, Neurology 301A, Stanford University, 2005 - 2008

Lecturer for Pediatrics 115, "The Experience of Chronic Illness from the Developing Child's Perspective," Stanford University, 2006

Lecturer for Health Policy and Research 230, "Cancer Epidemiology," Stanford University, 2006, 2008, 2010

Pediatric Neuro-Oncology Fellowship Director, Stanford University School of Medicine, 2006 - 2011

Lecturer for Human Biology 121, "Critical Issues in Child Health," Stanford University, 2009 -

INVITED LECTURES

1. "Brain Tumors," The 7th Annual Educational Symposium: A Workshop for School Professionals of Students with Chronic Illnesses, The Johns Hopkins Hospital, Baltimore, MD, November 17, 1993

2. "Clinical Clues in Diagnosing Brain Tumors," 21st Annual Pediatric Trends, The Johns Hopkins Hospital, Baltimore, MD, April 14, 1994

3. "What's New in Infant Brain Tumors?" Pediatric Hematology-Oncology for the Practitioner, Marriott Inner Harbor Hotel, Baltimore, MD, July 8, 1994

4. "Brain Tumors," The 8th Annual Educational Symposium: A Workshop for School Professionals of Students with Chronic Illnesses, The Johns Hopkins Hospital, Baltimore, MD, January 10, 1995

5. "Neurologic Complications of Cancer," 23rd Annual Pediatric Trends, The Johns Hopkins Hospital, Baltimore, MD, April 18, 1996

6. Grand Rounds, "Pediatric Neurologic Emergencies," Department of Pediatrics, St. Agnes Hospital, Baltimore, MD, June 7, 1996

7. "Effects of Radiation Treatment on the Brain," Summer Lecture Series for Survivors of Childhood Cancer, Greenspring Station, Johns Hopkins Oncology Center, Lutherville, MD, September 19, 1996

8. "Pediatric and Adult Brain Tumors," Physician Assistants' Program, Essex Community College, Essex, MD, January 27, 1997

9. "Simplifying How We Approach Childhood Brain Tumors," American Brain Tumor Association Town Hall Meeting, Marriott Inner Harbor Hotel, Baltimore, MD, March 16, 1997

10. Grand Rounds, "An Approach to Pediatric Headaches," Department of Pediatrics, Bayview Medical Center, Baltimore, MD, April 8, 1997

11. "Simplifying Childhood Brain Tumors," Mt. Washington Pediatric Hospital, Baltimore, MD, April 9, 1997

12. "Management of Your Pediatric Headaches," 24th Annual Pediatric Trends, The Johns Hopkins Hospital, Baltimore, MD, April 17, 1997

13. "Late Effects of Radiotherapy on the Nervous System," The Childhood Brain Tumor Foundation Retreat, Rockville, MD, May 3, 1997

14. Grand Rounds, "Seizures in Children," Department of Pediatrics, Franklin Square Hospital, Baltimore, MD, August 27, 1997

15. Grand Rounds, "Re-Thinking Baby Brain Tumors," Department of Neurology, Stanford University Medical Center, Palo Alto, CA, February 11, 1998

16. PREP: The Course, "Neurology in Review," American Academy of Pediatrics, Washington, D.C., April 20-21, 1998

17. "Childhood Brain Tumors," Department of Pediatrics, Alexian Brothers Hospital, San Jose, CA, June 5, 1998

18. "Tumors of the Central Nervous System," Child's Brain Day: Practical Management of Childhood CNS Disorders, University of California, San Francisco, September 26, 1998

19. PREP: The Course, "Neurology in Review," American Academy of Pediatrics, Phoenix, AZ, October 5-6, 1998

20. "Meet the Expert: Managing Headaches in Children," American Academy of Pediatrics Annual Meeting, San Francisco, CA, October 19, 1998

21. Grand Rounds, "A Pediatrician's View on Brain Tumors," Department of Pediatrics, Lucile Salter Packard Children's Hospital at Stanford, Palo Alto, CA, November 6, 1998

22. "An Approach to Headaches in Children," Department of Pediatrics, El Camino Hospital, Mountain View, CA, November 30, 1998

23. "Neuro-Oncology Tumor Board," UCSF Stanford Tumor Board at Silverado, Napa, CA, March 19, 1999

24. "Brain Tumors in Neurofibromatosis," South Bay Neurofibromatosis Support Network, Santa Clara, CA, September 12, 1999

25. Adolescent Medicine PREP, "Neurology Review," American Academy of Pediatrics and Society for Adolescent Medicine, Scottsdale, AZ, September 30 - October 1, 1999

26. "Kids Get Headaches, Too," Lucile Salter Packard Children's Hospital Community Education Series, Palo Alto, CA, November 18, 1999

27. "Nuts and Bolts of Brain Tumors," National Brain Tumor Foundation and Home Care Companions Caregiver Workshop, Palo Alto, CA, February 16, 2000

28. Grand Rounds, "Why Can't We Cure Brainstem Gliomas?" Department of Neurology, Stanford University Medical Center, Palo Alto, CA, March 1, 2000

29. "Neurological Emergencies: What You Need to Know," "Managing Headaches in Children," and "Non-Epileptic Paroxysmal Events," Northern California Chapter of the American Academy of Pediatrics Annual Meeting, Monterey, CA, May 28-29, 2000

30. "Case Studies: Managing Headaches in Children," 8th Annual Pediatric Update, Lucile Salter Packard Children's Hospital at Stanford, Palo Alto, CA, July 15, 2000

31. "Neurologic Emergencies for Every Pediatric Oncology Nurse," Bay Area Pediatric Oncology Nurses, San Mateo, CA, January 18, 2001

32. "Kids Get Headaches, Too," Lucile Salter Packard Children's Hospital Community Education Series, Palo Alto, CA, February 28, 2001

33. "Neurological Emergencies: What You Need to Know, What You Need to Do," "Spots on the Brain: A Look at the Neurocutaneous Disorders," "Not Everything That Shakes Is a Seizure: Non-epileptic Paroxysmal Events," and "Case Studies in Managing Headaches." Practical Pediatrics, American Academy of Pediatrics, Hilton Head, SC, May 24-26, 2001

34. "Emerging Drug Therapies in Primary Brain Tumors and Metastases," Sutter Hospital Cancer Center, Sacramento, CA, May 30, 2001

35. "Headache Management in Children," 9th Annual Pediatric Update, Lucile Salter Packard Children's Hospital at Stanford, Palo Alto, CA, July 20, 2001

36. Grand Rounds, "Three Decades of Astrocytomas: What to Do?" Department of Neurosurgery, Stanford University Medical Center, Palo Alto, CA, August 24, 2001

37. Adolescent Medicine PREP, "Headaches and Pressure!" and "Bang, Drop, and Roll," American Academy of Pediatrics and Society for Adolescent Medicine, Chicago, IL, September 5 - 9, 2001

38. "Headache Diagnosis and Management Made Painless," American Academy of Pediatrics National Conference and Exhibition, San Francisco, CA, October 23, 2001

39. "PREP Live," American Academy of Pediatrics National Conference and Exhibition, San Francisco, CA, October 23, 2001

40. "Oncodiagnosis Panel: Pediatric Brain Tumors," Radiological Society of North America, Chicago, IL, November 28, 2001

41. "Headache Diagnosis and Management Made Painless," Department of Pediatrics, Dominican Hospital, Santa Cruz, CA, December 12, 2001

42. "Neurological Emergencies," "Spots on the Brain," "Epilepsy Made Easy," "Not Everything That Shakes Is a Seizure," and "Update on Childhood Headaches." 27th Annual Winter Ski and Study Symposium, Southern California Chapter of the American Academy of Pediatrics, Lake Tahoe, CA, January 27-30, 2002

43. "Neurological Emergencies: What You Need to Know and Do," Department of Pediatrics, Dominican Hospital, Santa Cruz, CA, February 13, 2002

44. PREP: The Course, "Neurology in Review," American Academy of Pediatrics, Atlanta, GA, March 4-6, 2002

45. "Current Problems and Trends in Pediatric Brain Tumors," Division of Child Neurology Clinical Conference, University of California, San Francisco, May 1, 2002

46. Grand Rounds, "Problems, Pitfalls and Directions in Neuro-Oncology" Department of Neurology, Stanford University Medical Center, Palo Alto, CA, May 8, 2002

47. "The Diagnostic Evaluation of Headaches" and "Headaches: Case Studies," Oregon Health Sciences University Pediatric Headache and Pain Symposium, Portland, OR, May 11, 2002

48. Griffith Visiting Professor, Riley Children's Hospital, "Child Neurology Made Practical and Easy," 37th Annual Indiana Multidisciplinary Child Care Conference, Indianapolis, IN, May 15, 2002

49. "Modern Therapies for Central Nervous System Malignancies: Obstacles and Advances in Treatment," San Diego County Medical Society, San Diego, CA, June 26, 2002

50. "Headache Diagnosis and Management Made Painless," 10th Annual Pediatric Update, Lucile Salter Packard Children's Hospital at Stanford, Palo Alto, CA, July 19, 2002

51. PREP: The Course, "Headaches and Pressure" and "Shake, Rattle, and Roll," American Academy of Pediatrics, Phoenix, AZ, September 23-26, 2002

52. "Advances in Therapies for Primary Brain Tumors and Metastases," Oncology Tumor Board, John Muir Hospital, Walnut Creek, CA, September 27, 2002

53. Grand Rounds, "Problems, Pitfalls, and Trends in Pediatric Brain Tumors," Department of Neurology, University of Miami, FL, November 8, 2002

54. "Not Everything that Shakes is a Seizure," "Headaches: When to Worry and When to Treat," "Spots on the Brain," and "Neurological Emergencies: Don't Miss These," 13th Annual Pediatric Symposium, Joe DiMaggio Children's Hospital, Fort Lauderdale, FL, November 9-10, 2002

55. "Headaches," 7th Annual Continuing Medical Education Conference, Northwest Radiology Network, Indianapolis, IN, December 6, 2002

56. Grand Rounds, "Headache Diagnosis and Management Made Painless," Department of Pediatrics, Lucile Salter Packard Children's Hospital at Stanford, December 20, 2002

57. "Update on Pediatric Brain Tumors," Hoag Hospital Advancements in the Treatment of Brain Tumors, Long Beach, CA, February 6, 2003

58. "Headaches in Children: Office Management," "Epilepsy Made Easy," "Inattentive, Autistic, or Delayed? What Should the Pediatrician Do?" and "Not Everything That Shakes is a Seizure: Nonepileptic Paroxysmal Events," Pediatrics 2003: Winter Ski Conference, Breckenridge, CO, February 24-27, 2003

59. "Neurologic Complications of Childhood Cancer and Its Treatment," Breakfast Seminar, 55th Annual Meeting of the American Academy of Neurology, Honolulu, HI, March 30, 2003

60. "Headache Diagnosis and Management," San Ramon Regional Medical Center, San Ramon, CA, April 24, 2003

61. "New Agents to Halt Migraine," 36th Annual Advances and Controversies in Pediatrics, University of California, San Francisco, CA, May 8, 2003

62. "Serious Causes of Headache," Pediatric Headache: A Guide for the Practitioner, University of Maryland School of Medicine, Baltimore, MD, May 31, 2003

63. "Headaches: When to Worry, When to Treat," and "Delayed, Inattentive, or Autistic? What is the Pediatrician to Do?" Stanford University Medical Center Alaskan Cruise Pediatric Clinical Potpourri, June 22-23, 2003

64. "Delayed, Inattentive, or Autistic: What Is the Pediatrician to Do?" 11th Annual Pediatric Update, Lucile Salter Packard Children's Hospital at Stanford, Palo Alto, CA, July 19, 2003

65. Adolescent Medicine PREP, "Bang, Pop, Stop, Drop, and Sleep," American Academy of Pediatrics and Society for Adolescent Medicine, Montreal, Quebec, September 15, 2003

66. "Headache: Diagnosis and Management," Kaiser Hospital, Fremont, CA, October 7, 2003

67. "Office Management of Migraines," and "Headache: Diagnosis and Management," American Academy of Pediatrics National Conference and Exhibition, New Orleans, LA, November 5, 2003

68. Practical Pediatrics, "Shake, Rattle, and Roll, "Headaches A to Z," "Inattentive, Autistic, or Delayed? What Should the Pediatrician Do?" and "Spots on the Brain," Practical Pediatrics, American Academy of Pediatrics, Tempe, AZ, November 14-16, 2003

69. Course Director, "Pediatric Headache: A Guide for Every Practitioner," Lucile Packard Children's Hospital, Sonoma, CA, March 13, 2004

70. Grand Rounds, "Why Do Children Get Brain Tumors?" Department of Neurology, the Johns Hopkins Hospital, Baltimore, MD, April 8, 2004

71. Grand Rounds, "Why Do Children Develop Brain Tumors?" Department of Neurology, University of California, San Diego, CA, April 23, 2004

72. "Neurological Emergencies," Kaiser Hospital, Hayward, CA, April 27, 2004

73. "Don't Miss Worrisome Headaches," "First and Second Seizures: What is an Emergency?" and "Don't Miss These Neurological Emergencies!" Northern California Chapter of the American Academy of Pediatrics Annual Meeting, Monterey, CA, May 30-31, 2004

74. "Inattentive, Autistic, or Delayed? You're on the Hot Seat," "A Not So Painful Look at Headaches," "Shake, Rattle, and Roll: Not Everything is a Seizure," and "Hail Seizure: Seizures Made Simple," University of Vermont Summer Pediatric Seminar, Manchester, VT, June 18-20, 2004

75. "Headaches in Children and Adolescents: Difficult Diagnoses and New Therapies," American Academy of Pediatrics National Conference and Exhibition, San Francisco, CA, October 9, 2004

76. "PREP Live," American Academy of Pediatrics National Conference and Exhibition, San Francisco, CA, October 10, 2004

77. "Brain Tumors and the Environment: Is There a Connection?" National Brain Tumor Foundation, San Francisco, CA, April 7, 2005

78. Grand Rounds, "An Update on Pediatric Migraine," Department of Pediatrics, Children's Hospital of Orange County, Orange, CA, May 11, 2005

79. Grand Rounds, "Help for Headaches" Department of Pediatrics, Lucile Salter Packard Children's Hospital at Stanford, Palo Alto, CA, June 3, 2005

80. Grand Rounds, "Why Do Children Get Brain Tumors?" Department of Neurology, Stanford University Medical Center, Palo Alto, CA, June 10, 2005

81. "Epilepsy Made Easy," "Shake, Rattle, and Roll," and "Help for Headaches!" 28th Annual Summer Pediatric Conference, Arizona Chapter of the American Academy of Pediatrics, Sedona, AZ, June 17-19, 2005

82. Adolescent Medicine PREP, "My Adolescent Head Hurts," American Academy of Pediatrics and Society for Adolescent Medicine, Phoenix, AZ, September 23, 2005

83. Grand Rounds, "Hot Topics in Neuro-Oncology?" Division of Hematology-Oncology, National Naval Medical Center, Bethesda, MD, October 7, 2005

84. "Headaches: When to Worry, When to Treat," American Academy of Pediatrics National Conference and Exhibition, Washington, DC, October 10, 2005

85. Grand Rounds, "High-Grade Gliomas: The Multi-Disciplinary Approach to Treatment," Lombardi Cancer Center, Washington, DC, October 27, 2005

86. "Headaches to Worry About," Children's Hospital of the King's Daughters Pediatrics 2005, Williamsburg, VA, November 4, 2005

87. "Neurological Emergencies in Your Office," "Headaches A to Z! Everything You Need to Know," Spots on the Brain: Name that Neurocutaneous Disorder," and "Complementary and Alternative Medicines for Headaches," Southern California Chapter of the American Academy of Pediatrics Postgraduate Meeting, Palm Springs, CA, February 16-19, 2006

88. "Acute Developmental Consequences Associated with the Treatment for Childhood Cancer," Center for Human Development Seminar Series, University of California, San Diego, April 21, 2006

89. "Latest Research on Brain Tumors and the Environment," Brain Tumors and the Environment: What's the Connection? National Brain Tumor Foundation, San Francisco, CA, June 24, 2006

90. "Shake, Rattle, and Roll: What's New in Managing Seizures," "Neurologic Emergencies: What to Know, What to Do," "Help for Headaches!" and "Inattentive, Delayed, or Autistic: You Make the Diagnosis," Practical Pediatrics, American Academy of Pediatrics, Ottawa, Canada, July 7-9, 2006

91. "Headaches: When to Worry, Triage, or Treat," and "Meet the Expert: Common Office Neurology Questions," American Academy of Pediatrics National Conference and Exhibition, Atlanta, GA, October 7, 2006

92. The Barbara Lord Education Speaker, "What's Up with Young Adults and Brain Tumors?" 33rd Annual Meeting of the California Cancer Registrars, Modesto, CA, October 13, 2006

93. PREP: The Course, "Seizures Made Simple" and "Common Office Neurology Questions," American Academy of Pediatrics, Costa Mesa, CA, March 4-5, 2007

94. "First and Second Seizure: What to Know, What to Do," "Neurological Emergencies," Inattentive, Autistic, or Delayed: You Make the Diagnosis," and "Headaches: Worry or Treat?," 18th Annual Las Vegas Postgraduate Pediatric Meeting, California Chapter 2 of the American Academy of Pediatrics, May 17-20, 2007

95. Adolescent Medicine PREP, "My Teenage Head Hurts," American Academy of Pediatrics and Society for Adolescent Medicine, Savannah, GA, September 6, 2007

96. PREP: The Course, "Seizures Made Simple" and "Common Office Neurology Questions," American Academy of Pediatrics, Philadelphia, PA, September 16-17, 2007

97. "Headaches: When Do I Worry, Whom Do I Scan?" "Meet the Expert: Neurology Questions in the Office," and "PREP Live," American Academy of Pediatrics National Conference and Exhibition, San Francisco, CA, October 27-28, 2007

98. Visiting Professor, Department of Pediatrics, Morehouse School of Medicine, "First and Second Seizure: What to Know and What's New?," and "Spot that Diagnosis: A Look at the Neurocutaneous Disorders," Atlanta, GA, November 1-2, 2007

99. "Inattentive, Autistic, or Delayed: You Make the Diagnosis," "Headaches: Worry or Treat?" "First and Second Seizure: What to Know, What to Do," and "Neurological Emergencies!" 18th Annual Pediatric Symposium, Joe DiMaggio Children's Hospital, Fort Lauderdale, FL, November 3-4, 2007

100. Grand Rounds, "Why Do Children with Cancer Develop Neurotoxicity?" Department of Pediatric Hematology-Oncology, University of Texas Southwestern Medical Center, Dallas, TX, December 4, 2007

101. "Pop and Drop: A Neurology Perspective on Head Trauma," "ABCs of Neurological Emergencies," "First and Second Seizure: What to Know and Do," and "Headaches: Worry or Treat?" Practical Pediatrics, American Academy of Pediatrics, Copper Mountain, CO, January 24-28, 2008

102. "Spots on the Brain: Name That Neurocutaneous Disorder," "First and Second Seizure: What Will You Do?" "Inattentive, Delayed or Autistic? What to Know and Do," and "Headaches: A to Z in 40 Minutes!" Phoenix Children's Hospital Pediatric Update 2008, Scottsdale, AZ, March 3-4, 2008

103. "First and Second Seizure: What Do You Do?" and "Make These Headaches Go Away!" 2008 Spring Meeting and Pediatric Update, Alabama Chapter of the American Academy of Pediatrics, Destin, FL, April 17-20, 2008

104. Grand Rounds and Visiting Professor, "What Neurotoxicity Do Children Develop from Cancer?" and "Why Do Children (and Adults too) with Cancer Develop Neurotoxicity?" Department of Pediatric Oncology, Dana-Farber Cancer Institute and Children's Hospital, Boston, MA, May 15-16, 2008

105. Invited Discussant, "What Can Epidemiology Teach Us About Childhood Brain Tumors?" Pediatric Cancer Oral Presentations, 44th Annual Meeting of the American Society of Clinical Oncology, Chicago, IL, June 1, 2008

106. Grand Rounds, "Hot Topics in Brain Tumors?" Division of Neurology, Cedars-Sinai Hospital, June 20, 2008

107. "First and Second Seizure: What to Know and Do," "Headaches: Worry, Treat, or Refer?" "Spot the Diagnosis: A Look at the Neurocutaneous Disorders," "Shake, Rattle, and Roll," and "ABCs of Neurological Emergencies," Pediatrics in the Islands: Clinical Pearls 2008, California Chapter 2 of the American Academy of Pediatrics, Honolulu, HI, June 22-26, 2008

107. "Emergent and Emerging Issues in Neurology," "First and Second Seizures: What Pediatricians Can Do!" and "Headaches in 60 Minutes," Pediatric Roundup 2008, Montana Chapter of the American Academy of Pediatrics, Pray, MT, September 27-28, 2008

108. "Pediatric Seizures," 11th Annual EMS for Children Conference, California EMS Authority, Sacramento, CA, October 8, 2008

109. "Developmental Delay: Inattentive, Autistic or Delay," "How Do I Manage the First and Second Seizure in a Child?" "Headaches: When to Worry, when to Treat, When to Refer," and "Neurological Emergencies," 50th Annual Pediatric Symposium, Southern California Permanente Medical Group, La Quinta, CA, October 31-November 2, 2008

110. "Late Effects in Childhood Brain Tumor Survivors," National Brain Tumor Society Regional Conference, San Francisco, CA, January 24, 2009

111. PREP: The Course, "Seizures Made Simple" and "Common Office Neurology Questions," American Academy of Pediatrics, Savannah, GA, March 22-23, 2009

112. Grand Rounds, "Pop and Drop: Sports, Kids, and Concussions" Department of Pediatrics, Lucile Salter Packard Children's Hospital at Stanford, Palo Alto, CA, March 27, 2009

113. Course Director, "Put Me in Coach! Pediatric and Adolescent Sports Medicine for the Primary Care Practitioner," 17th Annual Pediatric Update Lucile Packard Children's Hospital Pre-Conference, Palo Alto, CA, July 16, 2009

114. PREP: The Course, "Seizures Made Simple" and "Common Office Neurology Questions," American Academy of Pediatrics, Portland, OR, September 13-14, 2009

115. "Headaches A to Z," San Mateo County Medical Center, San Mateo, CA, February 3, 2010

116. "An Advanced Approach to Febrile and Afebrile Seizures: Issues and Controversies," and "Headaches in Children: When to Worry," Advanced Pediatric Emergency Medicine Assembly, New York, NY, April 13, 2010

