Docket No. 17-17153

In the

United States Court of Appeals

For the

Ninth Circuit

JONEE FONSECA, an individual parent and guardian of I.S., a minor and LIFE LEGAL DEFENSE FOUNDATION,

Plaintiffs-Appellants,

v.

KAREN SMITH, M.D. in her official capacity as Director of the California Department of Public Health,

Defendant-Appellee.

Appeal from a Decision of the United States District Court for the Eastern District of California, No. 2:16-cv-00889-KJM-EFB · Honorable Kimberly J. Mueller

EXCERPTS OF RECORD
VOLUME I OF V – Pages 1 to 16

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

JUDGMENT IN A CIVIL CASE

JONEE FONSECA,

CASE NO: **2:16−CV−00889−KJM−EFB**

V.

KAREN SMITH, ET AL.,

XX −− Decision by the Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

THAT JUDGMENT IS HEREBY ENTERED IN ACCORDANCE WITH THE COURT'S ORDER FILED ON 09/25/17

Marianne Matherly
Clerk of Court

ENTERED: **September 25, 2017**

by: /s/ A. Benson
Deputy Clerk

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, an individual parent and guardian of ISRAEL STINSON, a minor; LIFE LEGAL DEFENSE FOUNDATION,

Plaintiffs,

v.

KAREN SMITH, M.D., in her official capacity as Director of the California Department of Public Health; and DOES 2 through 10, inclusive,

Defendants.

No. 2:16-cv-00889-KJM-EFB

ORDER

This case arose after a toddler suffered a severe asthma attack. Following efforts to treat him, doctors declared the toddler brain dead. When the toddler's mother's legal efforts to maintain her son on a heart and lung machine proved unsuccessful, the child was removed from the machine and his heart and lungs ceased to function. The toddler's mother, Jonee Fonseca, sues to challenge the constitutionality of the state law that defines death to include brain death, as she believes life continues as long as the heart beats and the lungs draw breath. At an earlier stage, when the toddler Israel was still supported by a heart and lung machine, the court dismissed the complaint because Fonseca's pleadings did not allege the state law caused harm or that the court could redress any alleged injury, two necessary elements to invoke this court's jurisdiction.

The court permitted leave to amend the complaint. Upon careful consideration of the third amended complaint, and having heard from the parties, the court GRANTS defendant's motion to dismiss. ECF No. 83. Because further amendment would be futile, dismissal this time is without leave to amend.

I. FACTUAL AND PROCEDURAL BACKGROUND

On April 1, 2016, Israel Stinson suffered a severe asthma attack and was taken to Mercy General Hospital in Sacramento ("Mercy"), where he was intubated. Third Am. Compl. ("TAC") ¶ 7, ECF No. 80. Israel eventually was transferred to University of California Davis Medical Center, also in Sacramento ("UC Davis"), and admitted to the pediatric intensive care unit. *Id.* On April 10, after performing a series of tests, including a magnetic resonance imaging ("MRI") and computed tomography ("CT") scan, doctors at UC Davis concluded Israel had suffered brain death. *Id.* ¶ 20.

The next day, on April 11, Israel was transferred to Kaiser Permanente Roseville Medical Center – Women and Children's Center ("Kaiser"). *Id.* ¶ 21. On April 14, doctors there performed further tests and confirmed Israel had suffered brain death. *See id.* ¶¶ 21–24. That day, Kaiser doctor Michael Myette filled out and signed a Certificate of Death that declared Israel deceased, *id.* ¶¶ 25, 27, and Kaiser sought to remove him from life support, *id.* ¶¶ 30, 43.

On April 14, plaintiff filed a case in Placer County Superior Court seeking to enjoin Kaiser from withdrawing life support. *Id.* ¶ 43; Placer County Petition, ECF No. 14-2 (case entitled *Stinson v. UC Davis Children's Hosp.*, Case No. S-CV-0037673).[1] The Superior Court granted a temporary restraining order requiring Kaiser to maintain life support. *Id.* ¶¶ 43–44. After the Superior Court found on April 27 that Kaiser had satisfied all medical protocols in determining Israel's death, the court dissolved the restraining order and dismissed the case. *Id.* ¶ 45; Placer County Order, ECF No. 19-1 (order dated April 29, 2016).

[1] The court previously has taken judicial notice of the state court filings and orders relevant to this case. *See* ECF No. 48 at 4 n.2; ECF No. 79 at 2. It does so again here, without objection as confirmed at hearing. *See* Placer County Petition, ECF No. 14-2; Placer County Order, ECF No. 19-1; Los Angeles County Petition, ECF No. 68-3 at 27–35; Los Angeles County Petition, ECF No. 68-3 at 27–35.

On April 28, Fonseca filed this action in federal court. Compl., ECF No. 1. The complaint named Kaiser and Dr. Myette as defendants and alleged, *inter alia*, violation of plaintiff's right to privacy as guaranteed by the Fourteenth Amendment. *Id.* On May 2, the court heard arguments and granted plaintiff's request for a temporary restraining order requiring Kaiser to maintain life support. ECF No. 22. On May 3, plaintiff filed an amended complaint, adding as a defendant Karen Smith, M.D., in her official capacity as Director of the California Department of Public Health. First Am. Compl. ("FAC"), ECF No. 29. The amended complaint alleged that defendants violated plaintiff's right to due process as guaranteed by the Fifth and Fourteenth Amendments; it sought a declaration that the California Uniform Determination of Death Act ("CUDDA"), a statute that defines death in California, is unconstitutional on its face. *Id.*; FAC Prayer ¶ 3. On May 13, after further argument, the court denied plaintiff's request for a preliminary injunction, but stayed its order until May 20 to afford plaintiff time to appeal to the Ninth Circuit Court of Appeals. ECF Nos. 45, 48.

On May 20, the Ninth Circuit further stayed dissolution of the temporary restraining order to allow more time for review. ECF No. 55. On May 21, Israel was flown to Sanatorio Nuestra Señor del Pilar, a medical facility in Guatemala City, Guatemala, TAC ¶ 45, and plaintiff's interlocutory appeal was voluntarily dismissed. ECF No. 59. While Israel was abroad, plaintiff's case here continued; plaintiff dismissed Kaiser and Dr. Myette as defendants on June 8, ECF No. 60, and filed a Second Amended Complaint on July 1, 2016, Second Am. Compl. ("SAC"), ECF No. 64. Back at the Guatemala City facility, after performing additional examinations, including an electroencephalogram ("EEG"), doctors found Israel was not dead but instead in a "persistent vegetative state."[2] TAC ¶ 47. Israel stayed at the Guatemala City facility until August 6, when he was transported back to the United States by air ambulance and admitted to Children's Hospital of Los Angeles ("Children's Hospital"). TAC ¶ 52.

[2] A patient in a "persistent vegetative state" may have some lower- and mid-brain-stem activity, and is not considered dead under California law. *In re Christopher I.*, 106 Cal. App. 4th 533, 543 (2003) (citing Cal. Health & Safety Code § 7180(a)).

After transferring to Los Angeles, Israel's face and torso became increasingly red and swollen. *Id.* ¶ 53. Doctors at Children's Hospital stopped feeding Israel and sought to remove Israel's ventilator. *Id.* ¶¶ 53–54. On August 18, plaintiff filed a new case in Los Angeles County Superior Court to enjoin Children's Hospital from removing Israel from life support. *Id.* ¶ 55; Los Angeles County Petition, ECF No. 68-3 at 27–35. The Superior Court initially granted a temporary restraining order, TAC ¶ 55, which it dissolved on August 25, *id.* ¶ 60; Los Angeles County Order, ECF No. 68-3 at 46. That same day, on August 25, 2016, doctors at Children's Hospital removed Israel from life support. TAC ¶ 61. Plaintiffs' position is that it was on this date that Israel died. *Id.* ¶ 62.

On March 28, 2017, the court granted defendants' motion to dismiss the Second Amended Complaint on the grounds that plaintiff had not established Article III standing. Prior Order, ECF No. 79; SAC. Given the events occurring after the filing of the second amended complaint, including Israel's return to the United States and Children's Hospital's withdrawal of life support, the court granted leave to amend. *Id.* at 13.

The third amended complaint names as defendant only Karen Smith, sued in her official capacity as Director of the California Department of Public Health. TAC ¶ 5. The complaint names a new plaintiff, Life Legal Defense Foundation ("LLDF"), a not-for-profit organization whose mission "focuses on preservation of the lives of the most vulnerable members of society, including the very young and those facing the end of life." *Id.* ¶ 4. Plaintiffs assert the following claims: (1) Deprivation of Life and Liberty in Violation of Due Process of Law under the Fifth and Fourteenth Amendments; (2) Deprivation of Parental Rights in Violation of Due Process of Law under the Fifth and Fourteenth Amendments; (3) Deprivation of Life under California Constitution Article I, section 1; (4) Violation of Privacy Rights protected by the United States Constitution; and (5) Violation of Privacy Rights protected by California Constitution Article I, section 1. *Id.* ¶¶ 71–94. Plaintiff's prayer for relief includes the following: (1) an order expunging all records that state or imply Israel died on April 14, 2016 and not August 25, 2016 and requiring amendment to reflect the later date; (2) a declaration that CUDDA is

unconstitutional on its face; (3) a declaration that CUDDA is unconstitutional as applied; (4) any and all other appropriate relief; and (5) costs and attorney fees. *Id.* Prayer.

Defendant moves to dismiss under Federal Rules of Civil Procedure 12(b)(1) and (6). TAC; Mot., ECF No. 83. Plaintiffs oppose, and defendant filed a reply. Opp'n, ECF No. 84; Reply, ECF No. 85. On September 8, 2017, the court held a hearing on the motion, at which Kevin Snider, Matthew McReynolds and Alexandra Snyder appeared for plaintiffs and Ashante Norton appeared for defendant. ECF No. 87.

II. LEGAL STANDARDS

A. Rule 12(b)(1)

A motion to dismiss under Federal Rule of Civil Procedure 12(b)(1) challenges the court's subject-matter jurisdiction. *See, e.g.*, *Savage v. Glendale Union High Sch.*, 343 F.3d 1036, 1039–40 (9th Cir. 2003). The Federal Rules of Civil Procedure mandate that "[i]f the court determines at any time that it lacks subject-matter jurisdiction, the court must dismiss the action." Fed. R. Civ. P. 12(h)(3). "The Article III case or controversy requirement limits federal courts' subject matter jurisdiction by requiring, *inter alia*, that plaintiffs have standing." *Chandler v. State Farm Mut. Auto. Ins. Co.*, 598 F.3d 1115, 1121–22 (9th Cir. 2010) (citing *Allen v. Wright*, 468 U.S. 737, 750 (1984)). As "an essential and unchanging part of the case-or-controversy requirement of Article III," *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992), "[s]tanding is the threshold issue of any federal action," *Employers-Teamsters Local Nos. 175 & 505 Pension Trust Fund v. Anchor Capital Advisors*, 498 F.3d 920, 923 (9th Cir. 2007). "The party asserting federal subject matter jurisdiction bears the burden of proving its existence." *Chandler*, 598 F.3d at 1122 (citing *Kokkonen v. Guardian Life Ins. Co.*, 511 U.S. 375, 377 (1994)). However, "[a]s the Supreme Court has noted, the evidence necessary to support standing may increase as the litigation progresses." *Barnum Timber Co. v. U.S. E.P.A.*, 633 F.3d 894, 899 (9th Cir. 2011) (citing *Lujan*, 504 U.S. at 561). "Where standing is raised in connection with a motion to dismiss, the court is to 'accept as true all material allegations of the complaint, and construe the complaint in favor of the complaining party.'" *Levine v. Vilsack*, 587 F.3d 986, 991 (9th Cir. 2009) (quoting *Thomas v. Mundell*, 572 F.3d 756, 760 (9th Cir. 2009)).