117. "Pop and Drop: What Pediatricians Need to Know About Concussions," "Help, My Headaches!" "Delay? Autistic? Something Else? What to Do?" and "First and Second Seizures: What Should You Do?" 21st Annual Las Vegas Postgraduate Pediatric Meeting, California Chapter 2 of the American Academy of Pediatrics, April 23-25, 2010

118. Visiting Professor, Department of Pediatrics, James H. Quillen College of Medicine, East Tennessee State University, "First and Second Seizure: What To Do?" May 4-6, 2010

119. Grand Rounds, "What Can Epidemiology Teach Us About Brain Tumors?" Department of Neurology, and "Why Do Children with Cancer Develop Neurotoxicity?, Division of Child Neurology, The Johns Hopkins Hospital, Baltimore, MD, May 19-20, 2010

120. Grand Rounds, "An Emergency Medicine Approach to First and Second Seizures in Children: What Are the Guidelines? But What Is the Evidence?" Division of Emergency Medicine, Southwestern University Medical Center, Dallas, TX, May 27, 2010

121. Course Director, "Inattentive, Delayed, or Autistic: you Make the Call," "Neurological Emergencies: Do You Know What to Do?" and "First and Second Seizure: What to Know and What to Do," Symposia Medicus 12th Annual Summer Conference on Pediatrics, Napa, CA, July 7-10, 2010

122. "Pop and Drop: Kids, Concussions, and Sports," "Pediatric Headaches," and "Neurologic Emergencies—How to Avoid Mistakes!" 28th Kaiser Permanente National Pediatric Conference, Maui, HI, July 19-23, 2010

123. Grand Rounds, "Controversies and What to Do in the Child with a First or Second Seizure," and "Headaches in Kids: When to Worry? When to Treat?" Department of Emergency Medicine, Washington Hospital Center, Washington, DC, August 12, 2010

124. "Don't Even Think About Missing These Neurological Emergencies," California Pacific Medical Center 5th Annual Frontiers in Pediatric Hospital Medicine, San Francisco, CA, November 11, 2010

125. "Managing Changes From the Beginning of Treatment: Lessons Learned From the Pediatric Brain Tumor Professionals," 15th Annual Society for Neuro-Oncology Meeting, Montreal, Canada, November 18, 2010

126. "Migraines in Pediatric Populations," Department of Pediatrics, Dominican Hospital, Santa Cruz, CA, March 9, 2011

127. Keynote Speaker, "What Can Epidemiology Teach Neurologists About Childhood Brain Tumors?" North Pacific Pediatric Neurology Colloquium, Portland, OR, April 1, 2011

128. "Neurology for Pediatricians I: Seizures," "Neurology for Pediatricians II: Headaches," and "Neurology for Pediatricians III: Concussions," Northern California Chapter of the American Academy of Pediatrics Annual Meeting—The Pediatrician as Specialist, Part 2, Monterey, CA, May 28-30, 2011

129. Invited Discussant, "How Low-Grade Can *You* Go?" Pediatric Cancer Poster Discussion Session, 47th Annual Meeting of the American Society of Clinical Oncology, Chicago, IL, June 5, 2011

130. Grand Rounds, "Pop, Drop, and Then What? How to Manage Pediatric Concussions," Department of Pediatrics, Sequoia Hospital, Redwood City, CA, September 27, 2011

131. Grand Rounds, "Pop and Drop: What Do Pediatricians Need to Do for Concussions?" Department of Pediatrics, Mills Peninsula Hospital, San Mateo, CA, October 19, 2011

132. "Not Everything That Shakes is a Seizure," "Headaches A to Z," "A Practical Approach to Neurologic Emergencies," and "Pop and Drop: What Do You Know About Concussions?" 33rd Annual Las Vegas Seminars Pediatric Update, American Academy of Pediatrics California District, Chapters 1, 2, 3 & 4, November 18-20, 2011

133. Conference Director, "Medulloblastoma in the Mountains," Alpine Meadows, CA, December 14-16, 2011

134. Grand Rounds, "First and Second Seizure: What do You Do?" Department of Pediatrics, Dominican Hospital, Santa Cruz, CA, February 8, 2012

135. "Shake, Rattle, and Roll: What to Do Now or Later?" Clinical Concepts and Conundrums in Pediatric Hospital Medicine, Children's Hospital of Colorado, Denver, CO, March 9, 2012

136. "Shake, Rattle, and Roll: What to Do Now or Later?" and "Headaches: When to Worry, When to Treat?" 34th Annual Sanford Black Hills Pediatric Symposium, Deadwood, SD, June 15-16, 2012

137. 17th Annual Marjorie Kantor Lecture and Grand Rounds, "Pop, Drop, and Then What? What is the Evidence on Concussions?" Children's Mercy Hospital, University of Missouri School of Medicine, Kansas City, MO, October 4, 2012

138. "Is That a Migraine?" American Academy of Pediatrics National Conference and Exhibition, New Orleans, LA, October 21, 2012

139. "Spot the Diagnosis: A Look at the Neurocutaneous Disorders," "Everyday Neurologic Scenarios," "Headaches: Worry, Treat, or Refer?" "First and Second Seizure: What to Know and Do," and "ABCs of Neurological Emergencies," Aloha Update: Pediatrics, American Academy of Pediatrics, District IX, California Chapter 2, Kauai, HI, October 28-November 1, 2012

140. Grand Rounds, "Management of Young Athlete Head Trauma," O'Connor Hospital, San Jose, CA, November 27, 2012

141. "Diagnosis and Management of Sports-Related Concussion in Youth: The Role of the Child Neurologist," Institute of Medicine and National Research Council Workshop on Sports-Related Concussion in Youth, Washington, D.C., February 25, 2013

142. "Headaches: When Do I Worry? When Do I Treat?" "First and Second Seizure: What to Know and Do," and "Neurological Emergencies: You Make the Call," 57th Annual Pediatric Spring Conference, Blank Children's Hospital, Des Moines, IA, April 19, 2013

143. "Big Headaches in Little Kids" and "Pop & Drop: Getting to the Heart of Concussion," Pediatric Roundup 2013, Montana Chapter of the American Academy of Pediatrics, Big Sky, MT, September 28-29, 2013.

144. "Baby Talk from Neurologists" and "James W. Bass Pediatric Bowl," American Academy of Pediatrics National Conference and Exhibition, Orlando, FL, October 26-29, 2013

JOURNAL REVIEWS

1996 - 2000	**Arch Pediatr Adol Med**
1996	**Physician Data Query**, the National Cancer Institute
1998 -	**Ann Neurol**
1999 -	**J Adol Health**

2001 -	**Cancer**
2001 -	**J Pediatr Hematol Oncol**
2001 -	**J Clin Oncol**
2002 -	**Pediatrics**
2003 -	**Neuro-Oncol**
2003 -	**J Pediatr**
2003	**Epilepsia**
2004 -	**Pediatr Blood Cancer**
2004 -	**Indian J Cancer**
2004	**Exp Rev Anticancer Ther**
2008	**The Cancer Journal**
2009	**Cancer Epidemiol Biomarkers Prev**
2009	**Brain Pathol**
2009 -	**J Neuro-Oncol**
2010	**Mol Cancer Ther**
2011	**Clin Cancer Res**
2011	**Neuroepidemiology**
2011	**Environ Res**
2013	**Neurosurgery**
2013	**Cancer Epidemiol**
2013	**PLOS ONE**
2013	**JAMA Pediatr**

EDITORIAL BOARDS

2002 - 2006	PREP Self-Assessment Editorial Board, American Academy of Pediatrics
2006 - 2008	Editorial Board, **J Clin Oncol**
2006 -	Editorial Board, **J Pediatr**
2010 -	Editorial Board, **J Neuro-Oncol**
2011 -	Editorial Board, **Front Pediatr Oncol**

ORIGINAL ARTICLES

1. **Fisher PG**, Wechsler DS, Singer HS. Anti-Hu antibody in a neuroblastoma-associated paraneoplastic syndrome. **Pediatr Neurol** 1994;10:309-12.

2. Carson BS, Weingart JD, Guarnieri M, **Fisher PG**. Third ventricular choroid plexus papilloma with psychosis. **J Neurosurg** 1997;87:103-5.

3. **Fisher PG**, Needle MN, Cnaan A, Zhao H, Molloy PT, Goldwein JW, Hermann-Liu AC, Geyer JR, Phillips PC. Salvage therapy after postoperative chemotherapy for primary brain tumors in infants and very young children. **Cancer** 1998;83:566-74.

4. **Fisher PG**, Jenab J, Goldthwaite PT, Tihan T, Wharam MD, Foer DR, Burger PC. Outcomes and failure patterns in childhood craniopharyngiomas. **Childs Nerv Syst** 1998;14:558-63.

5. Tihan T, **Fisher PG,** Kepner JL, Godfraind C, McComb RD, Goldthwaite PT, Burger PC. Pediatric astrocytomas with monomorphous pilomyxoid features and a less favorable outcome. **J Neuropath Exp Neurol** 1999;58:1061-1068.

6. Moredecai D, Shaw RJ, **Fisher PG**, Mittelstadt PA, Guterman T, Donaldson SS. Case study: suprasellar germinoma presenting with psychotic and obsessive-compulsive symptom. **J Am Acad Child Adol Psych** 2000;39:116-19.

7. **Fisher PG**, Chiello C. Meningeal leukemia with cerebrospinal fluid block, **Med Pediatr Oncol** 2000;34:281-3.

8. Korones DN, **Fisher PG**, Cohen K, Dubowy R. No responses to oral etoposide in 15 recurrent brain tumors. **Med Pediatr Oncol** 2000;35:80-2.

9. **Fisher PG**, Breiter SN, Carson BS, Wharam MD, Williams JA, Weingart JD, Foer DR, Goldthwaite PT, Burger PC. A clinicopathologic reappraisal of brainstem tumor classification: identification of pilocytic astrocytoma and fibrillary astrocytoma as distinct entities. **Cancer** 2000;89:1569-76.

10. Chinn DM, Donaldson SS, Dahl GV, Wilson J, Huhn SL, **Fisher PG**. Management of children with spinal myxopapillary ependymoma using craniospinal irradiation. **Med Pediatr Oncol** 2000;35:443-5.

11. Colby C, Rozance P, Goodwin TL, **Fisher PG**. Rapid deterioration of a newborn with congenital spinal cord astrocytoma. **Med Pediatr Oncol** 2001;36:500-2.

12. Hurwitz MD, Burger PC, Goldthwaite PT, Tihan T, Wharam MD, **Fisher PG**. Prognostic implications for gadolinium enhancement of the meninges in low-grade astrocytomas of childhood. **Pediatr Neurosurg** 2001;34:88-93.

13. Belson A, Alcorn DM, **Fisher PG**, Yorgin PD, Sarwal M. Visual loss caused by pseudotumor cerebri in an infant on peritoneal dialysis. **Pediatr Nephrol** 2001;3:216-8.

14. Yu D, Dahl GVH, Shames R, **Fisher PG**. Weekly dosing of carboplatin with vincristine increases risk of allergy in children. **J Pediatr Hematol Oncol** 2001;23:349-52.

15. Peterson K, Harsh G, **Fisher PG**, Adler J, Le Q. Daily low-dose carboplatin as a radiation sensitizer for newly diagnosed malignant glioma. **J Neurooncol** 2001;53:27-32.

16. Minn YA, Pollock BH, Garzarella L, Dahl GV, Kun LE, Ducore JM, Shibata A, Kepner J, **Fisher PG**. Surveillance neuroimaging to detect relapse in childhood brain tumors: a Pediatric Oncology Group study. **J Clin Oncol** 2001;19:4135-40.

17. **Fisher PG**, Kadan-Lottick NS, Korones DN. Intrathecal thiotepa: reappraisal of an "established" therapy. **J Pediatr Hematol Oncol** 2002;24:274-8.

18. **Fisher PG**, Tontiplaphol A, Pearlman EM, Stolle CA, Duffner PK, Hyder DR, Vortmeyer AO, Zhuang Z. Childhood hemangioblastoma does not predict germline or somatic mutations in the von Hippel-Lindau tumor suppressor gene. **Ann Neurol** 2002;51:257-60.

19. Lehman NL, Jorden MA, Huhn SL, Barnes PD, Nelson GB, **Fisher PG**, Horoupian DS. Cortical ependymoma: a case report and review. **Pediatr Neurosurg** 2003;39:50-4.

20. Haas-Kogan DA, Missett, BT, Wara WM, Donaldson SS, Lamborn KR, Prados MD, **Fisher PG**, Huhn SL, Fisch BM, Berger MS, Le QT. Radiation therapy for intracranial germ cell tumors, **Int J Radiat Oncol Biol Phys** 2003;56:511-8.

21. Bhat SR, Goodwin TL, Burwinkle TM, Lansdale MF, Dahl GV, Huhn SL, Gibbs IC, Donaldson SS, Rosenblum RK, Varni JW, **Fisher PG**. A profile of daily life in children with brain tumors: an assessment of health related quality of life. **J Clin Oncol** 2005;23:5493-500.

22. Greenberg ML, **Fisher PG**, Freeman C, Korones DN, Bernstein M, Friedman H, Blaney S, Hershon L, Zhou T, Chen Z, Kretschmar C. Etoposide, vincristine, and cyclosporin A with standard dose radiation therapy in newly diagnosed diffuse intrinsic brainstem gliomas: a Pediatric Oncology Group phase I study. **Pediatr Blood Cancer** 2005;45:644-8.

23. Minn AY, **Fisher PG**, Barnes PD, Dahl GV. A syndrome of irreversible leukoencephalopathy following pediatric allogeneic bone marrow transplantation. **Pediatr Blood Cancer** 2007;48:213-7.

24. Monje ML, Vogel H, Masek M, Ligon KL, **Fisher PG**, Palmer T. A cellular basis for memory dysfunction after treatment for CNS malignancies. **Ann Neurol** 2007;62:515-20.

25. Korones DN, **Fisher PG**, Kretschmar C, Zhou T, Chen Z, Kepner J, Freeman C. Treatment of children with diffuse intrinsic brain stem glioma with concurrent radiotherapy, vincristine, and oral etoposide: a Pediatric Oncology Group phase II study. **Pediatr Blood Cancer** 2008;50:227-30.

26. Dearlove JV, **Fisher PG**, Buffler PA. Family history of cancer among patients with childhood brain tumors: a critical review. **J Pediatr Hematol Oncol** 2008;30:8-14.

27. Schiffman JD, Chun N, **Fisher PG**, Dahl GV, Ford JM, Eggerding FA. A novel p53 gene in-frame deletion in a Li-Fraumeni-like family. **Pediatr Blood Cancer** 2008;50:914-6.

28. Balmaceda C, Peereboom D, Pannullo S, Cheung YKK, **Fisher PG**, Alavi J, Sisti M, Chen J, Fine RL. Multi-institutional phase II study of temozolomide administered twice daily in the treatment of recurrent high-grade gliomas. **Cancer** 2008;112:1139-46.

29. Hou LC, Bababeygy SR, Sarkissian V, **Fisher PG**, Vogel H, Barnes P, Huhn SC. Congenital glioblastoma multiforme: case report and review of the literature. **Pediatr Neurosurg** 2008;44:304-12.

30. **Fisher PG**, Tihan T, Goldthwaite PT, Wharam MD, Carson BS, Weingart JD, Repka MX, Cohen KJ, Foer DR, Burger PC. Outcome analysis of childhood low-grade astrocytomas. **Pediatr Blood Cancer** 2008;51:245-50.

31. Kirschen MP, Davis-Ratner MS, Milner MW, Chen SHA, Schraedley-Desmond P, **Fisher PG**, Desmond JE. Verbal memory impairments in children after cerebellar tumor resection. **Behav Neurol** 2008;20:39-53.

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Exhibit 15

Good morning, ladies and gentlemen.

Just to anticipate and plan my day and to be of service to Jahi McMath, her family, and Children's Hospital Oakland, please allow me just to recap explicit details below, as I anticipate you will need all the plans before appearing this morning in front of your judge.

I am available today 12/23/14 to perform a repeat brain death evaluation for Jahi McMath at Children's Hospital Oakland. Optimal time is 3 or 4 pm. That will be a standard, clinical, bedside examination, and include an apnea test, assisted by a respiratory therapist. I could be available the morning of December 24, if there were a scheduling problem. After that, I ail be unavailable to come to Children's in person, though available by phone and email.

Prior to that brain death evaluation, it sounds like family and their counsel wish to obtain repeat electroencephalogram (EEG) and repeat head computed tomography (CT) as ancillary tests. This is reasonable and customary as part of the brain death process. I would concur with these. These tests should be conducted prior to my seeing Jahi, so that I can review the results.

Prior to my seeing the child, Jahi must have blood tests including: a) complete blood count; b) electrolytc panel; and c) chemistry panel. I will need to review these results.

I will need a list of all medications Jahi is receiving when I examine her. For the exam to proceed, Jahi must have a) temperature within a normal range; and b) blood pressure within a normal range

The family and their counsel may request a repeat radionuclide cerebral blood flow study. That too is a reasonable and customary ancillary test for brain death. I would concur with this. That study would be performed not by me, but by a nuclear medicine physician, and the results reported to me. This could be done either before or after my visit. That is, I do not want the scheduling of that study to preclude my evaluation of the child.

I will complete a handwritten note of my evaluation immediately upon its completion, for placement in the medical record at Children's Oakland. I will also complete the American Academy of Pediatrics 2011 Brain Death Examination checklist (per attached).

As compensation for this evaluation, a flat fee of $900 will be the charge, and I would like that money to be split between two children's charities: Jack's Helping Hand (P.O. Box 14718, San Luis Obispo, CA 93406) and Jasper Ridge Farm (2995 Woodside Road, #620924, Woodside, CA 94062) in honor of Jahi McMath. That money could be paid directly to the two charities or routed through me--I have no preference, as long as such is done appropriately and in timely manner.

Again, I consent to this email being shared with any parties.

Best regards, and thanks,

Paul

Paul Graham Fisher, M.D. | Professor, Neurology and Pediatrics, and by courtesy, Neurosurgery and Human Biology | The Beirne Family Professor of Pediatric Neuro-Oncology | Chief, Division of Child Neurology| The Bing Director, Program in Human Biology | Stanford University and Lucile Packard Children's Hospital

Exhibit 16

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FILED
ALAMEDA COUNTY
DEC 23 2013
By

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

LATASHA WINKFIELD, the Mother of Jahi McMath, a minor Petitioner, v. CHILDREN'S HOSPITAL OAKLAND, Dr. David Durand M.D. and DOES 1 through 100, inclusive Respondents	Case No. RG13-707598 CASE MANAGEMENT ORDER REGARDING PETITION FOR AUTHORIZING MEDICAL TREATMENT AND AUTHORIZING PETITIONER TO GIVE CONSENT TO MEDICAL TREATMENT; [Prob. Code §§ 3200 *et seq.*, §§ 4600 *et seq.*] Date: December 23, 2013 Time: 9:30 am Dept: 31

The court held a continued hearing on the verified petition of Latasha Linkfield at 9:30 p.m. on December 23, 2013, in Department 31 the Honorable Evelio M. Grillo presiding. Following the hearing in open court, the court conferred with counsel in chambers.

IT IS ORDERED THAT:

1. The court appoints Dr. Paul Graham Fisher as court appointed independent expert as defined by H&S 7800 and 7801.
2. Dr. Fisher will conduct his assessment as soon as possible. Respondent has agreed to provide Dr. Fisher with access to facilities, services, and records of Jahi McMath.

3. As soon as possible Dr. Fisher must provide to Petitioner and Respondent all records of his investigation and a brief written report stating his analysis and conclusions.
4. Respondent has agreed to provide Petitioner with all requested records relating to Jahi McMath as soon as reasonably available.
5. The court will hold a hearing on Tuesday December 24, 2013, at 9:30 am.
6. The court anticipates that the hearing will be closed to the public under CRC 2.550 et seq. because it involves the medical records of a minor.
7. The hearing will involve testimony by Dr. Robin Shanahan and Dr. Paul Graham Fisher. The hearing may also involve other matters as determined by the court.
8. At the conclusion of the hearing on Tuesday December 24, 2013, the court will schedule further proceedings as deemed appropriate.

Dated: December 23, 2013

Evelio Grillo
Judge of the Superior Court

Exhibit 17

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

LATASHA WINKFIELD, the Mother of Jahi McMath, a minor Petitioner, v. CHILDREN'S HOSPITAL OAKLAND, Dr. David Durand M.D. and DOES 1 through 100, inclusive Respondents	Case No. RG13-707598 TEMPORARY RESTRAINING ORDER FOLLOWING PETITION FOR EMERGENCY PROTECTIVE/RESTRAINING ORDER AUTHORIZING MEDICAL TREATMENT AND AUTHORIZING PETITIONER TO GIVE CONSENT TO MEDICAL TREATMENT; [Prob. Code §§ 3200 *et seq.*, §§ 4600 *et seq.*] Date: December 23, 2013 Time: 9:00 am Dept: 31

The court held a continued hearing on the verified petition of Latasha Linkfield at 1:30 p.m. on December 23, 2013, in Department 31 the Honorable Evelio M. Grillo presiding.

IT IS ORDERED THAT:

The Temporary Restraining Order entered on December 22, 2013, is hereby extended to Monday December 30, 2013. This order precludes the Respondent from removing Petitioner from the ventilator or ending any of the current treatment and support provided by Respondent- in essence, the Court orders the respondent to maintain the "status quo" of treatment and support.

This Temporary Restraining Order orders the following:

1. Respondent CHO, its agents, employees, servants and independent contractors are ordered to continue to provide Jahi McMath with the treatment and support which is currently being provided as per the current medications and physicians orders until further order of the court.
2. The order is to remain effect until further order of the court.

Dated: December 23, 2013

Evelio Grillo
Judge of the Superior Court

Exhibit 18

Douglas C. Straus (Bar No. 96301)
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Attorneys for
CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF ALAMEDA

LATASHA WINKFIELD, the mother of Jahi McMath, a minor, Petitioner, v. CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND, et al. Respondents..	Case No. RG 13-707598 **OPPOSITION TO PETITION TO APPOINT DR. PAUL A. BYRNE AS INDEPENDENT EXPERT AND REQUEST TO LIFT DECEMBER 23, 2013 TEMPORARY RESTRAINING ORDER** Date: December 24, 2013 Time: 9:30 A.M. Dept: 31

INTRODUCTION

This brief assumes that Dr. Paul Fisher's Independent Expert Report presented to the Court December 24, 2013 will conclude that Jahi McMath is, unfortunately, brain dead as defined by both California Health & Safety Code section 7180 and medically recognized criteria. Based on that assumption, Respondent Children's Hospital & Research Center at Oakland (Children's) respectfully suggests that: (1) the Temporary Restraining Order obligating Children's to provide continuing care to Jahi McMath should be lifted because Dr. Fisher's independent evaluation of Jahi McMath satisfies the requirements of Health & Safety Code section 7181; and (2) the request

of Petitioner Latasha Winkfield to appoint Paul Byrne as a second independent expert should be denied because such an appointment is unnecessary and Dr. Byrne, who is neither a neurologist nor a California physician, is not qualified and has already taken a position on this matter..