B. Rule 12(b)(6)

Under Federal Rule of Civil Procedure 12(b)(6), a party may move to dismiss a complaint for "failure to state a claim upon which relief can be granted." The motion may be granted only if the complaint "lacks a cognizable legal theory or sufficient facts to support a cognizable legal theory." *Hartmann v. Cal. Dep't of Corr. & Rehab.*, 707 F.3d 1114, 1122 (9th Cir. 2013). Although a complaint need contain only "a short and plain statement of the claim showing that the pleader is entitled to relief," Fed. R. Civ. P. 8(a)(2), in order to survive a motion to dismiss this short and plain statement "must contain sufficient factual matter . . . to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). A complaint must include something more than "an unadorned, the-defendant-unlawfully-harmed-me accusation" or "'labels and conclusions' or 'a formulaic recitation of the elements of a cause of action.'" *Id.* (quoting *Twombly*, 550 U.S. at 555). Determining whether a complaint will survive a motion to dismiss for failure to state a claim is a "context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Id.* at 679. Ultimately, the inquiry focuses on the interplay between the factual allegations of the complaint and the dispositive issues of law in the action. *See Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984).

In making this context-specific evaluation, this court must construe the complaint in the light most favorable to the plaintiff and accept its factual allegations as true. *Erickson v. Pardus*, 551 U.S. 89, 93–94 (2007). However, "'conclusory allegations of law and unwarranted inferences' cannot defeat an otherwise proper motion to dismiss." *Schmier v. U.S. Court of Appeals for Ninth Circuit*, 279 F.3d 817, 820 (9th Cir. 2002) (quoting *Associated Gen. Contractors of Am. v. Metro. Water Dist. of S. California*, 159 F.3d 1178, 1181 (9th Cir. 1998)).

III. DISCUSSION

A. The Prior Order

In its prior order, the court dismissed Fonseca's challenge to California's Uniform Determination of Death Act for lack of standing. A brief summary of CUDDA and the court's prior order is necessary as background here.

California has adopted the Uniform Determination of Death Act as Health & Safety Code section 7180 and defines death 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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

Cal. Health & Safety Code § 7180(a). The statute provides two independent bases for a determination of death. *People v. Flores*, 3 Cal. App. 4th 200, 210 (1992) ("Since death is present when only one of the prongs of the statute is satisfied, neither must be satisfied for life to be present."). As the statute makes clear on its face, any determination must be "made in accordance with accepted medical standards." *Dority v. Super. Ct.*, 145 Cal. App. 3rd 273, 278 (1983) (citing Cal. Health & Safety Code § 7180(a)). The Uniform Determination of Death Act language and similar brain death definitions have been uniformly accepted throughout the United States.[3] *In re Guardianship of Hailu*, 361 P.3d 524, 528 (Nev. 2015) (citing Leslie C. Griffin & Joan H. Krause, Practicing Bioethics Law 106 (2015) ("Thus all fifty states define brain death as legal death even if the heart continues to beat.")).

The court previously held Fonseca lacked standing to challenge CUDDA. Prior Order at 9–13. As the court explained then, to establish standing, a plaintiff must satisfy a three-part test:

> First, [plaintiff] must suffer an "injury in fact"—a "concrete and particularized" and "actual or imminent" harm to a legally protectable interest. Second, plaintiff[] must demonstrate a "causal connection between the injury and the conduct complained of" such that the injury is "fairly traceable" to the defendant's actions. Third, it must be "likely" that [plaintiff's] injury will be redressed by a favorable court decision.

[3] Though New Jersey has codified this definition, N.J. Stat. §§ 26:6A-2–3, it also has enacted a religious exemption prohibiting a declaration of death on the basis of brain death when to do so would violate the patient's religious beliefs, *id.* § 26:6A-5. "In these cases, death shall be declared, and the time of death fixed, solely upon the basis of cardio-respiratory criteria[.]" *Id.*

Id. at 9 (quoting *Harris v. Bd. of Supervisors, L.A. Cty.*, 366 F.3d 754, 760 (9th Cir. 2004) (quoting *Lujan*, 504 U.S. at 560–61). Looking at the Second Amended Complaint, the court found Fonseca established the first but not the last two requirements. *Id.* at 9–13.

The court first found Fonseca satisfied the injury requirement because the threat of removal of life support while Israel was still alive was sufficient to establish the "invasion of a legally-protected interest that is concrete and particularized, and actual or imminent, not conjectural or hypothetical." *Id.* at 9 (quoting *Didrickson v. U.S. Dep't of Interior*, 982 F.2d 1332, 1340 (9th Cir. 1992) (quoting *Lujan*, 504 U.S. at 560)). "Thus, even without amending her complaint to reflect Israel's death after he was removed from life support, plaintiff has pled sufficient facts to establish the injury prong of the standing inquiry." *Id.*

Next, the court found causation lacking because CUDDA did not plausibly lead to an incorrect declaration of Israel's death. *Id.* at 10–11. To the extent Fonseca alleged doctors incorrectly determined Israel's condition was irreversible, the court found the statute could not cause that harm: CUDDA defines death as the "irreversible cessation of all functions of the entire brain," Cal. Health & Safety Code § 7180(a)(2), so plaintiff's contention was inconsistent with CUDDA's plain language requiring permanence and inability to reverse. *Id.* at 10. To the extent Fonseca alleged doctors relied on CUDDA to refuse to revisit an incorrect determination, that position also was undermined by the statute: CUDDA mandates that "[a] determination of death must be made in accordance with accepted medical standards," Cal. Health & Safety Code § 7180(a), and nothing in CUDDA prevented doctors from performing independent examinations in light of indications Fonseca say pointed to Israel's improving condition. Prior Order at 11.

Finally, the court found Fonseca did not establish redressability, or "a substantial likelihood that the relief sought would redress the injury." *Id.* at 11. As the court reasoned then, Fonseca's claims turned on the likely actions of third-party doctors who, even without CUDDA, might have made the same decision. *Id.* at 12. Indeed, doctors in a case such as this "retain[] broad and legitimate discretion the courts cannot presume either to control or predict." *Id.* (quoting *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1125 (9th Cir. 2006)). Thus, invalidating CUDDA was not substantially likely to reverse or

otherwise impact the medical opinion that Israel died on April 14, when doctors at Kaiser determined Israel was brain dead. *Id.* at 11–13.

B. The Third Amended Complaint

The Third Amended Complaint largely mirrors the Second Amended Complaint. *Compare* TAC *with* SAC. Many of the changes in the allegations reflect the events occurring after the Second Amended Complaint was filed but before the court held a hearing on the motion to dismiss it. *See, e.g.*, TAC ¶¶ 45–61. Most significantly, the complaint now alleges that doctors withdrew Israel from life support[5] on August 25, 2016, the day Fonseca says her son actually died. *Id.* ¶¶ 61–62. The question here is whether that change, or any other in the Third Amended Complaint, provides Fonseca with standing to pursue her claims in this forum. As explained below, the court concludes they do not.

As in the Second Amended Complaint, Fonseca alleges she was harmed when doctors, following the definition and procedures set forth in CUDDA, determined her son had died. TAC ¶¶ 38–40. That determination, she alleges, led to the withdrawal of Israel's life support. *Id.* ¶¶ 54, 59. Fonseca's amended complaint thus establishes an "injury in fact." *Cf.* Prior Order at 9. Even before the withdrawal of life support, the threat of removal while Israel was allegedly "biologically alive" was sufficiently concrete, particularized, and imminent. *Id.*

[5] Although the parties did not raise the issue, the withdrawal of life support might moot this case. *See Protectmarriage.com-Yes on 8 v. Bowen*, 752 F.3d 827, 834 (9th Cir. 2014) (citations omitted) (case moot where "federal court can no longer effectively remedy a 'present controversy' between the parties"). This case might trigger the "capable of repetition, yet evading review" exception to mootness, because life support was maintained only by removing Israel from this country. *See also McMath v. California*, 15-CV-06042-HSG, 2016 WL 7188019, at *1 (N.D. Cal. Dec. 12, 2016) (brain dead patient sustained on life support by moving her to state with religious exception for determination of death). On the other hand, because life support can be continued after the determination of death, this case may not be of "inherently limited duration" to trigger that exception. *Bowen*, 752 F.3d at 836 (quoting *Doe No. 1 v. Reed*, 697 F.3d 1235, 1240 (9th Cir. 2012)). Alternatively, the addition of an organizational plaintiff here may create an ongoing controversy. *See Abigail All. for Better Access to Developmental Drugs v. Eschenbach*, 469 F.3d 129, 132–33 (D.C. Cir. 2006) (organization that assisted terminally ill patients had standing to challenge FDA policies without regard to whether organization's members continued to live). The court need not resolve this question, as both plaintiffs here lack standing in the first instance.

(citing *Harris*, 366 F.3d at 761). The new allegations of the actual withdrawal of life support only bolster the court's finding of a cognizable injury. But as with the previous complaint, the Third Amended Complaint does not establish the remaining requirements of causation and redressability.

To establish causation, Fonseca must draw a fairly traceable causal chain between her injury and defendant's conduct, unbroken by the independent actions of some third party. *Ass'n of Pub. Agency Customers v. Bonneville Power Admin.* (*Bonnerville Power*), 733 F.3d 939, 953 (9th Cir. 2013). "[A] causal chain does not fail simply because it has several links, provided those links are not hypothetical or tenuous and remain plausible." *Native Vill. of Kivalina v. ExxonMobil Corp.*, 696 F.3d 849, 867 (9th Cir. 2012) (citations, quotations, and brackets omitted).

Here, Fonseca's causal story is that CUDDA causes doctors to declare a brain dead patient to be dead, which in turn causes doctors to withdraw life support. Both links in the chain are speculative. First, CUDDA does not require a declaration of death, although it includes brain death as one of two independent grounds for making such a determination. Cal. Health & Safety Code § 7180(a)(1)–(2). Fonseca conceded this point at hearing, but argued CUDDA "empowers" doctors to declare a brain dead patient to be deceased and provides a social and cultural context in which such a determination is acceptable. Even if true, under CUDDA, that determination "must be made in accordance with accepted medical standards." Cal. Health & Safety Code § 7180(a). This requirement leaves the ultimate decision to the discretion of third-party doctors implementing standards that the statute itself does not identify or define. To the extent Fonseca argues that medical standards vary and that "the determination of brain death can differ from patient to patient depending on the protocol chosen," TAC ¶ 67, this argument bolsters the court's conclusion in effectively if not expressly conceding CUDDA does not prescribe a protocol. *See In re Guardianship of Hailu*, 361 P.3d at 530 (suggesting two protocols, the so-called "Harvard criteria" and the newer American Association of Neurology guidelines, could both be the "accepted medical standard" under Nevada's substantially similar Uniform Determination of Death).

Second, Fonseca has not shown that a doctor's declaration of death, independently confirmed, necessarily leads to the withdrawal of life support. A doctor may no longer face criminal or civil liability for withdrawing life support after a determination of death has been made, but "[t]his does not mean the hospital or the doctors are given the green light to disconnect a life-support device . . . ." *Dority*, 145 Cal. App. at 280. A parent has a right to consultation and participation in the decision to withdraw life support. *Id.* In other words, the decision to withdraw life support is ordinarily the product not only of third-party doctors implementing independent standards while also consulting with the patient's family; to the extent that Fonseca alleges doctors did not properly consult her before withdrawing life support, her claim is against those doctors who allegedly failed to follow state law and not with the law itself. Thus, both steps in Fonseca's causal story turn on "independent actions of third parties that break the causal link between" CUDDA and Fonseca's injury. *Bonneville Power*, 733 F.3d at 953 (quoting *Lujan*, 504 U.S. at 560). Fonseca has not established causation.