LEGAL ANALYSIS

1. The TRO Should Be Lifted As Health & Safety Code Sections 7180-81 and 1254.4 Have Been Satisfied and There is No Evidence of Diagnostic Error.

This Court is well aware that Jahi McMath is deceased according to California law if she has sustained "irreversible cessation of all functions of the entire brain, including the brain stem.". California Health & Safety Code § 7180. Children's presented two declarations of attending physicians who both concluded that Jahi McMath was brain dead.

Health & Safety Code § 7181 requires independent confirmation of any determination of brain death by a second physician. Because the Court was concerned that both these physicians were affiliated with Children's, the Court appointed Dr. Paul Fisher as an independent expert. Assuming Dr. Fisher concludes that Jahi McMath is dead, there can no longer be any controversy that the statutory criteria establishing brain death have been met.

Petitioner insists that, because she would have a legal right to dictate healthcare measures for her daughter if she were still alive, that her consent is also required before Jahi McMath can be disconnected from the ventilator now that she is deceased. There is simply no law that supports this contention. Petitioner relies exclusively on cases where the patient has ongoing brain activity and section 7180 is inapplicable. In *Bartling v. Superior Court* (1984) 163 Cal. App. 3d 186, the patient was attempting to pull out medical devices because he wished to end his life. In *Conservatorship of Valerie N.* (1985) 40 Cal.3d 143, the conservatee was a disabled adult with an IQ of 30. *In The Matter of Baby K* 832 F.Supp. 1022 (1993 D. Va.), which had nothing to do with California law, involved an infant who had brain stem function and, contrary to the

claim of Petitioner, brain death was not the central issue. *In re Wanglie*, No. PX-91-283 (Hennepin County, Minnesota), involved a woman in a persistent vegetative state (i.e., brain activity but unconscious). In *Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, the Court of Appeal carefully explains that the conservatee is not dead because he can breath without a ventilator and his EEG "is not flat." 200 Cal.App.3d at 190.

Because Ms. McMath is dead, practically and legally, there is no course of medical treatment to continue or discontinue; there is nothing to which the family's consent is applicable. Cases cited by Petitioner, regarding the right to self-determination of treatment of a person living in a vegetative state, or on life support, are not applicable. To be blunt, Children's is currently merely preserving Ms. McMath's body from the natural post-mortem course of events. There is no legal, ethical or moral requirement that it continue to do so or that the family consent in the decision to stop doing so.

Petitioner cites no authority for the proposition that the patient's legal representatives have an automatic right to participate in the determination of brain death. Sections 7180-7181 are directly to the contrary. The California Legislature has decided that this is a *medical* determination. Health & Safety Code section 1254.4 recognizes that, after death has been declared, the hospital must provide a reasonable period of accommodation before discontinuation of cardiopulmonary support for the patient. That has, of course, been done here.

Dority v. Superior Court (1983) 145 Cal. App. 3d 273 is 100% consistent with the conclusion that the patient's representatives have no ongoing right to object to a medical determination of death under the facts here and that further court intervention is unwarranted in this case. *Dority* holds that the courts should be involved in second-guessing medical determinations of death only "***upon a sufficient showing that it is reasonably probable that a mistake has been made in the diagnosis of brain death or where the diagnosis was not made in***

accord with accepted medical standards." Emphasis added. 145 Cal. App. 3d at 281. The *Dority* decision goes on to confirm that medical devices should not be disconnected without consulting with the family and giving them time "until the initial shock of the diagnosis dissipates.[1]" *Ibid.* Children's has, of course, done this.

Nothing in *Dority* suggests that the trial court is automatically required to function as final arbiter any time the family objects to the determination of brain death. Rather, *Dority* holds that judicial intervention is appropriate only after proof is offered that it is "reasonably probable" that a mistake has been made or that the diagnosis deviated from accepted medical standards.

Petitioner has offered not a scintilla of evidence of any diagnostic error or deviation from accepted medical standards in the determination of brain death. Children's has fully complied with sections 7180, 7181 and 1254.4 The temporary restraining order requiring continuing care of the body of Jahi McMath should be lifted.

2. Appointment of Another Expert is Unnecessary and Petitioner's Proposed Appointee is Neither Qualified Nor Impartial.

The Court has appointed Dr. Paul Fisher of the Stanford University and Lucile Packard Children's Hospital (Children's Stanford) to serve as an independent expert in this matter. Dr. Fisher has conducted a brain death evaluation of Jahi McMath. Assuming Dr. Fisher has confirmed brain death, the criteria of sections 7180 and 7181 have been satisfied. Absent some proof of a reasonable probability of error—and there is no such evidence—further expert examination of Jahi McMath is unwarranted.

Moreover, respectfully, Dr. Paul A. Byrne is not qualified. Fundamentally, he is not licensed in California. He is simply not allowed to examine patients in the State of California. Indeed, Children's would likely be in violation of licensing and credentialing standards if it were

[1] The *Dority* decision pre-dated section 1254.4.

to allow such an unlicensed professional to examine one of its patients.

In addition, Dr. Byrne is not a neurologist. He is not trained to read EEGs and he has shown no expertise in performing brain death examinations on teenagers. Indeed, Dr. Byrne has shown no knowledge or experience with the California statutory scheme governing brain death.

Finally, Dr. Byrne is not impartial as he has already published on the internet his opinions regarding Jahi McMath. *See* "Jahi Is Not Truly Dead," December 24, 2013, by Paul A. Byrne, renewamerica.com, in which Dr. Byrne, without examining Ms. McMath, concludes "And for Jahi, they just want to kill her, yes change the living Jahi into a cadaver."[2]

CONCLUSION

For the foregoing reasons, Respondent respectfully requests that the Court deny Petitioner's request to appoint Dr. Byrne and that the Court lift the Temporary Restraining Order.

Dated: December 24, 2013

ARCHER NORRIS

By Douglas C. Straus
Attorneys for CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND

[2] Dr. Byrne's lack of objectivity and his rush to asn erroneous judgment here are unsurprising. Internet search also revealed Dr. Byrne has authored a paper titled "Brain Death Is Not Death" (*see* TruthAboutOrganDonation.com) and similar papers—always presented or published in religious rather than academic scientific publications. Dr. Byrne is a crusader with an ideology-based bias, not a neutral expert physician.

Exhibit 19

Court Exhibit 1

Children's Hospital Oakland

747 Fifty Second Street • Oakland, CA 94609 • (510) 428-3000

TREATMENT AND PROGRESS RECORD

MR # 059459

McMATH, JAMI

10/24/00

FISHER, PNL 6 PICU

DATE	TIME
12/23/13	1845

NEUROLOGY CONSULTATION NOTE

ASKED BY COUNSEL FOR PATIENT AND CHO TO PERFORM INDEPENDENT BRAIN DEATH EXAM. IN BRIEF, 13 1/2-YEAR-OLD FEMALE S/P TONSILLECTOMY, COMPLICATED BY HEMORRHAGE & CARDIAC ARREST, AND THEN CATASTROPHIC BRAIN INJURY. PATIENT HAS ALREADY HAD 2 BRAIN DEATH EXAMINATIONS, ONE BY A NEUROLOGIST, ONE BY A CRITICAL CARE MD.

PREVIOUSLY, 12/11 HEAD CT - STRIKINGLY DECREASED DENSITY THROUGHOUT BRAIN, WITH PROMINENCE OF VESSELS.

12/11 EEG - ELECTROCEREBRAL SILENCE.

TODAY, EEG - ELECTROCEREBRAL SILENCE, REVIEWED BY MYSELF.

RADIONUCLIDE CEREBRAL BLOOD FLOW STUDY/SPECT - NO BLOOD FLOW IN BRAIN.

MEDICATIONS AT PRESENT -

ARTIFICIAL TEARS

VASOPRESSIN

NO SEDATIVES

ABG EARLIER TODAY 7.45/30/71/-3.5

LABS 144 | 110 / 4.6 | 25

ON MY EXAM:

VS - T 36.5, P 70-71, BP 90-107/56-62, O_2 SAT 95-98%

ON MECHANICAL VENT, NO SPONTANEOUS RESPIRATORY EFFORT

CVR - NO RESPIRATORY VARIABILITY, NO MURMUR.

NEUROLOGICAL -

MENTAL STATUS - NO EYE OPENING, NO MOVEMENT, NO VOCALIZATION

CRANIAL NERVES - FUNDI PALE, PUPILS 5 mm OU AREFLEXIC, NO OCULOCEPHALIC REFLEX, NO OCULOVESTIBULAR REFLEX (NO

05740 (8/00)

DATE	
12/23/13 1845	RESPONSE TO CALORICS), NO RESPONSE TO FACIAL PAIN, NO CORNEAL REFLEX TO TOUCH OR AIR, NO GAG. MOTOR - FLACCID TONE THROUGHOUT. NO MOVEMENT. REFLEXES - NO DEEP TENDON REFLEXES, NO BABINSKI SIGN, NO SPINAL REFLEXES. SENSORY - NO RESPONSE TO PAIN IN EXTREMITIES x 4, OR TRUNK. AUTONOMIC - ϕ RESP EFFORT, NO CARDIAC VARIABILITY, NO SPHINCTERIC REFLEX. APNEA TEST RESULTS, WITH VENT OFF, 100 % O_2 START 1538 7.309 / 49 / 126 / -1.4 END 1547 7.198 / 73.3 / 143.4 / 0.4 THAT IS, PATIENT FAILED APNEA TEST OVERALL, UNFORTUNATE CIRCUMSTANCES IN 13-YEAR-OLD WITH KNOWN, IRREVERSIBLE BRAIN INJURY AND NOW COMPLETE ABSENCE OF CEREBRAL FUNCTION AND COMPLETE ABSENCE OF BRAINSTEM FUNCTION, CHILD MEETS ALL CRITERIA FOR BRAIN DEATH, BY PROFESSIONAL SOCIETIES AND STATE OF CALIFORNIA. MOREOVER, ANCILLARY TESTS EEG SHOWS NO ELECTRICAL BRAIN ACTIVITY, AND BLOOD FLOW STUDY SHOWS NO CEREBRAL BLOOD FLOW. BY MY INDEPENDENT EXAM, CHILD BRAIN DEAD 12/23/13 AT 1845. REDACTED REDACTED Paul Fisher MD CA LIC 684211 FISHER, Paul Graham OFFICE (650) 721-5889

HCMATH, JAHI DOB 10/24/00

12/23/13 1845

MR # 059459

Please see full handwritten note. PP

APPENDIX 1 Check List for Documentation of Brain Death

Brain Death Examination for Infants and Children

Two physicians must perform independent examinations separated by specified intervals.

Age of Patient	Timing of first exam	Interexam Interval
Term newborn 37 weeks gestational age and up to 30 days old	First exam may be performed 24 hours after birth OR following cardiopulmonary resuscitation or other severe brain injury	At least 24 hours; Interval shortened because ancillary study (section 4) is consistent with brain death
31 days to 18 years old	First exam may be performed 24 hours following cardiopulmonary resuscitation or other severe brain injury	At least 12 hours OR; Interval shortened because ancillary study (section 4) is consistent with brain death

Section 1. PREREQUISITES for brain death examination and apnea test

A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma (Please check)

☐ Traumatic brain injury ☒ Hypoxic brain injury ☐ Known metabolic disorder Other (Specify)

B. Correction of confounding factors that can interfere with the neurologic examination	Examination One		Examination Two	
a. Core Body Temp is over 95° F (35° C)	☒ Yes	☐ No	☐ Yes	☐ No
b. Systolic blood pressure or MAP in acceptable range (Systolic BP not less than 2 standard deviations below age appropriate norm) based on age	☒ Yes	☐ No	☐ Yes	☐ No
c. Sedative/analgesic drug effect excluded as a confounding factor	☒ Yes	☐ No	☐ Yes	☐ No
d. Metabolic derangements excluded as a confounding factor	☒ Yes	☐ No	☐ Yes	☐ No
e. Neuromuscular blockade excluded as a confounding factor	☒ Yes	☐ No	☐ Yes	☐ No

If ALL prerequisites are marked YES, then proceed to section 2, OR confounding variable was present. Ancillary study was therefore performed to document brain death. (Section 4)

Section 2. Physical Examination (Please check) NOTE: SPINAL CORD REFLEXES ARE ACCEPTABLE	Examination One Date/Time:		Examination Two Date/Time:	
a. Flaccid tone, patient unresponsive to deep painful stimuli	☒ Yes	☐ No	☐ Yes	☐ No
b. Pupils are midposition or fully dilated and light reflexes are absent	☒ Yes	☐ No	☐ Yes	☐ No
c. Corneal, oculo, gag reflexes are absent. Sucking and rooting reflexes are absent (in neonates and infants)	☒ Yes	☐ No	☐ Yes	☐ No
d. Oculocephalic reflexes are absent	☒ Yes	☐ No	☐ Yes	☐ No
e. Spontaneous respiratory effort while on mechanical ventilation is absent	☒ Yes	☐ No	☐ Yes	☐ No

If the _____ (specify) element of the exam could not be performed because _____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death. (Section 4)

Section 3. APNEA Test	Examination One	Examination Two
No spontaneous respiratory efforts were observed despite final $PaCO_2$ > 60 mm Hg and a ≥ 20 mm Hg increase above baseline. (Examination One) No spontaneous respiratory efforts were observed despite final $PaCO_2$ ≥ 60 mm Hg and a ≥ 20 mm Hg increase above baseline, of examination Two)	Date/Time: Pretest $PaCO_2$: 48.0 Apnea duration: 1 ☐ min ☐ hr Posttest $PaCO_2$: 73.3	Date/Time: Pretest $PaCO_2$: Apnea duration: _____ min Posttest $PaCO_2$:

Apnea test is contraindicated or could not be performed to completion because _____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death. (Section 4)

Section 4. ANCILLARY testing is required when (1) any components of the examination or apnea testing cannot be completed; (2) if there is uncertainty about the results of the neurologic examination; or (3) if a medication effect may be present.

Ancillary testing can be performed to reduce the inter-examination period however a second neurologic examination is required. Components of the neurologic examination that can be performed safely should be completed in close proximity to the ancillary test

	Date/Time:	
Electrogenic Suppression (EEG) study appropriately documents electrocortical silence OR	☒ Yes	☐ No
Cerebral Blood Flow (CBF) study report documents no cerebral perfusion	☒ Yes	☐ No

Section 5. Signatures

Examiner One

I certify that my examination is consistent with cessation of function of the brainstem and brainstem. Confirmatory exam to follow

(Printed Name) _____ (Signature) _____

(Specialty) _____ (Page's #License #) _____ (Date mm/dd/yyyy) _____ (Time) _____

Examiner Two

I certify that my examination and/or ancillary test report confirm unchanged and irreversible cessation of function of the brain and brainstem. The patient is declared brain dead at this hour

Date/Time of death: 12/23/13 1845

(Printed Name) NEUROLOGY CA (Page's #License #) 684211 12/23/13 1845 (Date mm/dd/yyyy) (Time)

(Specialty) _____

Paul Fisher MD

FISHER, Paul Graham

UC CA 684211

OFFICE (650) 721-5889

Exhibit 20

Court Exhibit 2

[redacted]

TABLE 1 Summary Recommendations for the Diagnosis of Brain Death in Neonates, Infants, and Children

Recommendation	Evidence Score	Recommendation Score
1. Determination of brain death in neonates, infants and children relies on a clinical diagnosis that is based on the absence of neurologic function with a known irreversible cause of coma. Coma and apnea must coexist to diagnose brain death. This diagnosis should be made by physicians who have evaluated the history and completed the neurologic examinations.	High	Strong
2. Prerequisites for initiating a brain death evaluation		
a. Hypotension, hypothermia, and metabolic disturbances that could affect the neurological examination must be corrected prior to examination for brain death.	High	Strong
b. Sedatives, analgesics, neuromuscular blockers, and anticonvulsant agents should be discontinued for a reasonable time period based on elimination half-life of the pharmacologic agent to ensure they do not affect the neurologic examination. Knowledge of the total amount of each agent (mg/kg) administered since hospital admission may provide useful information concerning the risk of continued medication effects. Blood or plasma levels to confirm high or supratherapeutic levels of anticonvulsants with sedative effects that are not present should be obtained (if available) and repeated as needed or until the levels are in the low to mid therapeutic range.	Moderate	Strong
c. The diagnosis of brain death based on neurologic examination alone should not be made if supratherapeutic or high therapeutic levels of sedative agents are present. When levels are in the low or in the mid therapeutic range, medication effects sufficient to affect the results of the neurologic examination are unlikely. If uncertainty remains, an ancillary study should be performed.	Moderate	Strong
d. Assessment of neurologic function may be unreliable immediately following cardiopulmonary resuscitation or other severe acute brain injuries and evaluation for brain death should be deferred for 24 to 48 hours or longer if there are concerns or inconsistencies in the examination.	Moderate	Strong
3. Number of examinations, examiners and observation periods		
a. Two examinations including apnea testing with each examination separated by an observation period are required.	Moderate	Strong
b. The examinations should be performed by different attending physicians involved in the care of the child. The apnea test may be performed by the same physician, preferably the attending physician who is managing ventilator care of the child.	Low	Strong
c. Recommended observation periods:		
(1) 24 hours for neonates (37 weeks gestation to term infants 30 days of age)	Moderate	Strong
(2) 12 hours for infants and children (> 30 days to 18 years).		
d. The first examination determines the child has met neurologic examination criteria for brain death. The second examination, performed by a different attending physician, confirms that the child has fulfilled criteria for brain death.	Moderate	Strong
e. Assessment of neurologic function may be unreliable immediately following cardiopulmonary resuscitation or other severe acute brain injuries and evaluation for brain death should be deferred for 24 to 48 hours or longer if there are concerns or inconsistencies in the examination.	Moderate	Strong
4. Apnea testing		
a. Apnea testing must be performed safely and requires documentation of an arterial $Paco_2$ 20 mm Hg above the baseline $Paco_2$ and ≥ 60 mm Hg with no respiratory effort during the testing period to support the diagnosis of brain death. Some infants and children with chronic respiratory disease or insufficiency may only be responsive to supranormal $Paco_2$ levels. In this instance, the $Paco_2$ level should increase to ≥ 20 mm Hg above the baseline $Paco_2$ level.	Moderate	Strong
b. If the apnea test cannot be performed due to a medical contraindication or cannot be completed because of hemodynamic instability, desaturation to < 85%, or an inability to reach a $Paco_2$ of 60 mm Hg or greater, an ancillary study should be performed.	Moderate	Strong
5. Ancillary studies		
a. Ancillary studies (ECG and radionuclide CBF) are not required to establish brain death unless the clinical examination or apnea test cannot be completed.	Moderate	Strong
b. Ancillary studies are not a substitute for the neurologic examination.	Moderate	Strong
c. For all age groups, ancillary studies can be used to assist the clinician in making the diagnosis of brain death to reduce the observation period or when (i) components of the examination or apnea testing cannot be completed safely due to the underlying medical condition of the patient; (ii) if there is uncertainty about the results of the neurologic examination; or (iii) if a medication effect may interfere with evaluation of the patient. If the ancillary study supports the diagnosis, the second examination and apnea testing can then be performed. When an ancillary study is used to reduce the observation period, all aspects of the examination and apnea testing should be completed and documented.	Moderate	Strong
d. When an ancillary study is used because there are inherent examination limitations (ie, i to iii), then components of the examination done initially should be completed and documented.	High	Strong
e. If the ancillary study is equivocal or if there is concern about the validity of the ancillary study, the patient cannot be pronounced dead. The patient should continue to be observed until brain death can be declared on clinical examination criteria and apnea testing, or a follow-up ancillary study can be performed to assist with the determination of brain death. A waiting period of 24 hours is recommended before further clinical reevaluation or repeat ancillary study is performed. Supportive patient care should continue during this time period.	Moderate	Strong
6. Declaration of death		
a. Death is declared after confirmation and completion of the second clinical examination and apnea test.	High	Strong
b. When ancillary studies are used, documentation of components from the second clinical examination that can be completed must remain consistent with brain death. All aspects of the clinical examination, including the apnea test, or ancillary studies must be appropriately documented.	High	Strong
c. The clinical examination should be carried out by experienced clinicians who are familiar with infants and children, and have specific training in neurocritical care.	High	Strong

The "evaluation score" is based on the strength of the evidence available at the time of publication.
The "recommendation score" is the strength of the recommendations based on available evidence at the time of publication. Scoring guidelines are listed in Table 2.

Exhibit 21

Court Exhibit 3

PEDIATRICS®
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Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations

Thomas A. Nakagawa, Stephen Ashwal, Mudit Mathur, Mohan Mysore and the Society of Critical Care Medicine, Section on Critical Care and Section on Neurology of the American Academy of Pediatrics, and the Child Neurology Society

Pediatrics 2011;128;e720; originally published online August 28, 2011;
DOI: 10.1542/peds.2011-1511

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Guidance for the Clinician in Rendering Pediatric Care

Clinical Report—Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations

abstract

OBJECTIVE: To review and revise the 1987 pediatric brain death guidelines.

METHODS: Relevant literature was reviewed. Recommendations were developed using the GRADE system.

CONCLUSIONS AND RECOMMENDATIONS: (1) Determination of brain death in term newborns, infants and children is a clinical diagnosis based on the absence of neurologic function with a known irreversible cause of coma. Because of insufficient data in the literature, recommendations for preterm infants less than 37 weeks gestational age are not included in this guideline.

(2) Hypotension, hypothermia, and metabolic disturbances should be treated and corrected and medications that can interfere with the neurologic examination and apnea testing should be discontinued allowing for adequate clearance before proceeding with these evaluations.