To establish redressability, Fonseca must show "a substantial likelihood that the relief sought would redress the injury." *Mayfield v. United States*, 599 F.3d 964, 971 (9th Cir. 2010) (citation omitted).

The Third Amended Complaint seeks two forms of relief: a declaration that CUDDA is unconstitutional either on its face or as applied and an order amending Israel's medical records to indicate August 25, 2016, the day his heart stopped beating, as the date of death. TAC Prayer ¶¶ 1–3. The first remedy would not redress Fonseca's injury. Invalidating CUDDA would not reverse or otherwise impact the medical opinion that Israel died on April 14, 2016. *Cf.* Prior Order at 11. Due to an attenuated chain of causation, Fonseca has not shown a "substantial likelihood" that declaring CUDDA unconstitutional would redress her injury. *Id.* at 11–13 (citing *Simon v. E. Kentucky Welfare Rights Org.*, 426 U.S. 26, 43 (1976); *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1124 (9th Cir. 2006)). Fonseca has not provided any basis for the court to revisit its prior conclusion.

The court is without power to provide the second remedy, amending the declaration of death. Also as explained in the court's prior orders, although the *Rooker-Feldman*

doctrine could permit this court's entertaining a general challenge to CUDDA's constitutionality, the doctrine prohibits this court from disrupting or undoing a prior state-court judgment. Prior Order at 7–8; *see also* ECF No. 48 at 6–7 (citing *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923); *District of Columbia Court of Appeals v. Feldman*, 460 U.S. 462 (1983)). Here, two state courts have reviewed the determination of death. *See* Place County Order; Los Angeles County Order. This court may not act as a *de facto* appellate court to review those judgments. *Cf. Feldman*, 460 U.S. at 466–68, 87 (graduates of unaccredited law school could not seek relief in federal court of state court's application of rule prohibiting them from sitting for state's bar exam, but could challenge only the rule itself).

The court is thus unable to redress Fonseca's alleged injury of loss of medical insurance coverage and government benefits flowing from an incorrect date of death. *See* TAC ¶ 63; Opp'n at 14. The court also cannot review whether doctors' determination of death here was "made in accordance with accepted medical standards." Cal. Health & Safety Code § 7180(a). To the extent Fonseca alleges doctors applied a protocol that was not an "accepted medical standard" and that doctors would have found signs of life had they conducted an EEG under the "Harvard criteria," that argument appears to belong in a state appellate court, if it can be made in this case at this point. *See In re Guardianship of Hailu*, 361 P.3d at 532 (Nevada Supreme Court's reversal of trial court's denial of injunction and remand for further consideration regarding which protocols were consistent with accepted medical standards). Alternatively, Fonseca's recourse lies with the state legislature or the Uniform Law Commission. Although California has not adopted the religious exemption Fonseca seeks, she may advocate for a change in state law, with New Jersey's enactment of a similar exemption as a model. *See* N.J. Stat. § 26:6A-5. But none of this addresses the fundamental defect in Fonseca's case here, as this court cannot redress her injury.

Fonseca has not established causation or redressability to support her standing. The court next evaluates whether the outcome is any different for LLDF, the newly named plaintiff in the Third Amended Complaint.

C. Organizational Standing

An organization can have standing on its own behalf, *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 378–79 (1982), or on behalf of its members, *Friends of the Earth, Inc. v. Laidlaw Envtl. Services (TOC), Inc.*, 528 U.S. 167, 181 (2000). LLDF proceeds on both bases. *See* TAC ¶ 4.

To sue on behalf of its members, an association must show "[1] its members would otherwise have standing to sue in their own right, [2] the interests at stake are germane to the organization's purpose, and [3] neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Friends of the Earth*, 528 U.S. at 181 (citing *Hunt v. Wash. State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1977)). Here, LLDF's associational standing fails with the first element. While LLDF provides no detail about any member, the court assumes Fonseca is a member or client[7], as counsel argued at hearing. And Fonseca lacks standing for the reasons discussed above. Because plaintiffs have not shown LLDF's members or clients would otherwise have standing to sue in their own right, LLDF does not have standing to sue on behalf of its members here.

To sue on behalf of itself, an organization must show the same "irreducible constitutional minimum of standing" that applies to an individual, which requires (1) injury in fact; (2) causation; and (3) redressability. *La Asociacion de Trabajadores de Lake Forest v. City of Lake Forest*, 624 F.3d 1083, 1088 (9th Cir. 2010) (citing *Havens Realty*, 455 U.S. at 378). An organization can establish injury by showing it suffered "both a diversion of its resources and a frustration of its mission." *Fair Hous. of Marin v. Combs*, 285 F.3d 899, 905 (9th Cir. 2002). An organization cannot manufacture injury by "incurring litigation costs or simply choosing to spend money fixing a problem that otherwise would not affect the organization at all." *La Asociacion de Trabajadores*, 624 F.3d at 1088 (citing *Fair Employment Council v. BMC Mktg. Corp.*, 28

[7] The court assumes without deciding that LLDF's "clients," as argued by counsel at hearing, are the constitutional equivalent of "members" for which an organization may assert associational standing.