(3) Two examinations including apnea testing with each examination separated by an observation period are required. Examinations should be performed by different attending physicians. Apnea testing may be performed by the same physician. An observation period of 24 hours for term newborns (37 weeks gestational age) to 30 days of age, and 12 hours for infants and chi (> 30 days to 18 years) is recommended. The first examination determines the child has met the accepted neurologic examination criteria for brain death. The second examination confirms brain death based on an unchanged and irreversible condition. Assessment of neurologic function following cardiopulmonary resuscitation or other severe acute brain injuries should be deferred for 24 hours or longer if there are concerns or inconsistencies in the examination.

(4) Apnea testing to support the diagnosis of brain death must be performed safely and requires documentation of an arterial $Paco_2$ 20 mm Hg above the baseline and ≥ 60 mm Hg with no respiratory effort during the testing period. If the apnea test cannot be safely completed, an ancillary study should be performed.

(5) Ancillary studies (electroencephalogram and radionuclide cerebral blood flow) are not required to establish brain death and are not a substitute for the neurologic examination. Ancillary studies may be us d to assist the clinician in making the diagnosis of brain death (i) when components of the examination or apnea testing cannot be completed safely due to the underlying medical condition of the patient; (ii) if there is uncertainty about the results of the neurologic examination; (iii) if a medication effect may be present; or (iv) to reduce the inter-examination observation period. When ancillary studies are used, a second clinical examination and apnea test should be performed and components that can be completed must remain consistent with brain death. In this instance the observation interval may be shortened and the second neurologic examination and apnea test (or all components that are able to be completed safely) can be performed at any time thereafter.

(6) Death is declared when the above criteria are fulfilled. *Pediatrics* 2011;128: e720–e740

Thomas A. Nakagawa, MD, Stephen Ashwal, MD, Mudit Mathur, MD, Mohan Mysore, MD, and THE SOCIETY OF CRITICAL CARE MEDICINE, SECTION ON CRITICAL CARE AND SECTION ON NEUROLOGY OF THE AMERICAN ACADEMY OF PEDIATRICS, AND THE CHILD NEUROLOGY SOCIETY

KEY WORDS
apnea testing, brain death, cerebral blood flow, children, electroencephalography, infants, neonates, pediatrics

ABBREVIATIONS
EEG—electroencephalogram
CBF—cerebral blood flow
CT—computed tomography
MRI—magnetic resonance imaging
ETT—endotracheal tube
CPAP—continuous positive airway pressure
ICP—intracranial pressure
ECS—electrocerebral silence

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

www.pediatrics.org/cgi/doi/10.1542/peds.2011-1511

doi:10.1542/peds.2011-1511

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

INTRODUCTION

In 1987, guidelines for the determination of brain death in children were published by a multi-society task force.[1,2] These consensus based guidelines were developed because existing guidelines from the President's Commission failed to adequately address criteria to determine brain death in pediatric patients. They emphasized the importance of the history and clinical examination in determining the etiology of coma so that correctable or reversible conditions were eliminated. Additionally, age-related observation periods and the need for specific neurodiagnostic tests were recommended for children younger than 1 year of age. In children older than 1 year, it was recommended that the diagnosis of brain death could be made solely on a clinical basis and laboratory studies were optional. Little guidance was provided to determine brain death in neonates less than 7 days of age because of limited clinical experience and lack of sufficient data.

These guidelines generally have been accepted and used to guide clinical practice; however they have not been reviewed nor revised since originally published. Several inherent weaknesses have been recognized including: (1) limited clinical information at the time of publication; (2) uncertainty concerning the sensitivity and specificity of ancillary testing; (3) biological rationale for the use of age-based criteria; and (4) little direction as to whether, when and how the diagnosis of brain death could be made in neonates. Despite national and legal acceptance of the concept of brain death, these limitations have resulted in the lack of a standardized approach to determining brain death in children.[3–9] These issues are not unique to infants and children[10] nor limited to the United States. The American Academy of Neurology published guidelines to determine brain death in adults in 1995 which have been revised in 2010.[11,12] Additionally, guidelines to determine brain death in adults and children have been published in Canada.[13]

The Society of Critical Care Medicine (SCCM) and the Section on Critical Care and Section on Neurology of the American Academy of Pediatrics (AAP), in conjunction with the Child Neurology Society (CNS), formed a multidisciplinary committee of medical and surgical subspecialists under the auspices of the American College of Critical Care Medicine (ACCM) to review and revise the 1987 guidelines. Its purpose was to review the neonatal and pediatric literature from 1987, including any prior relevant literature, and update recommendations regarding appropriate examination criteria and use of ancillary testing to diagnose brain death in neonates, infants and children. The committee was also charged with developing a checklist to provide guidance and standardization to document brain death. Uniformity in the determination of brain death should allow physicians to pronounce brain death in pediatric patients in a more precise and orderly manner and ensure that all components of the examination are performed and appropriately documented.

Tables 1–3 of this publication contain the committee's updated recommendations, the GRADE classification system, and clinical and neurologic examination criteria for brain death. Appendices 1–7 provide additional information concerning the diagnosis of brain death in children. Appendix 1 (check list) and Appendix 2 (pharmacological data for the time interval to testing after medication discontinuation) provide additional resources to aid the clinician in diagnosing brain death. Appendix 3 summarizes data regarding apnea testing. Appendices 4–6 provide data on the diagnostic yield of ancillary testing, specifically electroencephalography (EEG), and radionuclide cerebral blood flow (CBF) studies. Appendix 7 compares the 1987 guideline's criteria to the revised recommendations. Appendix 8 provides an algorithm for the determination of brain death in infants and children.

This update affirms the definition of death as stated in the 1987 pediatric guidelines. This definition had been established by multiple organizations including the American Medical Association, the American Bar Association, the National Conference of Commissioners on Uniform State Laws, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research and the American Academy of Neurology as follows: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards."[1]

METHODS

A multidisciplinary committee composed of physicians and nurses with expertise in pediatrics, pediatric critical care, neonatology, pediatric neurology and neurosurgery, nuclear medicine, and neuroradiology was formed by the SCCM and the AAP to update the guidelines for the diagnosis of pediatric brain death. The committee was divided into three working groups, each charged with reviewing the literature on brain death in neonates, infants and children for the following specific areas: (1) examination criteria and observation periods; (2) ancillary testing; and (3) declaration of death by medical personnel including legal and ethical implications.

A Medline search of relevant literature published from January 1987 to June

TABLE 1 Summary Recommendations for the Diagnosis of Brain Death in Neonates, Infants, and Children

Recommendation	Evidence Score	Recommendation Score
1. Determination of brain death in neonates, infants and children relies on a clinical diagnosis that is based on the absence of neurologic function with a known irreversible cause of coma. Coma and apnea must coexist to diagnose brain death. This diagnosis should be made by physicians who have evaluated the history and completed the neurologic examinations.	High	Strong
2. Prerequisites for initiating a brain death evaluation		
a. Hypotension, hypothermia, and metabolic disturbances that could affect the neurological examination must be corrected prior to examination for brain death.	High	Strong
b. Sedatives, analgesics, neuromuscular blockers, and anticonvulsant agents should be discontinued for a reasonable time period based on elimination half-life of the pharmacologic agent to ensure they do not affect the neurologic examination. Knowledge of the total amount of each agent (mg/kg) administered since hospital admission may provide useful information concerning the risk of continued medication effects. Blood or plasma levels to confirm high or supratherapeutic levels of anticonvulsants with sedative effects that are not present should be obtained (if available) and repeated as needed or until the levels are in the low to mid therapeutic range.	Moderate	Strong
c. The diagnosis of brain death based on neurologic examination alone should not be made if supratherapeutic or high therapeutic levels of sedative agents are present. When levels are in the low or in the mid-therapeutic range, medication effects sufficient to affect the results of the neurologic examination are unlikely. If uncertainty remains, an ancillary study should be performed.	Moderate	Strong
d. Assessment of neurologic function may be unreliable immediately following cardiopulmonary resuscitation or other severe acute brain injuries and evaluation for brain death should be deferred for 24 to 48 hours or longer if there are concerns or inconsistencies in the examination.	Moderate	Strong
3. Number of examinations, examiners and observation periods		
a. Two examinations including apnea testing with each examination separated by an observation period are required.	Moderate	Strong
b. The examinations should be performed by different attending physicians involved in the care of the child. The apnea test may be performed by the same physician, preferably the attending physician who is managing ventilator care of the child.	Low	Strong
c. Recommended observation periods:		
(1) 24 hours for neonates (37 weeks gestation to term infants 30 days of age)	Moderate	Strong
(2) 12 hours for infants and children (> 30 days to 18 years).		
d. The first examination determines the child has met neurologic examination criteria for brain death. The second examination, performed by a different attending physician, confirms that the child has fulfilled criteria for brain death.	Moderate	Strong
e. Assessment of neurologic function may be unreliable immediately following cardiopulmonary resuscitation or other severe acute brain injuries and evaluation for brain death should be deferred for 24 to 48 hours or longer if there are concerns or inconsistencies in the examination.	Moderate	Strong
4. Apnea testing		
a. Apnea testing must be performed safely and requires documentation of an arterial $Paco_2$ 20 mm Hg above the baseline $Paco_2$ and ≥ 60 mm Hg with no respiratory effort during the testing period to support the diagnosis of brain death. Some infants and children with chronic respiratory disease or insufficiency may only be responsive to supranormal $Paco_2$ levels. In this instance, the $Paco_2$ level should increase to ≥ 20 mm Hg above the baseline $Paco_2$ level.	Moderate	Strong
b. If the apnea test cannot be performed due to a medical contraindication or cannot be completed because of hemodynamic instability, desaturation (to < 85%, or an inability to reach a $Paco_2$ of 60 mm Hg or greater, an ancillary study should be performed.	Moderate	Strong
5. Ancillary studies		
a. Ancillary studies (EEG and radionuclide CBF) are not required to establish brain death unless the clinical examination or apnea test cannot be completed.	Moderate	Strong
b. Ancillary studies are not a substitute for the neurologic examination.	Moderate	Strong
c. For all age groups, ancillary studies can be used to assist the clinician in making the diagnosis of brain death to reduce the observation period or when (i) components of the examination or apnea testing cannot be completed safely due to the underlying medical condition of the patient; (ii) if there is uncertainty about the results of the neurologic examination; or (iii) if a medication effect may interfere with evaluation of the patient. If the ancillary study supports the diagnosis, the second examination and apnea testing can then be performed. When an ancillary study is used to reduce the observation period, all aspects of the examination and apnea testing should be completed and documented.	Moderate	Strong
d. When an ancillary study is used because there are inherent examination limitations (ie, i to iii), then components of the examination done initially should be completed and documented.	High	Strong
e. If the ancillary study is equivocal or if there is concern about the validity of the ancillary study, the patient cannot be pronounced dead. The patient should continue to be observed until brain death can be declared on clinical examination criteria and apnea testing, or a follow-up ancillary study can be performed to assist with the determination of brain death. A waiting period of 24 hours is recommended before further clinical reevaluation or repeat ancillary study is performed. Supportive patient care should continue during this time period.	Moderate	Strong
6. Declaration of death		
a. Death is declared after confirmation and completion of the second clinical examination and apnea test.	High	Strong
b. When ancillary studies are used, documentation of components from the second clinical examination that can be completed must remain consistent with brain death. All aspects of the clinical examination, including the apnea test, or ancillary studies must be appropriately documented.	High	Strong
c. The clinical examination should be carried out by experienced clinicians who are familiar with infants and children, and have specific training in neurocritical care.	High	Strong

The "evaluation score" is based on the strength of the evidence available at the time of publication.
The "recommendation score" is the strength of the recommendations based on available evidence at the time of publication. Scoring guidelines are listed in Table 2.

TABLE 2 Grading of Recommendations Assessment, Development and Evaluation (GRADE) System[14,15]

1. Classification of evidence	
Grade	
A. High	Further research is very unlikely to change our confidence in the estimate of effect
B. Moderate	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate
C. Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate
D. Very low	Any estimate of effect is very uncertain
2. Recommendations. The strength of a recommendation reflects the extent to which we can be confident that desirable effects of an intervention outweigh undesirable effects	
Strong	When the desirable effects of an intervention clearly outweigh the undesirable effects, or clearly do not. (a) For patients—most people in your situation would want the recommended course of action and only a small proportion would not (b) For clinicians—most patients should receive the recommended course of action (c) For policy makers—the recommendation can be adopted as a policy in most situations
Weak	Evidence suggests that desirable and undesirable effects are closely balanced or the quality of evidence is low. (a) For patients—most people in your situation would want the recommended course of action, but many would not (b) For clinicians—you should recognize that different choices will be appropriate for different patients and you must help each patient to arrive at a management decision consistent with his or her values and preferences. (c) For policy makers—policy making will require substantial debate and involvement of many stakeholders
No specific recommendations	The advantages and disadvantages of the recommendations are equivalent or where there is insufficient evidence on which to formulate a recommendation

2008 was conducted. Key words included: brain death, neurologic death, neonatal, pediatric, cerebral blood flow, electroencephalography, apnea test, and irreversible coma with the subheading, "children." Additional articles cited in the post 1987 literature that were published prior to 1987 were also reviewed if they contained data relevant to this guideline. Abstracts and articles were independently reviewed and summarized by at least two individuals on each committee. Data were summarized into five categories: clinical examination, apnea testing, observation periods, ancillary tests, and other considerations.

Methodological issues regarding analysis of evidence warrant further discussion as they directly affected the decision of how information and recommendations about brain death are presented. No randomized control trials examining different strategies regarding the diagnosis of brain death exist. Standard evidence-based approaches for guidelines used by many organizations attempting to link the "strength of the evidence" to the "strength of the recommendations" therefore cannot be used in this instance. There is, however, considerable experiential consensus within observational studies in the pediatric population. Grading of Recommendations Assessment, Development and Evaluation (GRADE), a recently developed standardized methodological consensus-based approach, allows panels to evaluate the evidence and opinions and make recommendations.[14–17] GRADE uses 5 domains to judge the balance between the desirable and undesirable effect of an intervention. *Strong recommendations* are made when there is confidence that the desirable effects of adherence to a recommendation outweigh the undesirable effects. *Weak recommendations* indicate that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, but the panel is less confident. *No specific recommendations* are made when the advantages and disadvantages of alternative courses of action are equivalent or where there is insufficient evidence on which to formulate a recommendation.[15,18] Table 2 outlines the GRADE methodology used in formulating recommendations for this guideline. Each committee member assigned a GRADE score for (i) the strength of evidence linked to a specific recommendation and (ii) indicated (*a*) "yes," (*b*) "no" or (*c*) "uncertain" for each of the six recommendations listed at the end of this report. By a priori consensus, the committee decided that a "strong" recommendation could only be made if greater than 80% of the committee members voted "yes"

TABLE 3 Neurologic Examination Components to Assess for Brain Death in Neonates, Infants and Children* Including Apnea Testing

Reversible conditions or conditions that can interfere with the neurologic examination must be excluded prior to brain death testing.
See text for discussion

1. **Coma. The patient must exhibit complete loss of consciousness, vocalization and volitional activity.**
   - Patients must lack all evidence of responsiveness. Eye opening or eye movement to noxious stimuli is absent.
   - Noxious stimuli should not produce a motor response other than spinally mediated reflexes. The clinical differentiation of spinal responses from retained motor responses associated with brain activity requires expertise.
2. **Loss of all brain stem reflexes including:**

Midposition or fully dilated pupils which do not respond to light.
Absence of pupillary response to a bright light is documented in both eyes. Usually the pupils are fixed in a midsize or dilated position (4–9 mm). When uncertainty exists, a magnifying glass should be used.

Absence of movement of bulbar musculature including facial and oropharyngeal muscles.
Deep pressure on the condyles at the level of the temporomandibular joints and deep pressure at the supraorbital ridge should produce no grimacing or facial muscle movement.

Absent gag, cough, sucking, and rooting reflex
The pharyngeal or gag reflex is tested after stimulation of the posterior pharynx with a tongue blade or suction device. The tracheal reflex is most reliably tested by examining the cough response to tracheal suctioning. The catheter should be inserted into the trachea and advanced to the level of the carina followed by 1 or 2 suctioning passes.

Absent corneal reflexes
Absent corneal reflex is demonstrated by touching the cornea with a piece of tissue paper, a cotton swab, or squirts of water. No eyelid movement should be seen. Care should be taken not to damage the cornea during testing.

Absent oculovestibular reflexes
The oculovestibular reflex is tested by irrigating each ear with ice water (caloric testing) after the patency of the external auditory canal is confirmed. The head is elevated to 30 degrees. Each external auditory canal is irrigated (1 ear at a time) with ~10 to 50 mL of ice water. Movement of the eyes should be absent during 1 minute of observation. Both sides are tested, with an interval of several minutes.

3. **Apnea. The patient must have the complete absence of documented respiratory effort (if feasible) by formal apnea testing demonstrating a $Paco_2$ ≥ 60 mm Hg and ≥ 20 mm Hg increase above baseline.**
   - Normalization of the pH and $Paco_2$, measured by arterial blood gas analysis, maintenance of core temperature > 35°C, normalization of blood pressure appropriate for the age of the child, and correcting for factors that could affect respiratory effort are a prerequisite to testing.
   - The patient should be preoxygenated using 100% oxygen for 5–10 minutes prior to initiating this test.
   - Intermittent mandatory mechanical ventilation should be discontinued once the patient is well oxygenated and a normal $Paco_2$ has been achieved.
   - The patient's heart rate, blood pressure, and oxygen saturation should be continuously monitored while observing for spontaneous respiratory effort throughout the entire procedure.
   - Follow up blood gases should be obtained to monitor the rise in $Paco_2$ while the patient remains disconnected from mechanical ventilation.
   - If no respiratory effort is observed from the initiation of the apnea test to the time the measured $Paco_2$ ≥ 60 mm Hg and ≥ 20 mm Hg above the baseline level, the apnea test is consistent with brain death.
   - The patient should be placed back on mechanical ventilator support and medical management should continue until the second neurologic examination and apnea test confirming brain death is completed.
   - If oxygen saturations fall below 85%, hemodynamic instability limits completion of apnea testing, or a $Paco_2$ level of ≥ 60 mm Hg cannot be achieved, the infant or child should be placed back on ventilator support with appropriate treatment to restore normal oxygen saturations, normocarbia, and hemodynamic parameters. Another attempt to test for apnea may be performed at a later time or an ancillary study may be pursued to assist with determination of brain death.
   - Evidence of any respiratory effort is inconsistent with brain death and the apnea test should be terminated.
4. **Flaccid tone and absence of spontaneous or induced movements, excluding spinal cord events such as reflex withdrawal or spinal myoclonus.**
   - The patient's extremities should be examined to evaluate tone by passive range of motion assuming that there are no limitations to performing such an examination (eg, previous trauma, etc) and the patient observed for any spontaneous or induced movements.
   - If abnormal movements are present, clinical assessment to determine whether or not these are spinal cord reflexes should be done.

* Criteria adapted from 2010 American Academy of Neurology criteria for brain death determination in adults (Wijdicks et al, 2010).

for a recommendation and that a "weak" recommendation was made if greater than 60% but less than 80% voted "yes." "No recommendation" was made if less than 60% of the committee voted "yes" for a specific recommendation. Table 1 summarizes GRADE recommendations and evidence scores.

The committee believes these revised diagnostic guidelines, summarized in Table 1 and a standardized checklist form (Appendix 1), will assist physicians in determining and documenting brain death in children. This should ensure broader acceptance and utilization of such uniform criteria. The committee recognizes that medical judgment of involved pediatric specialists will direct the appropriate course for the medical evaluation and diagnosis of brain death. The committee also recognizes that no national brain death law exists. State statutes and policy may restrict determination of brain death in certain circumstances. Physicians should become familiar with laws and policies in their respective institution. The committee also recognizes that variability exists for the age designation of pediatric trauma patients. In some states, the age of the pediatric trauma patient is defined as less than 14 years of age.

Trauma and intensive care practitioners are encouraged to follow state/local regulations governing the specified age of pediatric trauma patients. The committee believes these guidelines to be an important step in protecting the health and safety of all infants and children. These revised guidelines and accompanying checklist are intended to provide a framework to promote standardization of the neurologic examination and use of ancillary studies based on the evidence available to the committee at the time of publication.

TERM NEWBORNS (37 WEEKS GESTATIONAL AGE) TO CHILDREN 18 YEARS OF AGE

Definition of Brain Death and Components of the Clinical Examination (*Recommendation 1, Table 1 and Table 3*)

Brain death is a clinical diagnosis based on the absence of neurologic function with a known diagnosis that has resulted in irreversible coma. Coma and apnea must coexist to diagnose brain death. A complete neurologic examination that includes the elements outlined in Table 3 is mandatory to determine brain death with all components appropriately documented.

Prerequisites for Initiating a Clinical Brain Death Evaluation (*Recommendations 2a–d, Table 1*)

Determination of brain death by neurologic examination should be performed in the setting of normal age-appropriate physiologic parameters. Factors potentially influencing the neurologic examination that must be corrected before examination and apnea testing include: (1) shock or persistent hypotension based on normal systolic or mean arterial blood pressure values for the patient's age. Systolic blood pressure or MAP should be in an acceptable range (systolic BP not less than 2 standard deviations below age appropriate norm) based on age; (2) hypothermia; (3) severe metabolic disturbances capable of causing a potentially reversible coma including electrolyte/glucose abnormalities; (4) recent administration of neuromuscular blocking agents; and (5) drug intoxications including but not limited to barbiturates, opioids, sedative and anesthetic agents, antiepileptic agents, and alcohols. Placement of an indwelling arterial catheter is recommended to ensure that blood pressure remains within a normal range during the process of diagnosing brain death and to accurately measure $Paco_2$ levels during apnea testing.

Hypothermia is used with increasing frequency as an adjunctive therapy for individuals with acute brain injury.[19–22] Hypothermia has also been used following cardiac arrest to protect the brain because it reduces cerebral metabolic activity.[23–26] The clinician caring for critically ill infants and children should be aware of the potential impact of therapeutic modalities such as hypothermia on the diagnosis of brain death. Hypothermia is known to depress central nervous system function[27–29] and may lead to a false diagnosis of brain death. Hypothermia may alter metabolism and clearance of medications that can interfere with brain death testing. Efforts to adequately rewarm before performing any neurologic examination and maintain temperature during the observation period are essential. The 1987 guidelines stated that the patient must not be significantly hypothermic however no definition was provided.[1] It is reasonable that the core body temperature at the time of brain death examination be as close to normal to reproduce normal physiologic conditions. A core body temperature of >35°C (95°F) should be achieved and maintained during examination and testing to determine death. This temperature is consistent with current adult guidelines and is relatively easy to achieve and maintain in children.[11,13]

Severe metabolic disturbances can cause reversible coma and interfere with the clinical evaluation to determine brain death. Reversible conditions such as severe electrolyte imbalances, hyper or hyponatremia, hyper or hypoglycemia, severe pH disturbances, severe hepatic or renal dysfunction or inborn errors of metabolism may cause coma in a neonate or child.[28,29] These conditions should be identified and treated before evaluation for brain death, especially in situations where the clinical history does not provide a reasonable explanation for the neurologic status of the child.

Drug intoxications including barbiturates, opioids, sedatives, intravenous and inhalation anesthetics, antiepileptic agents, and alcohols can cause severe central nervous system depression and may alter the clinical examination to the point where they can mimic brain death.[28,29] Testing for these drugs should be performed if there is concern regarding recent ingestion or administration. When available, specific serum levels of medications with sedative properties or side effects should be obtained and documented to be in a low to mid therapeutic range before neurologic examination for brain death testing. Longer acting or continuous infusion of sedative agents can also interfere with the neurologic evaluation. These medications should be discontinued. Adequate clearance (based on the age of the child, presence of organ dysfunction, total amount of medication administered, elimination half-life of the drug and any active metabolites) should be allowed before the neurologic examination. In some instances this may require waiting several half-

lives and rechecking serum levels of the medication before conducting the brain death examination. If neuromuscular blocking agents have been used, they should be stopped and adequate clearance of these agents confirmed by use of a nerve stimulator with documentation of neuromuscular junction activity and twitch response. Other unusual causes of coma such as neurotoxins, and chemical exposure (ie, organophosphates, and carbamates) should be considered in rare cases where an etiology for coma has not been established. Recommendations of time intervals before brain death evaluation for many of the commonly used medications administered to critically ill neonates and children are listed in Appendix 2.

Clinical criteria for determining brain death may not be present on admission and may evolve during hospitalization. Assessment of neurologic function may be unreliable immediately following resuscitation after cardiopulmonary arrest[30–33] or other acute brain injuries and serial neurologic examinations are necessary to establish or refute the diagnosis of brain death. Additionally, initial stabilization may take several hours during which time correcting metabolic disturbances and identifying and treating reversible conditions that may imitate brain death can be accomplished. It is reasonable to defer neurologic examination to determine brain death for 24 hours or longer if dictated by clinical judgment of the treating physician in such circumstances. If there are concerns about the validity of the examination (eg, flaccid tone or absent movements in a patient with high spinal cord injury or severe neuromuscular disease) or if specific examination components cannot be performed due to medical contraindications (eg, apnea testing in patients with significant lung injury, hemodynamic instability, or high spinal cord injury), or if examination findings are inconsistent, continued observation and postponing further neurologic examinations until these issues are resolved is warranted to avoid improperly diagnosing brain death. An ancillary study can be pursued to assist with the diagnosis of brain death in situations where certain examination components cannot be completed.

Neuroimaging with either computed tomography (CT) or magnetic resonance imaging (MRI) should demonstrate evidence of an acute central nervous system injury consistent with the profound loss of brain function. It is recognized that early after acute brain injury, imaging findings may not demonstrate significant injury. In such situations, repeat studies are helpful in documenting that an acute severe brain injury has occurred. CT and MRI are not considered ancillary studies and should not be relied on to make the determination of brain death.

Number of Examinations, Examiners and Observation Periods (*Recommendations 3a–e, Table 1*)

Number of Examinations and Examiners

The 1987 guidelines recommended observation periods between brain death examinations based on age and the results of neurodiagnostic testing.[1] Two examinations and EEG's separated by at least 48 hours were recommended for infants 7 days to 2 months. Two examinations and EEG's separated by at least 24 hours were recommended for children 2 months to 1 year. A repeat EEG was not necessary if a cerebral radionuclide scan or cerebral angiography demonstrated no flow or visualization of the cerebral arteries. For children older than 1 year, an observation period of 12 hours was recommended and ancillary testing was not required when an irreversible cause existed. The observation period in this age group could be decreased if there was documentation of electrocerebral silence (ECS) or absent cerebral blood flow (CBF).[1] The general consensus was the younger the child, the longer the waiting period unless ancillary studies supported the clinical diagnosis of brain death and if so, the observation period could be shortened.

The current committee supports the 1987 guideline recommending performance of two examinations separated by an observation period. The committee recommends that these examinations be performed by different attending physicians involved in the care of the child. Children being evaluated for brain death may be cared for and evaluated by multiple medical and surgical specialists. The committee recommends that the best interests of the child and family are served if at least two different attending physicians participate in diagnosing brain death to ensure that (i) the diagnosis is based on currently established criteria, (ii) there are no conflicts of interest in establishing the diagnosis and (iii) there is consensus by at least two physicians involved in the care of the child that brain death criteria are met. The committee also believes that because the apnea test is an objective test, it may be performed by the same physician, preferably the attending physician who is managing ventilator care of the child.

Duration of Observation Periods

A literature review of 171 children diagnosed as brain dead found that 47% had ventilator support withdrawn an average of 1.7 days after the diagnosis of brain death was made.[34] Seventy-nine children (46%) in whom support was continued after declaration of brain death suffered a cardiac arrest an average of 22.7 days later. The re-

maining children died by an unknown mechanism (5%), or made an incomplete (1%) or complete recovery (0.5%). Review of the children who survived indicates they did not fulfill brain death criteria by accepted medical standards. The age range of the children in this study included preterm and term neonates and older infants and children up to 18 years of age. These data and the reports of more recent studies[35,36] suggest that there is likely no biological justification for using different durations of observation to diagnose brain death in infants greater than one month of age. In fact, there are no reports of children recovering neurologic function after meeting adult brain death criteria based on neurologic examination findings.[37] Although some authors have reported apparent reversibility of brain death, further review of these cases reveals these children would not have fulfilled brain death criteria by currently accepted US medical standards.[38]

Based on the above data, currently available literature and clinical experience, the committee recommends the observation period between examinations should be 24 hours for neonates (37 weeks up to 30 days), and 12 hours for infants and children (> 30 days to 18 years). The first examination determines the child has met neurologic examination criteria for brain death. The second examination confirms brain death based on an unchanged and irreversible condition. Timing of the first clinical brain death examination, reduction of the observation period, and use of ancillary studies are discussed in separate sections of this guideline.

Apnea Testing (*Recommendations 4a,b, Table 1*)

Apnea testing should be performed with each neurologic examination to determine brain death in all patients unless a medical contraindication exists. Contraindications may include conditions that invalidate the apnea test (such as high cervical spine injury) or raise safety concerns for the patient (high oxygen requirement or ventilator settings). If apnea testing cannot be completed safely, an ancillary study should be performed to assist with the determination of brain death.

The normal physiologic threshold for apnea (minimum carbon dioxide tension at which respiration begins) in children has been assumed to be the same as in adults with reports demonstrating that $Paco_2$ levels in the normal range (24–38 mm Hg) may be adequate to stimulate ventilatory effort in children with residual brainstem function.[39] Although expert opinion has suggested a range of $Paco_2$ levels from 44 to 60 mm Hg for apnea testing in adults, the general consensus in infants and children has been to use 60 mm Hg as a threshold.[40–42] Appendix 3 summarizes data from 4 studies (3 being prospective) on 106 apnea tests in 76 children 2 months old to 17 years with suspected brain death.[39–42] 73 of 76 children had no spontaneous ventilatory effort. In 3 of these studies mean $Paco_2$ values were 59.5 ± 10.2, 68.1 ± 17.7, and 63.9 ± 21.5 mm Hg; in the fourth study, mean $Paco_2$ values were not reported, only the range (ie, 60–116 mm Hg).[39–42] Three children exhibited spontaneous respiratory effort with measured $Paco_2$ levels < 40 mm Hg.[39,42] Serial measurements of $Paco_2$ were done in most studies and 15 minutes was the usual end point of testing although patients may have had apnea for longer periods. The maximum rate of $Paco_2$ increase usually occurred within 5 minutes. Sixty five children had no ventilatory effort during the apnea test. After completion of apnea testing, support was withdrawn in all of these patients. Patient outcome was not reported for one study although these 9 children all had absent brainstem reflexes for a period of > 72 hours.[41] In one study 4/9 patients had phenobarbital levels that were interpreted as not affecting the results of apnea testing.[41]

There are three case reports discussing irregular breaths or minimal respiratory effort with a Pco_2 > 60 mm Hg in children who otherwise met criteria for brain death.[43–45] Two children died, one after meeting all criteria for brain death including a second apnea test. The remaining child survived and was supported in a chronic care facility with a tracheostomy, chronic mechanical ventilation and a gastrostomy tube. One other report describes a 3-month-old who met all criteria for brain death including 2 apnea tests with serial Pco_2's of 69.3 mm Hg and 62.1 mm Hg respectively. This infant was declared dead on hospital day 5. This infant developed irregular spontaneous respirations at a rate of two to three breaths per minute 38 days later which continued while receiving mechanical ventilator support until death on day 71.[46] Review of this case and others remind us to be cautious in applying brain death criteria in young infants. However, these cases should not be considered to represent reversible deficits or failure of current brain death criteria.[47]

Technique for Apnea Testing

Apnea testing in term newborns, infants, and children is conducted similar to adults. Normalization of the pH and $Paco_2$, measured by arterial blood gas analysis, maintenance of core temperature > 35°C, normalization of blood pressure appropriate for the age of the child, and correcting for factors that could affect respiratory effort are a prerequisite to testing. The patient must be preoxygenated using 100% oxygen for 5–10 minutes before initiating this test. Intermittent manda-

tory mechanical ventilation should be discontinued once the patient is well oxygenated and a normal $Paco_2$ has been achieved. The patient can then be changed to a T piece attached to the endotracheal tube (ETT), or a self-inflating bag valve system such as a Mapleson circuit connected to the ETT. Tracheal insufflation of oxygen using a catheter inserted through the ETT has also been used, however caution is warranted to ensure adequate gas excursion and to prevent barotrauma. High gas flow rates with tracheal insufflation may also promote CO_2 washout preventing adequate $Paco_2$ rise during apnea testing. Continuous positive airway pressure (CPAP) ventilation has been used during apnea testing. Many current ventilators automatically change from a CPAP mode to mandatory ventilation and deliver a breath when apnea is detected. It is also important to note that spontaneous ventilation has been falsely reported to occur while patients were maintained on CPAP despite having the trigger sensitivity of the mechanical ventilator reduced to minimum levels.[48] Physician(s) performing apnea testing should continuously monitor the patient's heart rate, blood pressure, and oxygen saturation while observing for spontaneous respiratory effort throughout the entire procedure. $Paco_2$, measured by blood gas analysis, should be allowed to rise to ≥ 20 mm Hg above the baseline $Paco_2$ level and ≥ 60 mm Hg. If no respiratory effort is observed from the initiation of the apnea test to the time the measured $Paco_2$ ≥ 60 mm Hg and ≥ 20 mm Hg above the baseline level, the apnea test is consistent with brain death. The patient should be placed back on mechanical ventilator support and medical management should continue until the second neurologic examination and apnea test confirming brain death is completed. If oxygen saturations fall below 85%, hemodynamic instability limits completion of apnea testing, or a $Paco_2$ level of ≥ 60 mm Hg cannot be achieved, the infant or child should be placed back on ventilator support with appropriate treatment to restore normal oxygen saturations, normocarbia, and hemodynamic parameters. In this instance, another attempt to test for apnea may be performed at a later time or an ancillary study may be pursued to assist with determination of brain death. Evidence of any respiratory effort that is inconsistent with brain death and the apnea test should be terminated and the patient placed back on ventilatory support.

Ancillary Studies (*Recommendations 5a–e, Table 1*)

The committee recommends that ancillary studies are not required to establish brain death and should not be viewed as a substitute for the neurologic examination. Ancillary studies may be used to assist the clinician in making the diagnosis of brain death (i) when components of the examination or apnea testing cannot be completed safely due to the underlying medical condition of the patient; (ii) if there is uncertainty about the results of the neurologic examination; (iii) if a medication effect may be present; or (iv) to reduce the inter-examination observation period. The term "ancillary study" is preferred to "confirmatory study" since these tests assist the clinician in making the clinical diagnosis of brain death. Ancillary studies may also be helpful for social reasons allowing family members to better comprehend the diagnosis of brain death.

Four-vessel cerebral angiography is the gold standard for determining absence of CBF. This test can be difficult to perform in infants and small children, may not be readily available at all institutions, and requires moving the patient to the angiography suite potentially increasing risk of exacerbating hemodynamic and respiratory instability during transport of a critically ill child outside of the intensive care unit. Electroencephalographic documentation of electrocerebral silence (ECS) and use of radionuclide CBF determinations to document the absence of CBF remain the most widely used methods to support the clinical diagnosis of brain death in infants and children. Radionuclide CBF testing must be performed in accordance with guidelines established by the Society of Nuclear Medicine and the American College of Radiology.[49,50] EEG testing must be performed in accordance with standards established by the American Electroencephalographic Society.[51] Interpretation of ancillary studies requires the expertise of appropriately trained and qualified individuals who understand the limitations of these studies to avoid any potential misinterpretation.

Similar to the neurologic examination, hemodynamic and temperature parameters should be normalized before obtaining EEG or CBF studies. Pharmacologic agents that could affect the results of testing should be discontinued (Appendix 2) and levels determined as clinically indicated. Low to mid therapeutic levels of barbiturates should not preclude the use of EEG testing.[48] Evidence suggests that radionuclide CBF study can be used in patients with high dose barbiturate therapy to demonstrate absence of CBF.[52,53]

Diagnostic Yield of the EEG in Suspected Brain Dead Children

Appendix 4 summarizes EEG data from 12 studies in 485 suspected brain dead children in all age groups.[54,54–65] The data show that 76% of all children who were evaluated with EEG for brain death on the first EEG had ECS. Multiple EEGs increased the yield to 89%. For those children who had ECS on their

first EEG, 64/66 patients (97%) had ECS on a follow-up EEG. The first exception was a neonate who had a phenobarbital level of 30 μg/mL when the first EEG was performed.[65] The second exception was a 5 year old head trauma patient who was receiving pentobarbital and pancuronium at the time of the initial EEG.[62] This patient also had a CBF study performed demonstrating flow. In retrospect, these two patients would not have met currently accepted standards for brain death based on pharmacologic interference with EEG testing. Additionally, of those patients with EEG activity on the first EEG, 55% had a subsequent EEG that showed ECS. The remaining 45% either had persistent EEG activity or additional EEGs were not performed. All died (spontaneously or by withdrawal of support). Only one patient survived from this entire group of 485 patients, a neonate with an elevated phenobarbital level whose first EEG showed photic response and survived severely neurologically impaired.

Diagnostic Yield of Radionuclide CBF Studies in Suspected Brain Dead Children

Appendix 5 summarizes CBF data from 12 studies in 681 suspected brain dead children in all age groups.[36,54,55,57,58,60,63,64–68] Different but well standardized and conventional radionuclide cerebral angiography methods were used. Absent CBF was found in 86% of children who were clinically brain dead and the yield did not significantly change if more than one CBF study was done (89%). Appendix 5 also summarizes follow-up data on children whose subsequent CBF study showed no flow. 24/26 patients (92%) had no flow on follow-up CBF studies when the first study showed absent flow. The two exceptions where flow developed later were newborns. The first newborn had minimal flow on the second study and ventilator support was discontinued. The other newborn developed flow on the second study and had some spontaneous respirations and activity. A phenobarbital level two days after the second CBF study with minimal flow was 8 μg/mL.[65]

In those patients with preserved CBF on the first CBF study, 26% (9/34) had a second CBF study that showed no flow. The remaining 74% either had preserved flow or no further CBF studies were done and all but one patient died (either spontaneously or by withdrawal of support). Only one patient survived with severe neurologic impairment from this entire group of patients—the same neonate as noted previously with no CBF on the first study but presence of CBF on the second study.

Diagnostic Yield of the Initial EEG Versus Radionuclide CBF Studies in Brain Dead Children

Appendix 6 summarizes the comparative diagnostic yield of EEG versus CBF determinations in children who had both studies done as part of the initial brain death evaluation. Data from the 12 studies cited in Appendices 4 and 5 were stratified by 3 age groups: (i) all children ($n = 149$); (ii) newborns (< 1 month of age, $n = 30$); and (iii) children age > 1 month to 18 years ($n = 119$).[36,54–58,58–68]

The data in Appendices 4 and 5 show that the yield from the initial CBF studies was higher (86%) than from the initial EEG (76%) but no differences were present for any CBF study (89%) vs any EEG study (89%). In contrast the data in Appendix 6 for all children show that when both studies are initially performed, the diagnostic yield is the same (70% had ECS; and 70% showed absent CBF). The diagnostic yield for children greater than 1 month of age was similar for both tests (EEG with ECS, 78%; no CBF, 71%). For newborns, EEG with ECS was less sensitive (40%) than absence of CBF (63%) when confirming the diagnosis of brain death but even in the CBF group the yield was low.

In summary, both of these ancillary studies remain accepted tests to assist with determination of brain death in infants and children. The data suggest that EEG and CBF studies are of similar confirmatory value. Radionuclide CBF techniques are increasingly being used in many institutions replacing EEG as an ancillary study to assist with the determination of brain death in infants and children.[5,69] Other ancillary studies such as the Transcranial Doppler study and newer tests such as CT angiography, CT perfusion using arterial spin labeling, nasopharyngeal somatosensory evoked potential studies, MRI-MR angiography, and perfusion MRI imaging have not been studied sufficiently nor validated in infants and children and cannot be recommended as ancillary studies to assist with the determination of brain death in children at this time.

Repeating Ancillary Studies

If the EEG study shows electrical activity or the CBF study shows evidence of flow or cellular uptake, the patient cannot be pronounced dead at that time. The patient should continue to be observed and medically treated until brain death can be declared solely on clinical examination criteria and apnea testing based on recommended observation periods, or a follow-up ancillary study can be performed to assist and is consistent with the determination of brain death, or withdrawal of life-sustaining medical therapies is made irrespective of meeting criteria for brain death. A waiting period of 24 hours is recommended before further ancillary testing, using a radionuclide CBF study, is performed allowing adequate clearance of Tc-99m.[49,50] While no evidence exists for a recommended

waiting period between EEG studies, a waiting period of 24 hours is reasonable and recommended before repeating this ancillary study.

Shortening the Observation Period

If an ancillary study, used in conjunction with the first neurologic examination, supports the diagnosis of brain death, the inter-examination observation interval can be shortened and the second neurologic examination and apnea test (or all components that can be completed safely) can be performed and documented at any time thereafter for children of all ages.

SPECIAL CONSIDERATIONS FOR TERM NEWBORNS (37 WEEKS GESTATION) TO 30 DAYS OF AGE (*RECOMMENDATIONS 1–5, TABLE 1*)

Preterm and term neonates younger than 7 days of age were excluded from the 1987 Task Force guidelines. The ability to diagnose brain death in newborns is still viewed with some uncertainty primarily due to the small number of brain-dead neonates reported in the literature[34,63,70] and whether there are intrinsic biological differences in neonatal brain metabolism, blood flow and response to injury. The newborn has patent sutures and an open fontanelle resulting in less dramatic increases in intracranial pressure (ICP) after acute brain injury when compared with older patients. The cascade of events associated with increased ICP and reduced cerebral perfusion ultimately leading to herniation are less likely to occur in the neonate.

Clinical Examination

Limited data are available regarding the clinical examination for brain death in preterm and term infants.[70] It has been recognized that examination of the preterm infant less than 37 weeks gestation to determine if they meet brain death criteria may be difficult because of the possibility that some of the brainstem reflexes may not be completely developed and that it is also difficult to assess the level of consciousness in a critically ill, sedated and intubated neonate. Because of insufficient data in the literature, recommendations for preterm infants less than 37 weeks gestational age were not included in this guideline. However, as discussed in the following section on observation periods, the available data suggest that recovery of neurologic function is unlikely when a term newborn is diagnosed with brain death. Based on review of the literature, the task force supports that brain death can be diagnosed in term newborns (37 weeks gestation) and older, provided the physician is aware of the limitations of the clinical examination and ancillary studies in this age group. It is important to carefully and repeatedly examine term newborns, with particular attention to examination of brainstem reflexes and apnea testing. As with older children, assessment of neurologic function in the term newborn may be unreliable immediately following an acute catastrophic neurologic injury or cardiopulmonary arrest. A period of 24 hours or longer is recommended before evaluating the term newborn for brain death.

Apnea Testing

Neonatal studies reviewing $Paco_2$ thresholds for apnea are limited. However, data from 35 neonates who were ultimately determined to be brain dead revealed a mean $Paco_2$ of 65 mm Hg suggesting that the threshold of 60 mm Hg is also valid in the newborn.[35] Apnea testing in the term newborn may be complicated by the following: (1) Treatment with 100% oxygen may inhibit the potential recovery of respiratory effort.[71,72] (2) Profound bradycardia may precede hypercarbia and limit this test in neonates. A thorough neurologic examination must be performed in conjunction with the apnea test to make the determination of death in any patient. If the apnea test cannot be completed as previously described, the examination and apnea test can be attempted at a later time, or an ancillary study may be performed to assist with determination of death. Ancillary studies in newborns are less sensitive than in older children. There are no reported cases of any neonate who developed respiratory effort after meeting brain death criteria.

Observation Periods in Term Newborns

There is some experience concerning the duration of observation periods in neonates being evaluated for brain death. A review of 87 newborns revealed that the duration of coma from insult to brain death was 37 hours and the duration of time from the initial neurologic examination being indicative of brain death to final confirmation was 75 hours. The overall average duration of brain death in these neonates was about 95 hours or almost 4 days.[37] 53 neonates less than 7 days of age donating organs for transplantation had a total duration of brain death including time to transplantation that averaged 2.8 days; for neonates 1–3 weeks of age, the duration of brain death was approximately 5.2 days.[37] None of these patients recovered any neurologic function. These data suggest that once the diagnosis of brain death is made in newborns, recovery is unlikely. Based on data extracted from available literature and clinical experience the committee recommends the observation period between examinations should be 24 hours for term newborns (37 weeks) to 30 days of age.