F.3d 1268, 1276–77 (D.C. Cir. 1994)). "It must instead show that it would have suffered some other injury if it had not diverted resources to counteracting the problem." *Id.*

Here, plaintiffs sufficiently allege LLDF's injury. LLDF's mission "focuses on preservation of the lives of the most vulnerable members of society, including the very young and those facing the end of life." TAC ¶ 4. That mission is frustrated by "attempts by medical facilities to remove life-support for members of the public whose loved ones are declared brain dead, though they are not biologically dead." *Id.* LLDF also diverts significant time and resources to resist those attempts to withdraw life support, in counseling families, negotiating with hospitals, engaging in litigation and raising funds for these purposes. *Id.* LLDF has sufficiently alleged a frustration of its mission and a diversion of its resources to support injury.

Like Fonseca, however, LLDF's injury is not plausibly caused by CUDDA and will not be redressed by the remedies plaintiffs seek. Plaintiffs allege LLDF's mission is frustrated "[d]ue to the CUDDA protocol described herein." TAC ¶ 4. As discussed above, the complaint does not identify a precise protocol that CUDDA requires, but points instead to multiple types of protocols for brain death used in the medical community. *Id.* ¶ 67. As does Fonseca's causal story, then, LLDF's turns on the independent actions of third-party doctors, implementing medical standards that the statute does not define or require. LLDF has not established causation. Nor has it shown a "substantial likelihood" that declaratory relief will redress the frustration of LLDF's mission. LLDF fails to establish the causation and redressability prongs for constitutional standing.

IV. CONCLUSION

Plaintiffs have not shown they have standing to pursue their claims and the complaint must be dismissed. In the court's prior order concluding the same, the court granted leave to file a third amended complaint in light of arguments and subsequent events not reflected in the second amended complaint. Prior Order at 13. Plaintiffs now have not provided a basis to suggest granting leave to file a fourth amended complaint would not be futile. Accordingly, the court GRANTS the motion to dismiss without leave to amend.

The Clerk of the Court is directed to enter judgment and close this case.

This order resolves ECF No. 83.

IT IS SO ORDERED.

DATED: September 22, 2017.

Docket No. 17-17153

In the

United States Court of Appeals

For the

Ninth Circuit

JONEE FONSECA, an individual parent and guardian of I.S., a minor and LIFE LEGAL DEFENSE FOUNDATION,

Plaintiffs-Appellants,

v.

KAREN SMITH, M.D. in her official capacity as Director of the California Department of Public Health,

Defendant-Appellee.

Appeal from a Decision of the United States District Court for the Eastern District of California, No. 2:16-cv-00889-KJM-EFB · Honorable Kimberly J. Mueller

EXCERPTS OF RECORD
VOLUME II OF V – Pages 17 to 283

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UNITED STATES DISTRICT COURT
FOR THE
EASTERN DISTRICT OF CALIFORNIA

OFFICE OF THE CLERK
501 "I" Street
Sacramento, CA 95814

JONEE FONSECA,
Plaintiff

v.

CASE NO. 2:16−CV−00889−KJM−EFB

KAREN SMITH, ET AL.,
Defendant

You are hereby notified that a Notice of Appeal was filed on **October 19, 2017** in the above entitled case. Enclosed is a copy of the Notice of Appeal, pursuant to FRAP 3(d).

October 20, 2017

MARIANNE MATHERLY
CLERK OF COURT

by: /s/ H. Kaminski
Deputy Clerk

UNITED STATES DISTRICT COURT
FOR THE
EASTERN DISTRICT OF CALIFORNIA

OFFICE OF THE CLERK
501 "I" Street
Sacramento, CA 95814

TO: **CLERK, U.S. COURT OF APPEALS**

FROM: **CLERK, U.S. DISTRICT COURT**

SUBJECT: **NEW APPEALS DOCKETING INFORMATION**

CASE INFORMATION

USDC Number:	**2:16−CV−00889−KJM−EFB**
USDC Judge:	**DISTRICT JUDGE KIMBERLY J. MUELLER**
USCA Number:	**NEW APPEAL**
Complete Case Title:	**JONEE FONSECA vs. KAREN SMITH**
Type:	**CIVIL**
Complaint Filed:	**4/28/2016**
Appealed Order/Judgment Filed:	**9/25/2017**
Court Reporter Information:	**Jennifer Coulthard**

FEE INFORMATION

Fee Status: Paid on 10/19/2017 in the amount of $505.00

Information prepared by: /s/ **H. Kaminski , Deputy Clerk**

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GURDIAN OF ISRAEL STINSON, A MINOR, LIFE LEGAL DEFENSE FOUNDATION, Plaintiffs, v. KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; AND DOES 2-10, INCLUSIVE, Defendants.	2:16-cv-00889-KJM-EFB **NOTICE OF APPEAL TO THE UNITED STATES COURT OF APPEALS; REPRESENTATION STATEMENT**

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, and LIFE LEGAL DEFENSE FOUNDATION appeal to the United

States Court of Appeals for the Ninth Circuit from the final Judgment of the District Court, entered in this case on September 25, 2017, and the Order Granting Defendants' Motion to dismiss under Federal Rule of Civil Procedure Rule 12(b)(1) and (6), dated September 25, 2017.

Dated: October 19, 2017

/S/ Kevin Snider
Kevin T. Snider
Attorney for Jonee Fonseca & Life Legal Defense Foundation

REPRESENTATION STATEMENT

The undersigned represents Jonee Fonseca, an individual parent and guardian of Israel Stinson, and Life Legal Defense Foundation, Plaintiffs and Appellants in this matter. Below is a service list that shows all of the parties to the above-encaptioned action and identifies their counsel by name, firm, address, telephone and fax numbers, and e-mail addresses. (F.R.A.P. 12(b); Circuit Rule 3-2(b)).

Respectfully submitted,

Dated: October 19, 2017

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GURDIAN OF ISRAEL STINSON, A MINOR, LIFE LEGAL DEFENSE FOUNDATION, Plaintiffs v. KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; AND DOES 2-10, INCLUSIVE, Defendants.	2:16-cv-00889-KJM-EFB **APPELANTS' NOTICE AND STATEMENT OF ISSUES**

1. Whether the District Court erred in granting Defendants-Appellees Motion to Dismiss under Federal Rule of Civil Procedure 12(b)(1), as to Plaintiff Jonee Fonseca, without leave to amend for lack of subject matter jurisdiction.