Ancillary Studies

Ancillary studies performed in the newborn < 30 days of age are limited.[70] As summarized in Appendix 6, ancillary studies in this age group are less sensitive in detecting the pres-

ence/absence of brain electrical activity or cerebral blood flow than in older children. Of the two studies, detecting absence of CBF (63%) was more sensitive than demonstration of ECS (40%) in confirming the diagnosis of brain death, however even in the CBF study group the sensitivity was low.[70]

EEG activity is of low voltage in newborns raising concerns about a greater chance of having reversible ECS in this age group. In a retrospective review of 40 newborns with ECS, 9/10 with ECS on the initial EEG showed ECS on repeated studies.[70] The remaining patient had a phenobarbital level of 30 μg/mL at the time of the initial EEG, probably accounting for the initial ECS. Several other cases have been reported with initial ECS but careful review found that the patients were not clinically brain dead. Based on available data it is likely that if the initial EEG shows ECS (assuming an absence of correctable conditions) in a newborn who meets all clinical criteria for brain death, then it is an accurate and reliable predictor of brain death and repeat EEG studies are not indicated.

CBF in viable newborns can be extremely low because of the decreased level of brain metabolic activity.[50] However earlier studies using stable xenon computed tomography measurements of CBF have shown that the level of CBF in brain dead children is much lower than that seen in viable newborns.[73,74]

The available data suggest that ancillary studies in newborns are less sensitive than in older children. This can pose an important clinical dilemma in this age group where clinicians may have a greater level of uncertainty about performing a valid neurologic examination. There is a greater need to have more reliable and accurate ancillary studies in this age group. Awareness of this limitation would suggest that longer periods of observation and repeated neurologic examinations are needed before making the diagnosis of brain death and also that as in older infants and children, the diagnosis should be made clinically and based on repeated examinations rather than relying exclusively on ancillary studies.

DECLARATION OF DEATH (FOR ALL AGE GROUPS) (*RECOMMENDATIONS 6a–c, TABLE 1 AND APPENDIX 8 ALGORITHM*)

Death is declared after the second neurologic examination and apnea test confirms an unchanged and irreversible condition. An algorithm (Appendix 8) provides recommendations for the process of diagnosing brain death in children. When ancillary studies are used, documentation of components from the second clinical examination that can be completed, including a second apnea test, must remain consistent with brain death. All aspects of the clinical examination, including the apnea test, or ancillary studies must be appropriately documented. A checklist outlining essential examination and testing components is provided in Appendix 1. This checklist also provides standardized documentation to determine brain death.

ADDITIONAL CONSIDERATIONS (FOR ALL AGE GROUPS)

In today's modern pediatric and neonatal intensive care units, critical care practitioners and other physicians with expertise in neurologic injury are routinely called on to declare death in infants and children. Because the implications of diagnosing brain death are of great consequence, examination should be conducted by experienced clinicians who are familiar with neonates, infants and children and have specific training in neurocritical care. These physicians must be competent to perform the clinical examination and interpret results from ancillary studies. Qualified clinicians include: pediatric intensivists and neonatologists, pediatric neurologists and neurosurgeons, pediatric trauma surgeons, and pediatric anesthesiologists with critical care training. Adult specialists should have appropriate neurologic and critical care training to diagnose brain death when caring for the pediatric patient from birth to 18 years of age. Residents and fellows should be encouraged to learn how to properly perform brain death testing by observing and participating in the clinical examination and testing process performed by experienced attending physicians. It is recommended that both neurologic examinations be performed and documented by an attending physician who is qualified and competent to perform the brain death examination.

These revised pediatric brain death diagnostic guidelines are intended to provide an updated framework in an effort to promote standardization of the neurologic examination and use of ancillary studies. A standardized checklist (Appendix 1) will help to ensure that all components of the examination, and ancillary studies if needed, are completed and documented appropriately. Pediatric specialists should be invited to participate in the development of institutional guidelines to ensure that the brain death examination is conducted consistently each time the diagnosis is being considered. A comparison of the 1987 pediatric brain death guidelines and 2011 update for neonatal and pediatric brain death guidelines are listed in Appendix 7.

Diagnosing brain death must never be rushed or take priority over the needs of the patient or the family. Physicians are obligated to provide support and guidance for families as they face difficult end-of-life decisions and attempt to understand what has happened to their child. It is the responsibility of the physician to guide and direct families during the treatment of their child. Communication with families must be clear and concise using simple termi-

nology so that parents and family members understand that their child has died. Permitting families to be present during the brain death examination, apnea testing and performance of ancillary studies can assist families in understanding that their child has died. The family must understand that once brain death has been declared, their child meets legal criteria for death. Families may otherwise become confused or angry if discussions regarding withdrawal of support or medical therapies are entertained after declaration of death. It should be made clear that once death has occurred, continuation of medical therapies, including ventilator support, is no longer an option unless organ donation is planned. Appropriate emotional support for the family should be provided including adequate time to grieve with their child after death has occurred. Consultation or referral to the medical examiner or coroner may be required by state law in certain situations when death occurs.

FUTURE DIRECTIONS

Development of a national database to track infants and children who are diagnosed as brain dead should be strongly considered. Information compiled from this database would increase our knowledge about brain death, especially in neonates.

1. Studies comparing traditional ancillary studies to newer methods to assess CBF and neurophysiologic function should be pursued. Further information about ancillary studies, waiting periods, and research regarding validity of newer ancillary studies is needed for future recommendations to assist with determination of brain death in children.
2. Cerebral protective therapies such as hypothermia may alter the natural progression of brain death and their impact should be reviewed as more information becomes available. The clinician caring for critically ill infants and children should be aware of the potential impact of new therapeutic modalities on the diagnosis of brain death.
3. While each institution and state may have specific guidelines for the determination of brain death in infants and children, we should work with national medical societies to achieve a uniform approach to declaring death that can be incorporated in all hospital policies.[75] This will help eliminate confusion among medical personnel thereby fostering further trust from the community of patients and families that we serve.
4. Additional information or studies are required to determine if a single neurologic examination is sufficient for neonates, infants, and children to determine brain death as currently recommended for adults over 18 years of age.[12,76]

ENDORSEMENTS AND APPROVALS

This document has been reviewed and endorsed by the following societies:

American Academy of Pediatrics

Sub sections:

Section on Critical Care

Section on Neurology

American Association of Critical Care Nurses

Child Neurology Society

National Association of Pediatric Nurse Practitioners

Society of Critical Care Medicine

Society for Pediatric Anesthesia

Society of Pediatric Neuroradiology

World Federation of Pediatric Intensive and Critical Care Societies

American Academy of Neurology affirms the value of this manuscript.

The following societies have had the opportunity to review and comment on this document

American Academy of Pediatrics

Sub sections:

Committee on Bioethics

Committee on Child Abuse and Neglect

Committee on Federal Government Affairs

Committee on Fetus and Newborn

Committee on Hospital Care

Committee on Medical Liability and Risk Management

Committee on Pediatric Emergency Medicine

Committee on Practice and Ambulatory Medicine

Committee on State Government Affairs

Council on Children With Disabilities

Section on Anesthesiology and Pain Medicine

Section on Bioethics

Section on Child Abuse and Neglect

Section on Critical Care

Section on Emergency Medicine

Section on Hospital Medicine

Section on Neurology

Section on Perinatal Pediatrics

Section on Neurological Surgery

Section on Pediatric Surgery

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APPENDIX 1 Check List for Documentation of Brain Death

Brain Death Examination for Infants and Children

Two physicians must perform independent examinations separated by specified intervals.

Age of Patient	Timing of first exam	Inter-exam. interval
Term newborn 37 weeks gestational age and up to 30 days old	☐ First exam may be performed 24 hours after birth OR following cardiopulmonary resuscitation or other severe brain injury	☐ At least 24 hours ☐ Interval shortened because ancillary study (section 4) is consistent with brain death
31 days to 18 years old	☐ First exam may be performed 24 hours following cardiopulmonary resuscitation or other severe brain injury	☐ At least 12 hours OR ☐ Interval shortened because ancillary study (section 4) is consistent with brain death

Section 1. PREREQUISITES for brain death examination and apnea test

A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma (Please check)

☐ Traumatic brain injury ☐ Anoxic brain injury ☐ Known metabolic disorder ☐ Other (Specify) _____

B. Correction of contributing factors that can interfere with the neurologic examination	**Examination One**		**Examination Two**	
a. Core Body Temp is over 95° F (35° C)	☐ Yes	☐ No	☐ Yes	☐ No
b. Systolic blood pressure or MAP in acceptable range (Systolic BP not less than 2 standard deviations below age appropriate norm) based on age	☐ Yes	☐ No	☐ Yes	☐ No
c. Sedative/analgesic drug effect excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No
d. Metabolic intoxication excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No
e. Neuromuscular blockade excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No

☐ If ALL prerequisites are marked YES, then proceed to section 2, OR

☐ _____ confounding variable was present. Ancillary study was therefore performed to document brain death. (Section 4).

Section 2. Physical Examination (Please check) **NOTE: SPINAL CORD REFLEXES ARE ACCEPTABLE**	**Examination One** **Date/ time: _____**		**Examination Two** **Date/ Time: _____**	
a. Flaccid tone, patient unresponsive to deep painful stimuli	☐ Yes	☐ No	☐ Yes	☐ No
b. Pupils are midposition or fully dilated and light reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
c. Corneal, cough, gag reflexes are absent Sucking and rooting reflexes are absent (in neonates and infants)	☐ Yes ☐ Yes	☐ No ☐ No	☐ Yes ☐ Yes	☐ No ☐ No
d. Oculovestibular reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
e. Spontaneous respiratory effort while on mechanical ventilation is absent	☐ Yes	☐ No	☐ Yes	☐ No

☐ The _____ (specify) element of the exam could not be performed because _____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death. (Section 4).

Section 3. APNEA Test	**Examination One** **Date/ Time _____**	**Examination Two** **Date/ Time _____**
No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq 60$ mm Hg and a ≥ 20 mm Hg increase above baseline. (Examination One) No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq 60$ mm Hg and a ≥ 20 mm Hg increase above baseline. (Examination Two)	Pretest $PaCO_2$: _____ Apnea duration: _____min Posttest $PaCO_2$: _____	Pretest $PaCO_2$: _____ Apnea duration: _____min Posttest $PaCO_2$: _____

Apnea test is contraindicated or could not be performed to completion because _____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death. (Section 4).

Section 4. ANCILLARY testing is required when (1) any components of the examination or apnea testing cannot be completed; (2) if there is uncertainty about the results of the neurologic examination; or (3) if a medication effect may be present. **Ancillary testing can be performed to reduce the inter-examination period however a second neurologic examination is required. Components of the neurologic examination that can be performed safely should be completed in close proximity to the ancillary test**	**Date/Time:** _____
☐ Electroencephalogram (EEG) report documents electrocerebral silence OR	☐ Yes ☐ No
☐ Cerebral Blood Flow(CBF) study report documents no cerebral perfusion	☐ Yes ☐ No

Section 5. Signatures

Examiner One

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

_____ _____

(Printed Name) (Signature)

_____ _____ _____ _____

(Specialty) (Pager #/License #) (Date mm/dd/yyyy) (Time)

Examiner Two

I certify that my examination and/or ancillary test report I confirms unchanged and irreversible cessation of function of the brain and brainstem. The patient is declared brain dead at this time.

Date/Time of death: _____

_____ _____

(Printed Name) (Signature)

_____ _____ _____ _____

(Specialty) (Pager #/License #) (Date mm/dd/yyyy) (Time)

[redacted]

APPENDIX 2 Medications Administered to Critically Ill Pediatric Patients and Recommendations for Time Interval to Testing After Discontinuation

Medication	Infants/Children Elimination ½ life	Neonates Elimination ½ life
Intravenous induction, anesthetic, and sedative agents		
Thiopental	Adults: 3–11.5 hours (shorter ½ life in children)	
Ketamine	2.5 hours	
Etomidate	2.6–3.5 hours	
Midazolam	2.9–4.5 hours	4–12 hours[77,80]
Propofol	2–8 minutes. Terminal ½ life 200 minutes (range 300–700 minutes)	
Dexmedetomidine	Terminal ½ life 83–159 minutes[78,81]	Infants have faster clearance[81,82]
Antiepileptic drugs		
Phenobarbital	Infants: 20–133 hours* Children: 37–73 hours*	45–500 hours*[79,84,85]
Pentobarbital	25 hours*	
Phenytoin	11–55 hours*	63–88 hours*
Diazepam	1 month–2 years: 40–50 hours 2 years–12 years: 15–21 hours 12–16 years: 18–20 hours	50–95 hours[79,86,87]
Lorazepam	Infants: 40.2 hours (range 18–73 hours) Children: 10.5 hours (range 6–17 hours)	40 hours[88]
Clonazepam	22–33 hours	
Valproic Acid	Children > 2 months: 7–13 hours* Children 2–14 years: Mean 9 hours; range 3.5–20 hours	10–67 hours*
Levetiracetam	Children 4–12 years: 5 hours	
Intravenous narcotics		
Morphine sulfate	Infants 1–3 months: 6.2 hours (5–10 hours) 6 months–2.5 years: 2.9 hours (1.4–7.8 hours) Children: 1–2 hours	7.6 hours (range 4.5–13.3 hours)[79,83,91]
Meperidine	Infants < 3 months: 8.2–10.7 hours (range 4.9–31.7 hours) Infants 3–18 months: 2.3 hours Children 5–8 years: 3 hours	23 hours (range 12–39 hours)
Fentanyl	5 months–4.5 years: 2.4 hours (mean) 0.5–14 years: 21 hours (range 11–36 hours for long term infusions)	1–15 hours
Sufentanil	Children 2–8 years: 97 ± 42 minutes	382–1162 minutes
Muscle relaxants		
Succinylcholine	5–10 minutes Prolonged duration of action in patients with pseudocholinesterase deficiency or mutation	
Pancuronium	110 minutes	
Vecuronium	41 minutes	65 minutes
Atracurium	17 minutes	20 minutes
Rocuronium	3–12 months: 1.3 ± 0.5 hours 1 to < 3 years: 1.1 ± 0.7 hours 3 to < 8 years: 0.8 ± 0.3 hours Adults: 1.4–2.4 hours	

Modified from Ashwal and Schneider.[37]

Metabolism of pharmacologic agents may be affected by organ dysfunction and hypothermia.

Physicians should be aware of total amounts of administered medication that can affect drug metabolism and levels.

* Elimination ½ life does not guarantee therapeutic drug levels for longer acting medications or medications with active metabolites. Drug levels should be obtained to ensure that levels are in a low to mid therapeutic range prior to neurologic examination to determine brain death. In some instances this may require waiting several half lives and rechecking serum levels of the medication before conducting the brain death examination.

APPENDIX 3 Apnea Testing in Pediatric Brain Death

Author	*n*	Age Range	$Paco_2$	Comments
Rowland (1984)[41]	9 children, 16 apnea tests performed	4 months–13 years	Range 60–116 mm Hg after 15 minutes of apnea	No spontaneous respiratory effort noted in any patient during testing. Phenobarbital levels of 10,11.6,18,25 mg/dL were measured in 4 patients.
Outwater & Rockoff (1984)[42]	10 children	10 months–13 years	Mean 59.5 ± 10.2 mm Hg after 5 minutes of apnea	No spontaneous respiratory effort noted in any patient during testing or after support was withdrawn
Riviello (1988)[39]	19 children	2 months–15 years	Mean 63.9 ± 21.5 mm Hg	2 children with Pco_2 levels of 24 mm Hg and 38 mm Hg had spontaneous respirations during the apnea test. All other children had no spontaneous respiratory effort noted after support was withdrawn.
Paret (1995)[43]	38 children, 61 apnea tests performed	2 months–17 years	Mean 68.07 ± 17.66 after 5 minutes Mean 81.8 ± 20.2 after 10 minutes Mean 86.88 ± 25.6 after 15 minutes	1 child had spontaneous respiratory effort with a $Paco_2$ of 49 mm Hg. This patient was retested 24 hours later and had no respiratory effort.

APPENDIX 4 EEG in Pediatric Brain Death: Diagnostic Yield From First Versus Any Study

Study	Total # Pts in Study	% Patients With ECS on EEG#1	% Patients With ECS on Any EEG	% Pts With ECS on f/u EEG When First EEG Had ECS	% Pt With ECS on Later EEGs When First EEG Had Activity
Ruiz-Garcia et al, 2000 (60)	125	72% (88/122)	91% (111/122)	NA	68% (23/34)
Drake et al, 1988[35]	61	70% (33/47)	91% (43/47)	100% (17/17)	71% (10/14)
Parker et al, 1995[36]	60	100% (9/9)	100% (9/9)	NA	NA
Alvarez et al, 1988[37]	52	100% (52/52)	100% (52/52)	100% (28/28)	NA
Ashwal, 1993[54]	52	85% (28/33)	85% (28/33)	100% (3/3)	0% (0/1)
Ruiz-Lopez et al, 1999[61]	51	48% (14/29)	72% (21/29)	NA	47% (7/15)
Ashwal & Schneider, 1989[55]	18	50% (9/18)	78% (14/18)	88% (7/8)	56% (5/9)
Holzman et al, 1983[62]	18	61% (11/18)	67% (12/18)	67% (2/3)	14% (1/7)
Ashwal et al, 1977[58]	15	67% (10/15)	73% (11/15)	100% (2/2)	20% (1/5)
Coker et al, 1986[59]	14	100% (11/11)	100% (11/11)	100% (5/5)	NA
Furgiuele et al, 1984[63]	11	100% (10/10)	100% (10/10)	NA	NA
Okuyaz et al, 2004[64]	8	100% (8/8)	100% (8/8)	NA	NA
Total	485	76% (283/372)	89% (330/372)	97% (64/66)	55% (47/85)

EEG Electroencephalogram.
ECS Electrocerebral silence.

APPENDIX 5 CBF in Pediatric Brain Death: Diagnostic Yield From First Versus Any Study

Study	Total # of Pts in Study	CBF#1: % Patients With Absent CBF*	% Patients With Absent CBF on Any Study**	% Pts With No CBF on f/u Study When First Study Had Shown No CBF	% Pt With No CBF on Later Study When First Study Had CBF Present
Shimizu et al, 2000[65]	228	100% (27/27)	100% (27/27)	NA	NA
Ruiz-Garcia et al, 2000[60]	125	92% (83/90)	92% (83/90)	NA	NA
Drake et al, 1988[35]	61	68% (32/47)	81% (38/47)	100% (17/17)	40% (6/15)
Parker et al, 1995[36]	60	87% (26/30)	87% (26/30)	NA	NA
Coker et al, 1986[59]	55	100% (55/55)	100% (55/55)	NA	NA
Ashwal, 1993[54]	52	86% (19/22)	86% (19/22)	NA	NA
Ahmann et al, 1987[57]	32	83% (6/6)	83% (6/6)	NA	NA
Ashwal &Schneider, 1989[55]	18	65% (11/17)	65% (11/17)	71% (5/7)	0% (0/3)
Holzman et al, 1983[62]	18	39% (7/18)	44% (8/18)	100% (2/2)	9% (1/11)
Ashwal et al, 1977[58]	15	100% (11/11)	100% (11/11)	NA	NA
Schwartz et al, 1984[66]	9	100% (9/9)	100% (9/9)	NA	NA
Okuyaz et al, 2004[64]	8	75% (6/8)	100% (8/8)	NA	100% (2/2)
Total	681	86% (292/340)	89% (301/340)	92% (24/26)	26% (9/34)

* # pts with no CBF on first study/# pts with first CBF study.
** # pts with no CBF on any study/# pts with any CBF.
CBF Cerebral blood flow.

[redacted]

APPENDIX 6 EEG and CBF Diagnostic Screening Yield by Age Groups

	ECS	EEG*	Total	Diagnostic Screening Yield
All children (n = 149)*				
No CBF	85	18	104	% pt with ECS = 70%
CBF*	19	26	45	% pts with no CBF = 70%
Total	105	44	149	
Just newborns (< 1 month of age; n = 30)**				
No CBF	8	11	19	% pt with ECS = 40%
CBF*	4	7	11	% pts with no CBF = 63%
Total	12	18	30	
Children (> 1 month of age; n = 119)***				
No CBF	78	7	85	% pt with ECS = 78%
CBF*	15	19	34	% pts with no CBF = 71%
Total	93	26	119	

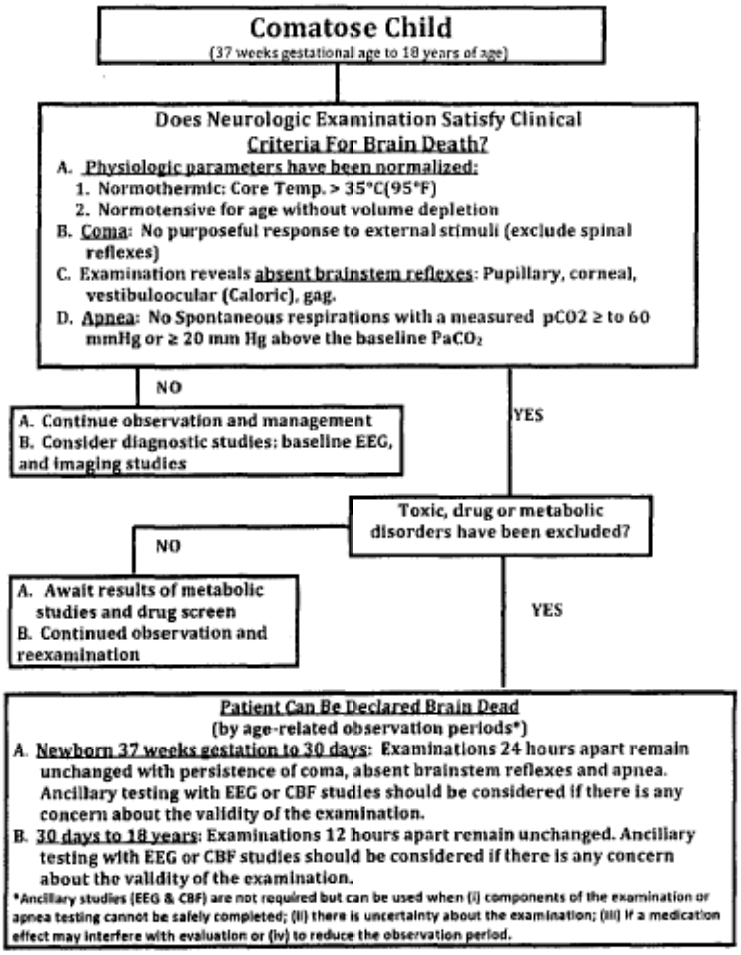
* Data extracted from references cited in Appendix 4,5.
** Data extracted from references cited in Ashwal S.[35]
*** Data represent the differences between "All children" and "just newborns" groups.
ECS Electrocerebral silence.
CBF Cerebral blood flow.
EEG* Activity on EEG.
CBF* Cerebral blood flow present.

APPENDIX 7 Comparison of 1987 Pediatric Brain Death Guidelines and the Updated Guideline for Determination of Brain Death in Infants and Children

	1987	Updated Guidelines
Waiting period before initial brain death examination	Not specified	24 hours following cardiopulmonary resuscitation or severe acute brain injury is suggested if there are concerns about the neurologic examination or if dictated by clinical judgment
Clinical examination	Required	Required
Core body temperature	Not specified	> 35°C (95°F)
Number of examinations	Two exams 2nd examination not necessary in 2 months–1 year age group if initial examination, EEG and concomitant CBF consistent with brain death	Two exams, irrespective of ancillary study results (if ancillary testing is being done in lieu of initial examination elements that cannot be safely performed, the components of the second examination that can be done must be completed)
Number of examiners	Not specified	Two (Different attending physicians must perform the first and second exam)
Observation interval between neurologic examinations	Age dependent • 7 days–2 months: 48 hours • 2 months–1 year: 24 hours • >1 year: 12 hours (24 hrs if HIE)	Age Dependent • Term newborn (37 weeks gestation) to 30 days of age: 24 hours • 31 days–18 years: 12 hours
Reduction of observation period between exams	Permitted only for > 1 year age group if EEG or CBF consistent with brain death	Permitted for both age groups if EEG or CBF consistent with brain death
Apnea testing	Required, number of tests ambiguous	Two apnea tests required unless clinically contraindicated
Final Pco_2 threshold for apnea testing	Not specified	≥60 mm Hg and >20 mm Hg above the baseline $Paco_2$
Ancillary study recommended	• Age dependent 7 days–2 months: 2 EEGs separated by 48 hrs • 2 months–1 year: 2 EEG's separated by 24 hours. CBF can replace the need for 2nd EEG • >1 year. No testing required	Not required except in cases where the clinical examination and apnea test cannot be completed • Term newborn (37 weeks gestation) to 30 days of age: EEG or CBF are less sensitive in this age group. CBF may be preferred • >30 days–18 years: EEG and CBF have equal sensitivity
Time of death	Not specified	Time of the second examination and apnea test (or completion of ancillary study and the components of the second examination that can be safely completed)

EEG Electroencephalogram.
CBF Cerebral blood flow.
HIE Hypoxic ischemic encephalopathy.

APPENDIX 8 Algorithm to Diagnose Brain Death in Infants and Children



[redacted]

APPENDIX 9 Taskforce Organization

Sub-Committee Chairs

Brain death examination criteria and testing intervals: Mudit Mathur, MD, FAAP, Mohan Mysore, MD, FAAP, FCCM, Thomas A. Nakagawa, MD, FAAP, FCCM

Ancillary testing: Stephen Ashwal, MD, FAAP

Declaration of death, legal, and ethical implications: Jacqueline A. Williams-Phillips, MD, FCCM

Taskforce Committee Members

Stephen Ashwal, MD. Professor of Pediatrics. Department of Pediatrics, Chief, Division of Child Neurology. Loma Linda University School of Medicine. Loma Linda, CA

Derek Bruce, MD Professor of Neurosurgery and Pediatrics. Children's National Medical Center, Washington, DC

Edward E. Conway Jr MD, MS, FCCM. Professor of Pediatrics. Beth Israel Medical Center, Hartsdale, NY

Susan E. Duthie, MD Pediatric Critical Care. Rady Children's Hospital-San Diego, San Diego, CA

Shannon Hamrick, MD Assistant Professor of Pediatrics. Emory University, Children's Healthcare of Atlanta. Atlanta GA

Rick Harrison, MD Professor of Pediatrics. David Geffen School of Medicine UCLA. Medical Director Mattel Children's Hospital UCLA. Los Angeles, CA

Andrea M. Kline, RN, MS, FCCM Nurse Practitioner. Riley Hospital for Children. Indianapolis, IN

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Vicki L. Montgomery, MD, FCCM Professor of Pediatrics. University of Louisville. Chief, Division of Pediatric Critical Care Medicine. Medical Director. Patient Safety Officer. Norton Healthcare Kosair Children's Hospital. Louisville, KY

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Sam D. Shemie, MD, FAAP, Professor of Pediatrics. Montreal Children's Hospital. Montreal, Canada

Amit Vohra, MD FAAP Assistant Professor of Pediatrics, Wright State University, Pediatric Critical Care, Children's Medical Center. Dayton, OH.

Jacqueline A. Williams-Phillips, MD, FAAP, FCCM Associate Professor of Pediatrics. UMDNJ-Robert Wood Johnson Medical School. Director, Pediatric Intensive Care Unit. Bristol-Myers Squibb Children's Hospital. New Brunswick, NJ

Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations

Thomas A. Nakagawa, Stephen Ashwal, Mudit Mathur, Mohan Mysore and the Society of Critical Care Medicine, Section on Critical Care and Section on Neurology of the American Academy of Pediatrics, and the Child Neurology Society

Pediatrics 2011;128;e720; originally published online August 28, 2011; DOI: 10.1542/peds.2011-1511

Exhibit 20

Court Exhibit 4

pediatrics.aappublications.org

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Pediatrics September 1, 2011 vol. 128 no. 3 e720-e740 doi: 10.1542/peds.2011-1511

From the American Academy of Pediatrics

Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations

TABLE 3

Neurologic Examination Components to Assess for Brain Death in Neonates, Infants and Children* Including Apnea Testing

Reversible conditions or conditions that can interfere with the neurologic examination must be excluded prior to brain death testing.
See text for discussion
1. **Coma. The patient must exhibit complete loss of consciousness, vocalization and volitional activity.** • Patients must lack all evidence of responsiveness. Eye opening or eye movement to noxious stimuli is absent. • Noxious stimuli should not produce a motor response other than spinally mediated reflexes. The clinical differentiation of spinal responses from retained motor responses associated with brain activity requires expertise.
2. **Loss of all brain stem reflexes including:** **Midposition or fully dilated pupils which do not respond to light.** Absence of pupillary response to a bright light is documented in both eyes. Usually the pupils are fixed in a midsize or dilated position (4–9 mm). When uncertainty exists, a magnifying glass should be used. **Absence of movement of bulbar musculature including facial and oropharyngeal muscles.** Deep pressure on the condyles at the level of the temporomandibular joints and deep pressure at the supraorbital ridge should produce no grimacing or facial muscle movement. **Absent gag, cough, sucking, and rooting reflex** The pharyngeal or gag reflex is tested after stimulation of the posterior pharynx with a tongue blade or suction device. The tracheal reflex is most reliably tested by examining the cough response to tracheal suctioning. The catheter should be inserted into the trachea and advanced to the level of the carina followed by 1 or 2 suctioning passes. **Absent corneal reflexes**

Absent corneal reflex is demonstrated by touching the cornea with a piece of tissue paper, a cotton swab, or squirts of water. No eyelid movement should be seen. Care should be taken not to damage the cornea during testing.

Absent oculovestibular reflexes

The oculovestibular reflex is tested by irrigating each ear with ice water (caloric testing) after the patency of the external auditory canal is confirmed. The head is elevated to 30 degrees. Each external auditory canal is irrigated (1 ear at a time) with ~10 to 50 mL of ice water. Movement of the eyes should be absent during 1 minute of observation. Both sides are tested, with an interval of several minutes.

3. **Apnea. The patient must have the complete absence of documented respiratory effort (if feasible) by formal apnea testing demonstrating a $Paco_2$ ≥ 60 mm Hg and ≥ 20 mm Hg increase above baseline.**

   - Normalization of the pH and $Paco_2$, measured by arterial blood gas analysis, maintenance of core temperature > 35°C, normalization of blood pressure appropriate for the age of the child, and correcting for factors that could affect respiratory effort are a prerequisite to testing.
   - The patient should be preoxygenated using 100% oxygen for 5 –10 minutes prior to initiating this test.
   - Intermittent mandatory mechanical ventilation should be discontinued once the patient is well oxygenated and a normal $Paco_2$ has been achieved.
   - The patient's heart rate, blood pressure, and oxygen saturation should be continuously monitored while observing for spontaneous respiratory effort throughout the entire procedure.
   - Follow up blood gases should be obtained to monitor the rise in $Paco_2$ while the patient remains disconnected from mechanical ventilation.
   - If no respiratory effort is observed from the initiation of the apnea test to the time the measured $Paco_2$ ≥ 60 mm Hg and ≥ 20 mm Hg above the baseline level, the apnea test is consistent with brain death.
   - The patient should be placed back on mechanical ventilator support and medical management should continue until the second neurologic examination and apnea test confirming brain death is completed.
   - If oxygen saturations fall below 85%, hemodynamic instability limits completion of apnea testing, or a $Paco_2$ level of ≥ 60 mm Hg cannot be achieved, the infant or child should be placed back on ventilator support with appropriate treatment to restore normal oxygen saturations, normocarbia, and hemodynamic parameters. Another attempt to test for apnea may be performed at a later time or an ancillary study may be pursued to assist with determination of brain death.

- Evidence of any respiratory effort is inconsistent with brain death and the apnea test should be terminated.

4. **Flaccid tone and absence of spontaneous or induced movements, excluding spinal cord events such as reflex withdrawal or spinal myoclonus.**

   - The patient's extremities should be examined to evaluate tone by passive range of motion assuming that there are no limitations to performing such an examination (eg, previous trauma, etc) and the patient observed for any spontaneous or induced movements.

   - If abnormal movements are present, clinical assessment to determine whether or not these are spinal cord reflexes should be done.

* Criteria adapted from 2010 American Academy of Neurology criteria for brain death determination in adults (Wijdicks et al, 2010).

Exhibit 23

Court Exhibit 5

Brain Death Examination for Infants and Children

Two physicians must perform independent examinations separated by specified intervals.

Age of Patient	Timing of first exam	Inter-exam. interval
Term newborn 37 weeks gestational age and up to 30 days old	○ First exam may be performed 24 hours after birth OR following cardiopulmonary resuscitation or other severe brain injury	○ At least 24 hours ○ Interval shortened because ancillary study (section 4) is consistent with brain death
31 days to 18 years old	○ First exam may be performed 24 hours following cardiopulmonary resuscitation or other severe brain injury	○ At least 12 hours OR ○ Interval shortened because ancillary study (section 4) is consistent with brain death

Section 1. PREREQUISITES for brain death examination and apnea test

A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma (Please check)

○ Traumatic brain injury ○ Anoxic brain injury ○ Known metabolic disorder ○ Other (Specify)

B. Correction of confounding factors that can interfere with the neurologic examination	Examination One		Examination Two	
a. Core Body Temp is over 95° F (35° C)	○ Yes	○ No	○ Yes	○ No
b. Systolic blood pressure or MAP in acceptable range (Systolic BP not less than 2 standard deviations below age appropriate norm) based on age	○ Yes	○ No	○ Yes	○ No
c. Sedative/analgesic drug effect excluded as a contributing factor	○ Yes	○ No	○ Yes	○ No
d. Metabolic intoxication excluded as a contributing factor	○ Yes	○ No	○ Yes	○ No
e. Neuromuscular blockade excluded as a contributing factor	○ Yes	○ No	○ Yes	○ No

If ALL prerequisites are marked YES, then proceed to section 2, OR

_____ confounding variable was present. Ancillary study was therefore performed to document brain death. (Section 4).

Section 2. Physical Examination (Please check) NOTE: SPINAL CORD REFLEXES ARE ACCEPTABLE	Examination One Date/ time:		Examination Two Date/ Time:	
a. Flaccid tone, patient unresponsive to deep painful stimuli	○ Yes	○ No	○ Yes	○ No
b. Pupils are midposition or fully dilated and light reflexes are absent	○ Yes	○ No	○ Yes	○ No
c. Corneal, cough, gag reflexes are absent Sucking and rooting reflexes are absent (in neonates and infants)	○ Yes ○ Yes	○ No ○ No	○ Yes ○ Yes	○ No ○ No
d. Oculovestibular reflexes are absent	○ Yes	○ No	○ Yes	○ No
e. Spontaneous respiratory effort while on mechanical ventilation is absent	○ Yes	○ No	○ Yes	○ No

The _____ (specify) element of the exam could not be performed because _____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death. (Section 4).

Section 3. APNEA Test	Examination One Date/ Time	Examination Two Date/ Time
No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq 60$ mm Hg and a ≥ 20 mm Hg increase above baseline. (Examination One) No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq 60$ mm Hg and a ≥ 20 mm Hg increase above baseline. (Examination Two)	Pretest $PaCO_2$: _____ Apnea duration: _____ min Posttest $PaCO_2$: _____	Pretest $PaCO_2$: _____ Apnea duration: _____ min Posttest $PaCO_2$: _____

Apnea test is contraindicated or could not be performed to completion because _____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death. (Section 4).

Section 4. ANCILLARY testing is required when (1) any components of the examination or apnea testing cannot be completed; (2) if there is uncertainty about the results of the neurologic examination; or (3) if a medication effect may be present. **Ancillary testing can be performed to reduce the inter-examination period however a second neurologic examination is required. Components of the neurologic examination that can be performed safely should be completed in close proximity to the ancillary test**	Date/Time:	
Electroencephalogram (EEG) report documents electrocerebral silence OR		○ Yes ○ No
Cerebral Blood Flow (CBF) study report documents no cerebral perfusion		○ Yes ○ No

Section 5. Signatures

Examiner One

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

(Printed Name) (Signature)

(Specialty) (Pager #/License #) (Date mm/dd/yyyy) (Time)

Examiner Two

I certify that my examination and/or ancillary test report confirms unchanged and irreversible cessation of function of the brain and brainstem. The patient is declared brain dead at this time.

Date/Time of death: _____

(Printed Name) (Signature)

(Specialty) (Pager #/License #) (Date mm/dd/yyyy) (Time)

Exhibit 04

Court Exhibit 6

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Attorneys for Respondent
CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND

ENDORSED
FILED
ALAMEDA COUNTY

DEC 20 2013

CLERK OF THE SUPERIOR COURT
By Jessica Sanchez
Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF ALAMEDA

_____,

Plaintiff,

v.

CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND,

Respondent.

Case No.

PHYSICIAN DECLARATION
of Robin Shanahan

I, Robin Shanahan, M.D., hereby declare as follows:

1. I am a duly licensed physician, board certified in the specialty of neurology with special competence in child neurology. I am a member in good standing of the medical staff of Children's Hospital & Research Center at Oakland (Children's).

2. On December 11, 2013, a brain death evaluation (the "Test") was ordered for patient Jahi McMath ("Ms. McMath"). The purpose of this Test was to determine whether Ms. McMath had sustained an irreversible cessation of all functions of her entire brain, including her brain stem.

3. The Test was performed on the morning of December 11, 2013. I personally performed the Test, which included review of her electroencephalogram (EEG) and clinical history, and performed a physical examination which included whether she responded to pain or other noxious stimuli and an evaluation of multiple brain stem reflexes. The Test revealed that Ms. McMath had sustained an irreversible cessation of all functions of the entire brain, including her brain stem. In addition, the results of the EEG revealed no cerebral activity.

4. The results of the Test confirm that Ms. McMath is considered brain dead in accordance with all accepted medical standards.

5. I also examined Ms. McMath before 9 a.m. on December 12, 2013, and found no changes in her condition.

6. There is absolutely no medical possibility that Ms. McMath's condition is reversible or that she will someday recover from death. Brain death is **always** followed by somatic death, i.e., it is inevitable that the heart will stop beating. Thus, there is no medical justification to provide any further medical treatment whatsoever to Ms. McMath.

I declare under the penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 20th day of December at Oakland, California.

Robin Shanahan M.D.

ROBIN SHANAHAN, M.D.

Exhibit 25

Court Exhibit 7

Court Exhibit 7 intentionally omitted because Superior Court ordered sealed.

Exhibit 26

10522610

FILED
ALAMEDA COUNTY
DEC 2 8 2013
By

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

LATASHA WINKFIELD, the Mother of Jahi McMath, a minor Petitioner, v. CHILDREN'S HOSPITAL OAKLAND, Dr. David Durand M.D. and DOES 1 through 100, inclusive Respondents	Case No. RP13-707598 ORDER (1) DENYING PETITION FOR MEDICAL TREATMENT AND (2) GRANTING IN PART APPLICATION TO SEAL PORTIONS OF RECORD. Date: December 23, 2013 Time: 9:30 am Dept: 31

The Petition of Latasha Winkfield as mother of Jahi McMath, a minor, and the motion of petitioner to seal came on for hearing on December 23 and 24, 2013, in Department 31 of this Court, the Honorable Evelio Grillo presiding. After consideration of the briefing and the argument, IT IS ORDERED: (1) the Petition of Latasha Winkfield as mother of Jahi McMath, a minor, is DENIED and (2) the motion of petitioner to seal is GRANTED IN PART.

///

///

PREOCEDURAL AND FACTUAL BACKGROUND[1]

On December 9, 2013, Jahi McMath, a thirteen year old child, had a tonsillectomy performed at Children's Hospital of Oakland ("CHO"). Following the tonsillectomy Jahi began to bleed profusely from her mouth and nose, and within a matter of minutes, went into cardiac arrest and lapsed into a coma. As of December 26, 2013, Jahi is currently being maintained on a ventilator at CHO.

On December 20, 2013, Latasha Winkfield, the mother of Jahi McMath filed a verified petition and ex parte application with the court pursuant to Probate Code section 3200 et seq. and 4600 et seq., seeking an order (1) authorizing the petitioner (Jahi's mother) to make medical care decisions for Jahi and for an injunction under to prohibit respondent CHO from withholding life support from Jahi. (Probate Code 3201, 4776, 4770.) The court set the application for hearing at 1:30 p.m. on December 20, 2013, in Department 31, and requested respondent CHO to submit written opposition to petitioner's ex parte application.

On December 20, 2013, the court heard Petitioner's application in Department 31. Christopher B. Dolan appeared for the petitioner and Douglas C. Strauss appeared for respondent CHO. At the hearing, respondent CHO submitted its opposition papers and argued that respondent CHO had no duty to continue mechanical ventilation or any other medical intervention for Jahi, because she was deceased as the result of an irreversible cessation of all functions of her entire brain, including her brain stem. Health & Safety Code section 7180. In support of its position, respondent submitted the physician declarations of Robert Heidersbach,

[1] Due to the confluence of facts concerning the medical records of a minor and the publicity that accompanied this case, the parties presented many of their arguments to the court in chambers and supported those arguments with offers of proof. The court has attempted in this order to reflect and address all the issues raised in the case even if they were not formally presented and preserved in court filings and transcribed hearings.

MD, Sharon Williams, MD, and Robin Shanahan, MD. Dr. Heidersbach and Dr. Shanahan were the examining physicians who determined Jahi's medical status, *i.e.*, brain dead. The physician declarations, read together, unequivocally stated that Jahi was considered brain dead in accordance with accepted medical standards, and that there was no medical possibility that Jahi's medical condition was reversible, or that she would recover from her present condition and that there was no medical justification to provide further medical intervention. Stated more plainly, CHO argued that Jahi was legally dead, as defined by Health and Safety Code section 7180 and 7181, and that neither Probate Code sections 3200 or 4600 et seq. authorized medical treatment of legally dead persons.[2] Petitioner responded with anecdotal evidence regarding Jahi's condition, and stated that Jahi was responsive to her mother's verbal stimulation, and to physical touching of her feet.

During oral argument on December 20, 2013, the court asked respondent's counsel whether the two examining physicians were affiliated with CHO.[3] Respondent's counsel responded that Drs. Heidersbach, and Shanahan did not work for CHO, that each satisfied the criteria for independence under Health and Safety Code section 7181, and thus intervention by the court was neither warranted, nor authorized by law. In effect, respondent's counsel argued that the court did not have jurisdiction to review the physicians' diagnosis of brain death because

[2] It would appear to be self evident that where legal death has occurred, one cannot invoke the provisions of Probate Code sections 3200 and 4600 to appoint a guardian to make health care decisions on behalf of a deceased person, *i.e.*, a person for whom additional medical treatment would be futile. There are specific statutory requirements for dealing with the remains of deceased persons. (Health and Safety Code 7000 et seq.) The issue presented by the petitioner in the instant matter was more complex: whether the petitioner's daughter was entitled to medical treatment in the form of life support (nutrition, intravenous fluids, ventilator breathing support, etc.) because her daughter was not legally dead. The issues in this case as presented by the petitioner necessarily required the court to reach the threshold issue of whether petitioner's daughter was legally dead.

[3] Health and Safety Code section 7181 states that a diagnosis of brain death requires confirmation by a second, independent physician.

two independent physicians had made the determination in compliance with Health and Safety Code section 7180 and 7181. On further questioning by the court, however, respondent's counsel conceded that both Drs. Heidersbach, and Shanahan maintained hospital privileges with CHO. The declarations submitted by Drs. Heidersbach, and Shanahan both self-describe their status as "a member in good standing of the medical staff of Children's Hospital & Research Center at Oakland." (Heidersbach Dec., Para 1; Shanahan Dec., para 1.)

Because Health and Safety Code section 7181 requires confirmation of brain death by an independent physician (but does not define or otherwise set a standard for determining independence), the court determined that, on the unique facts of this case,[4] the independent second opinion required by section 7181 should be provided by a physician who had no affiliation with CHO. The court ordered the parties to meet and confer to select a physician unaffiliated with CHO to provide the second independent opinion required by Health and Safety Code section 7180 and 7181. The parties met and conferred during a break in the hearing and presented the court with the names of five physicians affiliated with the University of California San Francisco Medical School.

By order dated December 20, 2013, the court temporarily restrained CHO from changing Jahi's level of medial support. The order stated in part: "Respondent CHO, its agents, employees, servants and independent contractors are ordered to continue to provide Jahi McMath with the treatment and support which is currently being provided as per the current medications

[4] The unique facts of this case include the fact of both affiant physicians being members of the CHO medical staff, the complete absence from the record of any information from which the court could determine whether the physician providing the second opinion was an "independent physician" within the meaning of Health and Safety Code section 7181, and the facts and circumstances surrounding Jahi's treatment while under the care of CHO, *i.e.*, immediate and dramatic death following a routine surgical procedure (a tonsillectomy), with virtually no information surrounding the circumstances of her treatment and death provided by CHO other than publically describing the outcome of the surgery as "catastrophic."

and physicians orders until further order of the court." The order also continued the hearing to Monday, December 23, 2013, and directed the parties to contact the UCSF physicians to determine whether any of them was available to examine Jahi and to provide the second independent opinion required by section 7181.