2. Whether the District Court erred in granting Defendants-Appellees Motion to Dismiss under Federal Rule of Civil Procedure 12(b)(6), as to Plaintiff Jonee Fonseca, without leave to amend for failure to state a claim upon which relief can be granted.

3. Whether the District Court erred in granting Defendants-Appellees Motion to Dismiss under Federal Rule of Civil Procedure 12(b)(1), as to Plaintiff Life Legal Defense Foundation, without leave to amend for lack of subject matter jurisdiction.

4. Whether the District Court erred in granting Defendants-Appellees Motion to Dismiss under Federal Rule of Civil Procedure 12(b)(6), as to Plaintiff Life Legal Defense Foundation, without leave to amend for failure to state a claim upon which relief can be granted.

Dated: October 19, 2017

/S/ Kevin Snider
Kevin T. Snider
Attorney for Jonee Fonseca & Life Legal Defense Foundation

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
BEFORE THE HONORABLE KIMBERLY J. MUELLER, JUDGE

---o0o---

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR; LIFE LEGAL DEFENSE FOUNDATION,

Plaintiffs,

Vs.

CASE NO. 2:16-CV-0889 KJM
APPEAL NO. 17-17153

KAREN SMITH, M.D., IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, AND DOES 2-10, INCLUSIVE,

Defendants.
_____/

---o0o---

REPORTER'S TRANSCRIPT OF PROCEEDINGS
RE: DEFENDANT'S MOTION TO DISMISS
FRIDAY, SEPTEMBER 8TH, 2017 - 10:20 A.M.

---o0o---

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(Appearances continued on page 2)

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TRANSCRIPT PRODUCED BY COMPUTER-AIDED TRANSCRIPTION

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---o0o---

SACRAMENTO, CALIFORNIA, FRIDAY, SEPTEMBER 8TH, 2017, 10:20 A.M.

---o0o---

THE CLERK: Calling Civil Case 16-889, Fonseca versus Kaiser Permanente Medical Center Roseville, et al. On for defendant's motion to dismiss.

THE COURT: Good morning. Appearances, please.

MR. MCREYNOLDS: Good morning, Your Honor. Matthew McReynolds for the plaintiff, Jonee Fonseca.

MR. SNIDER: Kevin Snider for the plaintiff.

THE COURT: All right. Good morning to you each.

MS. NORTON: Good morning, Your Honor. Ashante Norton with the Office of the Attorney General representing defendant, Karen Smith.

THE COURT: For plaintiffs' attorneys, is one of you representing the organizational plaintiff?

MR. MCREYNOLDS: She is -- Miss Snyder is not with us today, Your Honor.

MS. SNYDER: I actually am here.

MR. MCREYNOLDS: I spoke too soon.

THE COURT: Is there an attorney representing that organizational client?

MS. SNYDER: I apologize, Your Honor. Alexandra Snyder with Life Legal Defense Foundation.

THE COURT: That is Snyder, S-n-y-d-e-r?

MS. SNYDER: That's correct.

THE COURT: All right. I have a few questions here. The court is well familiar with this case, and I will give a brief opportunity to argue at the end if you feel there is not something fully covered by the briefing or our discussion.

Just a question as to the record. Any reason for me not to, again, take notice of the state court pleadings to the extent they're relevant here?

Mr. McReynolds?

MR. MCREYNOLDS: Yes. I'm not aware of any reason, Your Honor. I don't know that they're highly relevant. I think we can look at the face of the complaint, but have no objection to Your Honor taking notice again.

THE COURT: All right. Miss Norton?

MS. NORTON: No objection, Your Honor.

THE COURT: All right. It is not my job to litigate the parties' case, but an obvious question, I think, on one level is mootness. No one argues this case is moot, and it makes me wonder about one aspect of the pleadings.

One of the requests is that the date on the death certificate be modified. And there is a reference in the body of the complaint to an impact on medical insurance and benefits, but there is no prayer for relief that relates to benefits and insurance.

Am I reading the complaint correctly, Mr. McReynolds, Mr. Snider.

MR. MCREYNOLDS: Yes, Your Honor. The first prayer for relief is directed toward expungement of the record, and then I believe our position would be that other things that would flow from that may well include benefits and access. But you are correct, that is not directly included in the prayer for relief.

THE COURT: And that is understood, Miss Norton?

MS. NORTON: It is understood in terms of how Your Honor has framed the question, the prayer for relief definitely does not include any sort of rule or order regarding access to these benefits. But I would actually agree that that request, to the extent that they would impact his access to insurance, is mooted at this point.

THE COURT: All right. Let's talk about standing which continues to be a threshold question in the case. The plaintiffs repeatedly cite what they term the CUDDA, the California Uniform Determination of Death Act protocol, but isn't that overstatement looking at the face of the statute.

While it does define death in two alternative ways, it ultimately leaves the decision up to contemporary medical standards in so many words.

So doesn't CUDDA avoid actually putting in place a protocol and signals the legislature's reliance on medical professionals?

MR. MCREYNOLDS: Well, a few things in response to

that, Your Honor.

First of all, we have briefed so I won't repeat why we believe that definitions can trigger liability for the state government.

We think that's true with the beginning of life. Certainly it is true also at the end of life. And so we think definitions can actually result in liability and in need of a remedy by themselves. But I think we've gone well beyond that in this case because the two institutional institutions, the hospital, first Kaiser Permanente in Roseville, and then the Children's Hospital of Los Angeles, relied upon the death certificate in order to reach -- to decide that the family did not have a role in this life and death decision.

And as to Kaiser, we have noted that throughout the 30s paragraphs, paragraph 31, it talks about Kaiser invoking the statute as a reason why the parents were not able to participate in the final decision.