On Monday December 23, 2013, the court reconvened the hearing. At the hearing, respondent's counsel advised the court that the UCSF physicians had declined to provide a second section 7181 opinion on the advice of counsel as pending merger discussions between UCSF and CHO could raise concerns regarding the independence of the UCSF physicians. In place of the UCSF physicians, respondent's counsel offered, and petitioner's counsel agreed to, the appointment of Paul Fisher MD, the Chief of Child Neurology for the Stanford University School of Medicine, as the physician to provide the second, independent physician's opinion pursuant to Health and Safety Code section 7181. During the December 23 hearing, petitioner's counsel also requested that Paul A. Bryne, MD be allowed to examine Jahi and provide a second 7181 opinion, or alternatively, to provide expert testimony at the hearing.

By order dated December 23, 2013, appointed Dr. Fisher as the independent 7181 physician. Pursuant to that order, Dr. Fisher examined Jahi the afternoon of December 23, 2013. The court also continued the hearing to December 24, 2013, to receive Dr. Fisher's report and testimony from a CHO physician (Dr. Shanahan) who first determined that Jahi was brain dead, as of December 11, 2013. By separate order dated December 23, 2013, the court extended the restraining order through December 30, 2013, or such other date as the court might later determine.

On December 24, 2013, this court, during closed and public sessions received testimony from Dr. Shanahan and Dr. Fisher. During the course of the hearings, the court was presented

with and entered into evidence Dr. Shanahan's and Dr. Fisher's examination notes, as well as documents setting forth the standards for determining brain death in infants and children. (See, e.g., Exhibit 1 (Dr. Fisher's examination notes); Exhibit 2 (Guidelines for Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendation. Court); Exhibit 3 (Pediatrics, Official Journal of the American Academy of Pediatrics, August 28, 2011, Guidelines for Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendation); Exhibit 4 (Table 3 of Exhibit 3); Exhibit 5 (Checklist, Brain Death Examination for Infants and Children); Exhibit 6 (Shanahan Declaration filed 12/20/13); and Exhibit 7 (Consultation and Examination notes of Robin Shanahan MD dated 12/11/2013).[5] The court provided Petitioner's counsel the opportunity to cross examine both Dr. Fisher and Dr. Shanahan.

Dr. Fisher initially testified in a closed session. Dr. Fisher's written report served as his opening statement and counsel for petitioner in cross-examination questioned Dr. Fisher about the accepted medical standards for determining brain death in minors, his physical examination of Jahi, and his analysis. At the conclusion of Dr. Fisher's cross-examination, petitioner's counsel stipulated that Dr. Fisher conducted the brain death examination and made his brain death diagnosis in accord with accepted medical standards. In the open session immediately following, Dr. Fisher opined that Jahi was brain dead under accepted medical standards.

Dr. Shanahan then testified in a closed session. Dr. Shanahan testified as to the accepted medical standards for determining brain death in minors, the examination of Jahi that she conducted on December 11, 2013, and her conclusion on December 11, 2013, that Jahi was brain

[5] The court also received and considered the vita curricula of Dr. Fisher and Dr. Byrne. To provide a complete record, the court on its own motion augments the record to include those two documents as Exhibits 8 and 9.

dead as of that date. Petitioner's counsel was then provided with the opportunity to cross examine Dr. Shanahan.

At the conclusion of Dr. Shanahan's cross-examination in closed session, petitioner's counsel requested a continuance to review Jahi's medical records more carefully, to have time to consult an expert regarding Dr. Shanahan's examination of Jahi, and, if appropriate, to conduct further cross-examination of Dr. Sheehan. The court denied the request for a continuance. The court reasoned that the issue before the court was limited to whether the attesting physicians had conducted the 7180 and 7181 examinations in accord with accepted medical standards. The court determined, based on the testimony and medical records provided in the closed session (Exhibits 1 [Fisher notes] and 8 [Shanahan notes]), that although Jahi's complete medical records were relevant to the cause of her death they were not relevant to whether she had suffered brain death as defined under section 7181. Dr. Shanahan was then sworn in open court, and testified that Jahi was brain dead on December 11, 2013, under accepted medical standards.

The Court then took the matter under submission. The court returned to the bench after a brief recess and then denied the petition and dissolved the TRO effective 5:00 p.m. December 30, 2013.

ANALYSIS:

JURISDICTION OF THE COURT

During the initial and subsequent hearings, respondent's counsel argued that after two attesting physicians have determined a person to be brain dead pursuant to Health and Safety Code sections 7180 and 7181, that the court had no jurisdiction to review the issue. Or stated another way, counsel argued that the determination of brain death was a matter for physicians,

and not judges to decide, and the court lacked jurisdiction to review the physicians' determination of brain death.

It is true that physicians, and not courts, are uniquely qualified (and authorized by statute) to make the determination of brain death, but it does not follow that such determinations are insulated from all judicial review. (*Dority v. Superior Court* (1983) 145 Cal. App.3d 273, 278.) In *Dority* the trial court appointed a guardian for an infant who had been determined by physicians to be brain dead under Health & Saf. Code, § 7189, subd. (a)[6], and after hearing unrefuted medical testimony concluding that the infant was brain dead, the trial court ordered the temporary guardian to give the appropriate consent to the health care provider to withdraw life support. (*Dority*, 145 Cal.App.3d at 276.) The child's parents and counsel for the minor petitioned for a writ of prohibition against removing the life support device. The Court of Appeal denied the writs and held that the trial court's order for withdrawal of the life support system, after hearing the medical evidence and taking into consideration the rights of all the parties involved, and after finding that the infant was dead in accordance with applicable statutes, was proper and appropriate. (*Dority*, 145 Cal.App.3d at 279.)

Dority acknowledged "the moral and religious implications inherently arising when the right to continued life is at issue," but concluded that the court has jurisdiction to resolve the issue. *Dority* recognized "the difficulty of anticipating the factual circumstances under which a decision to remove life-support devices may be made, [and] determined that it would be

[6] It appears that the reference to Health & Saf. Code, § 7189(a) might be a typographical error. Former § 7189, as operative during 1983, was added by Stats.1976, c. 1439, § 1, related to the revocation of health care directives, and was repealed by Stats.1991, c. 895 (S.B.980), § 1. Health & Saf. Code 7180, the operative section for determining death as of 1983 (the year in which the events underlying *Dority* occurred) was added by Stats.1982, c. 810, p. 3098, § 2, and would have been the operative statute for determining death at that time.

"unwise" to deny courts the authority to make such a determination when circumstances warranted." (*Dority*, 145 Cal.App.3d at 275.)

Dority states "[t]he jurisdiction of the court can be invoked upon a sufficient showing that [1] it is reasonably probable that a mistake has been made in the diagnosis of brain death or [2] where the diagnosis was not made in accord with accepted medical standards." (*Dority*, 145 Cal.App.3d at 280.) *Dority* is silent on what showing is necessary to establish "reasonable probability of a mistake." *Dority* and the statutes, sections 7180 and 7181, are silent as to when a diagnosis is made "in accord with accepted medical standards." *Dority* does not state that the two identified bases for jurisdiction are exclusive and the statute does not state they are exclusive. The court interprets the statute and holds that application of the statute permits an inquiry into whether the second physician was independent. The court's jurisdiction can be invoked on a showing that the second physician required by section 7181 was not "independent."

In this case there is clearly was a conflict between the party representing Jahi and the health care providers as to whether brain death had occurred and whether further medical intervention was warranted. Petitioner presented evidence that her daughter, Jahi, was responsive (reacted to) her touch (Winkfield Decl. at para. 9), arguably suggesting that it was possible that a mistake has been made in the diagnosis of brain death. Petitioner presented evidence that CHO denied petitioner's request to have an independent physician examine Jahi and her studies and records (Winkfield Decl., para. 19) and that CHO repeatedly refused to provide petitioner with Jahi's medical records under the rationale that the hospital does not provide medical records of patients that they are still treating (Winkfield Decl. at paras. 20, 21).[7] These facts cast doubt on the neutrality of CHO and therefore also on the independence of the

[7] As of the hearing on Friday December 20, 2013, petitioner and petitioner's counsel had not yet received copies of Jahi's medical records.

physicians who were "member[s] in good standing of the medical staff of Children's" who had examined Jahi and made findings of brain death. These facts are sufficient to invoke the jurisdiction of the court to review whether the diagnosis was made by an independent physician in accord with acceptable medical standards.[8]

NATURE OF THE HEARING AND RELATED DUE PROCESS CONCERNS.

Counsel for petitioner objected that petitioner was not provided a full and fair opportunity to present evidence regarding whether Jahi had suffered brain death. Specifically, counsel for petitioner asserted that petitioner was not provided timely access to Jahi's complete medical files, that he needed additional time in which to prepare for cross-examination, and that he had the right to present a competing physician to provide testimony on the issue of brain death.

Health and Safety Code sections 7180 and 7181 do not provide any guidance regarding the nature of a proceeding to address brain death under those sections. *Dority*, supra, 145 Cal.App.3d 273, 276, did not address the nature of a proceeding under section 7181. The Uniform Determination of Death Act prepared by the Uniform Law Commission does not address the nature of a proceeding. The court can discern three options for categorizing the nature of the proceeding: (1) a summary judicial review of physician reports; (2) a focused proceeding that permits limited discovery and presentation of evidence; and (3) a civil

[8] There was some conflict in the argument at the December 20 hearing as to whether petitioner had been allowed to have a physician examine Jahi and/or review the records of Drs. Shanahan and Heidersbach, the physicians who declared Jahi to be brain dead. CHO's counsel (Mr. Strauss) contended that petitioner had consulted with three physicians of her choosing, each of whom confirmed the diagnosis of brain death. Petitioner's counsel denied Mr. Strauss' representation and further alleged that Jahi's medical records had not been provided to petitioner or petitioner's designated physicians, thereby precluding any meaningful review of Drs. Shanahan's and Heidersbach's diagnoses of brain death.

proceeding with challenges to the pleadings under CCP 430.10 and 435, discovery rights under CCP 2016 et seq, motions for summary judgment under CCP 437c, and a full trial on the merits.

The court rejects the first option as failing to provide appropriate due process to the interested parties. If the determination were so simple that the court could resolve it on the basis of declarations, then the court would not need to be involved at all in the process. (*Dority*, 145 Cal.App.3d at 278 [If the family and physicians agree, then "we find it completely unnecessary to require a judicial "rubber stamp" on this medical determination"].) If the determination is not simple, then the interested parties are entitled to cross-examine the physicians and to present their own evidence.

The court finds the second option consistent with the apparent intent of the legislature, California case law, and due process. Health and Safety Code sections 7180 and 7181 concern a single factual issue that is medical in nature. Physicians should be able to make the required examination and complete the required analysis in a relatively short time period. The legislature in Health and Safety Code 1254.4 states that after a finding of brain death under section 7180 that a hospital must continue previously ordered cardiopulmonary support for a "reasonably brief period" to afforded family or next of kin the opportunity to gather at the patient's bedside before removal of the support and that "in determining what is reasonable, a hospital shall consider the needs of other patients and prospective patients in urgent need of care." This suggests that following a finding of brain death under section 7180 that any challenge to the finding also be completed in relatively brief period.

California case law indicates that trial courts have conducted hearings under section 7180 expeditiously. In *Dority*, the physicians found no brain activity on November 22 and again about about one month later (mid-December), and the trial court held a hearing on January 17 and 21.

The testimony at the *Dority* trial court hearing was unrefuted. Although *Dority* did not address the nature of the proceeding or hearing, if also did not criticize the conduct of the trial court. (*Kinsman v. Unocal Corp.* (2005) 37 Cal.4th 659, 680 [An opinion is not authority for propositions not considered].)

Regarding due process, the Court has considered the following general principles as stated in *Oberholzer v. Commission on Judicial Performance* (1999) 20 Cal. 4th 371, 390-391:

> Under the California Constitution, the extent to which procedural due process is available depends on a weighing of private and governmental interests involved. The required procedural safeguards are those that will, without unduly burdening the government, maximize the accuracy of the resulting decision and respect the dignity of the individual subjected to the decision making process. Specifically, determination of the dictates of due process generally requires consideration of four factors: [1] the private interest that will be affected by the individual action; [2] the risk of an erroneous deprivation of this interest through the procedures used and the probable value, if any, of additional or substitute safeguards; [3] the dignitary interest of informing individuals of the nature, grounds and consequences of the action and of enabling them to present their side of the story before a responsible governmental official; and [4] the government interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

The first three considerations, the private interest, the risk involved, and the dignitary interest of the proceeding, all suggest that the due process rights of the party affected by a physician's determination of death are substantial. The fourth factor, the government interest in the form of administrative burden, is addressed by the focused nature of the inquiry under Health and Safety Code sections 7180 and 7181.

The court finds the third option to be inconsistent with the apparent purpose of the statute and the related statutes. The inquiry is focused and the Health and Safety Code 1254.4 suggest that the proceedings be commenced and concluded in a "reasonably brief period."

The court finds that the nature of the proceedings is that of a regular civil proceeding, but that the trial court has the discretion to focus the case on the limited issues presented and to expedite and narrow the proceedings accordingly. Paraphrasing *Dority*, 145 Cal.App.3d at 275, "Considering the difficulty of anticipating the factual circumstances under which a decision to remove life-support devices may be made, [limiting the discretion of the court to fashion the proceedings to the circumstances] may ... be unwise." The trial court may issue orders shortening time to ensure that the case is not unduly prolonged, the trial court may expedite and limit discovery under CCP 2019.020(a) and 2019.030, and the court may limit the scope of the evidence presented at the hearing under Evidence Code 352.

This court endeavored to provide petitioner with due process while completing the proceeding in a "reasonably brief period." CHO provided some medical records to petitioner late on Friday December 20 and provided more complete records to petitioner's counsel on Monday December 23, 2013. The court appointed its own independent physician to examine Jahi on Monday December 23, and counsel for petitioner was present during that examination. On Tuesday December 24, counsel for petitioner had the opportunity to cross-examine both Dr. Fisher and Dr. Shanahan.

During the proceedings, counsel for petitioner at various times requested that Paul A. Bryne, MD be allowed to examine Jahi and provide a second 7181 opinion, or provide expert testimony at the hearing, or to review Jahi's records to assist in the cross-examination of Dr. Shanahan. Petitioner withdrew the request that Dr. Bryne be allowed to examine Jahi and

provide an opinion based on his own examination. Petitioner did not pursue his request that Dr. Byrne provide expert testimony. During the discussions between the court and counsel it became apparent through a review of Dr. Byrne's publications that were the court to hold an Evidence Code 402 hearing to determine whether Dr. Byrne was qualified as an expert under Evidence Code 720 and *Sargon Enterprises, Inc. v. University of Southern Cal.* (2012) 55 Cal.4th 747, that Dr. Byrne might not qualify as an expert based on his religious and philosophical approach to the definition of death and the possibility that he would not be able to apply accepted medical standards. In addition, it became apparent that testimony and documents regarding the cause of death, as opposed to the fact of death, were not relevant to the court's inquiry. The court exercised its discretion in not continuing the hearing to permit petitioner to review Jahi's records to assist in the cross-examination of Dr. Shanahan. The court reasoned that the examinations were both under the accepted medical standards, the medical determinations were consistent, and that the detriment of a prolonged proceeding would materially outweigh any probable benefit to the court in making the limited finding required by section 7181.

The court acted consistent with the trial court in *Alvarado by Alvarado v. New York City Health & Hospitals Corp.* (N.Y.Sup.,1989) 145 Misc.2d 687, 698, 547 N.Y.S.2d 190, *order vacated and appeal dismissed as moot*, 157 A.D.2d 604, 550 N.Y.S.2d 353 (1st Dep't 1990), where the court addressed a similar situation and stated, "In the instant case, the Alvarados were notified before a determination was made, were given an opportunity to obtain an independent medical evaluation, and were offered a chance to have the matter discussed with religious leaders and friends. Therefore, it cannot be said that the family was deprived of its due process rights to participate in the medical care of the child."

FINDING OF BRAIN DEATH UNDER HEALTH AND SAFETY 7180 AND 7181.

A trial court may "hear testimony and decide whether the determination of brain death was in accord with accepted medical standards." (*Dority*, 145 Cal.App.3d at 279.) The law is unclear whether the court's determination is under the preponderance of the evidence standard, the clear and convincing evidence standard, or some other standard. This court applies the clear and convincing evidence standard.

The court is guided by *In re Christopher I* (2003) 106 Cal.App.4th 533, 552, where the court addressed the standard to be applied when removing life support from a minor who was in a persistent vegetative condition. In *Christopher*, the Court of Appeal noted that the Welfare and Institutions Code requires either proof by a preponderance of the evidence or clear and convincing evidence, depending on the rights being adjudicated and then stated, "Given the impact of this decision on Christopher, imposition of the highest standard within the Welfare and Institutions Code-the clear and convincing standard of proof-is appropriate." The court went on to review the law in different states and concluded "The evidentiary standards employed by other courts considering withholding or withdrawal of life-sustaining treatment from incompetent patients reinforce our belief that the clear and convincing standard is the correct one."

The court notes that although *Christopher* concerned a minor in a persistent vegetative condition and there are medical differences between a coma, a persistent vegetative state, and brain death, those differences pale in comparison to the difference between being legally alive and being legally dead. When a court is called on to determine whether a person has suffered brain death and is now dead under the law or can have support withdrawn and will become dead under the law, the court must make that finding by clear and convincing evidence.

The court heard the testimony of Dr. Fisher and Dr. Shanahan. Both doctors presented consistent testimony that established the accepted medical standards for determining brain death in minors. Dr. Shanahan conducted a physical examination of Jahi on December 11, 2013, and Dr. Fisher conducted an examination on December 23, 2013. Both doctors conducted their examinations consistent with the accepted medical standards and both doctors reached independent conclusions of brain death based on their application of the standards to Jahi's condition. In addition, Dr. Shanahan reviewed an EEG taken on or about December 11, 2013, and Dr. Fisher reviewed a different EEG taken on December 23, 2013, and those tests reinforced their conclusions. Dr. Fisher conducted an additional test, a cerebral profusion test, and that test was also consistent with the conclusion of brain death. This clear and convincing evidence was the basis of the court's conclusion on December 24, 2013, that Jahi had suffered brain death and was deceased as defined under Health and Safety Code 7180 and 7181.

The court is mindful of the language in *Dority* that states the fact of brain death "does not mean the hospital or the doctors are given the green light to disconnect a life-support device from a brain-dead individual without consultation with the parent or guardian. Parents do not lose all control once their child is determined brain dead," and that a parent should be fully informed of a child's condition and have the right to participate in a decision of removing the life-support devices. (*Dority*, 145 Cal.App.3d at 279-280.) (See also, Health & Safety Code section 1254.4 [requiring reasonable amount of time to accommodate family in event of declaration of brain death].) The court expressly does address whether that consultation and opportunity for participation required by Health & Safety Code section 1254.4 occurred in this case.

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APPLICABILITY OF PROBATE CODE 4735 AND 4736.

Petitioner's initial memorandum argued that if under Probate Code 4735 CHO made a determination to decline to comply petitioner's instructions on the basis that it would be "medically ineffective health care or health care contrary to generally accepted health care standards," then under Probate Code 4736 CHO had the obligation "to make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision" and had the obligation to "[p]rovide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished."

Probate Code 4736 appears to apply only when is it arguable whether the proposed health care would be medically effective. The court finds that Probate Code 4736 does not apply after a determination of death. The court notes that Probate Code 4736 provides for some time to move a patient and Health and Safety Code 1241.4 provides a "reasonably brief period" for family to gather at the bedside. Therefore, both statutes provide for a brief period following a determination of brain death before a hospital can remove all support. The court makes no findings and issues no orders under Probate Code 4735 and 4736.

MOTION TO SEAL

The Order of December 23, 2013, stated, "The court anticipates that the hearing will be closed to the public under CRC 2.550 et seq. because it involves the medical records of a minor." On December 23 and 24, 2013, petitioner moved to close the hearing in part and to seal and/or redact certain exhibits.

The court CLOSED the courtroom and SEALS the record on the oral testimony provided by Dr. Fisher and Dr. Shanahan in which they detailed their examinations of Jahi. This testimony was provided in chambers with a court reporter present.

The court REDACTS Exhibit 1 (Dr. Fisher's examination notes) in part because the redacted portion is not pertinent to the issues before the court and Jahi's family has an overriding privacy interest in the material that outweighs the public interest in the information. The court permits disclosure of the remainder of Exhibit 1. Although the exhibit reflects Dr. Fisher's examination of Jahi, Dr. Fisher was acting as a court appointed expert on a matter that petitioner had placed at issue in this case.

The court DOES NOT SEAL Exhibits 2-5. These are documents that reflect the accepted medical standards.

The court DOES NOT SEAL Exhibit 6 (Shanahan Declaration filed 12/20/13). This is already in the public file. In addition, although it concerns the medical information of a minor it is conclusory and does not disclose private information.

The court SEALS Exhibit 7. This exhibit reflects Dr. Shanahan's and Dr. Heidersbach's pre-litigation examinations of Jahi. These doctors were acting as agents of CHO and their notes reflect the medical information of a minor.

EXTENSION OF RESTRAINING ORDER, STAY OF THIS ORDER, AND PREPARATION OF JUDGMENT.

The court ORDERS that the Temporary Restraining Order is extended through Monday, December 30, 2013, at 5:00 pm. Until that time, Respondent CHO, its agents, employees, servants and independent contractors are ordered to continue to provide Jahi McMath with the treatment and support which is currently being provided as per the current medications and physicians orders until further order of the court.

In the event that before Monday, December 30, 2013, at 5:00 pm there is a change in Jahi's physiological condition despite CHO provision of the current level of treatment and support and petitioner wants an increased level of treatment and support that CHO is unwilling to provide, then the parties may seek the assistance of the court at any time. The court has provided its contact information to counsel.

The court STAYS the effect of this order until Monday, December 30, 2013, at 5:00 pm to permit petitioner or CHO to file a petition for relief with the Court of Appeal and to seek further relief from that court.

CHO is to submit a proposed final judgment consistent with this order on or before January 9, 2014. (C.R.C. 3.1312.)

The court sets a further case management conference for 1:30 pm on January 16, 2014, in Dept 31. If the case has been resolved or all further near term proceedings will be in the Court of Appeal, then counsel may so inform the court and the court will continue the case management conference to a later date.

IT IS SO ORDERED.

Dated: December 26, 2013

Evelio Grillo
Judge of the Superior Court