Paragraphs 34 and 39 continue that theme with Kaiser invoking and relying upon the statute. And then down, with Children's Hospital of L.A., at paragraphs 58 to 60, you have the death certificate being brought into the Superior Court there as the reason why the parents could not do anything about the termination of life support.

So we believe in a very real sense it goes well beyond definitions. And I think if you look at all the cases dealing

withstanding, beginning in with Lujan and extending to the Ninth Circuit, Seventh Circuit and D.C. Circuit cases, it talks about the causation element in particular as being something less than even proximate causation.

And so we've pled direct and proximate causation from the death certificate leading to the decision to end life support. And the standard is actually below what we've pled. So we think we've more than met that.

The cases from Lujan to the Harris versus Board of Supervisors case, that Your Honor has mentioned before, the Maya versus Centex case, talk about the causal chain being able to have several links so long as it is not attenuated.

And if the hospitals are invoking and relying upon the state statute as we've pled that they have, we think that's far from attenuated. So I can say more about that, but...

THE COURT: Here's my follow-up question given your reference to the hospitals relying on the statute. The complaint does not specifically allege that a doctor who did not desire to declare a patient dead based on brain death was required to under CUDDA. The complaint doesn't say that, does it?

MR. MCREYNOLDS: I think what we're alleging in terms of liability is that the facilities and the doctors believe that whether they're correct or not, they believe that the CUDDA statute dictates a certain outcome, and it empowers them

to prevent parents from having a say in termination of life support.

THE COURT: It gives them no choices given the ability to -- given their obligation to know their profession and apply their profession's accepted standards?

MR. MCREYNOLDS: I wouldn't say, Your Honor, that it gives them no choice, but I would say that that's not the standard for Article III causation. You can have joint tortfeasor as the Seventh Circuit has noted in the K.H. decision from Judge Posner that we have cited in our papers. You cannot have a joint tortfeasor situation.

What you can't have, withstanding Lujan and all of its progeny, as well as its predecessors, is a situation where, say, we're arguing that one particular defendant should be responsible for all the ills of global warming or of the housing crisis or something like that. And that's what a lot of the cases parse out.

You know, I would point the court's attention in particular to the Abigail Alliance case from the D.C. Circuit where the court said a number of important things about organizational standing which is important since we now have life --

THE COURT: We'll get to organizational standing.

MR. MCREYNOLDS: Okay. But it also addresses beyond organizational standing the core issues of causation and redressability. And what you have there was a situation where

the plaintiffs were pleading that the FDA had both a private stance and that it erected hurdles, was the word they used, to the plaintiffs being able to access drug trials.

Those weren't drug trials put on by the federal government. They were drug trials put on by drug companies. So the FDA argued, very much like the state is arguing here, Well, there is no -- there is not enough of a link, we don't know if a favorable court ruling will do anything to change what the drug companies are doing. And D.C. Circuit simply disagreed with that. And we think that's highly relevant, and we don't see -- really see a way around that in this case without just flatly disagreeing with that court.

THE COURT: So on redressability -- so let's just assume for sake of argument that the court does invalidated CUDDA, wouldn't -- don't doctors still implement the same accepted medical standards, and those medical standards, separate and apart from statute, currently are consistent with the statutory definition; are they not?

MR. MCREYNOLDS: Not entirely, Your Honor. And for this I would point you to the decision of the Nevada Supreme Court in the Gebreyes versus Prime Healthcare, also known as In Re: Hailu decision, if I'm pronouncing that right.

And the Nevada Supreme Court wrestled with a lot of these same kinds of questions, and was very, very troubled by the fact that we've identified in our papers that there are so many

different types of protocols that can be -- that hospitals and physicians think are accepted medical standards.

And the Nevada Supreme Court said that we're not, at all, convinced by that. At the adoption of the Uniform Determination of Death Act, it was the Harvard criteria, which most notably involves the use of an EEG.

The EEG not being used by Kaiser or by Children's Hospital of Los Angeles, in this case, became a big deal. And so to the Nevada Supreme Court, and we think, you know, rightfully so -- this is not just an issue about what the hospitals do, it is fundamentally an issue about what the state is doing to enable the deprivation of life without procedural or substantive due process of law.

THE COURT: But there is no allegation that if only accepted medical standards applied here that the doctors would have acted differently.

MR. MCREYNOLDS: Your Honor, the implication is that a change in the law necessarily would trigger a change in behavior.

To be sure, we could not say that doctors wouldn't act illegally, they wouldn't act criminally, but if you look at some of the leading state cases on this, for instance the Dority case, as well as Donaldson versus Lungren, what you have is the courts noting in similar circumstances end of life, termination of life support cases.

First in Dority, the necessity of these types of statutes being implemented in order to insulate the doctors and hospitals from liability for terminating life support with the full agreement of the family. And what you don't have in any of those cases is what we have here, which was termination of life support without the consent of the family.

And so that's a big, big difference. I think in Dority, as well as Donaldson, it was an assisted suicide case where the plaintiffs were going to court seeking an injunction that would insulate them from liability for participating in cryogenic preservation.

They felt the need to do that precisely because doctors don't continue to act however they want to act regardless of changes in the law. We think that's a fallacy that the state has put forward.

THE COURT: Miss Norton, response to that argument in particular, whether or not elimination of CUDDA would make any difference?

MS. NORTON: I think that the plaintiffs here have continued to dodge the court's question about whether or not in the absence of CUDDA there would be some sort of automatic change in the prevailing medical standards in the community which widely recognizes brain death.

One of the critical components that I have not heard from the plaintiffs here is the fact that even prior to CUDDA, the

medical community recognized brain death. That is what lead to UDDA being instituted and then adopted by now all of the 50 states is the medical community recognizes brain death as a means of determining death in this country.

And eliminating CUDDA, there is no factual allegation or evidence or indication that there would be this wide, sweeping change or alteration in physicians making brain death determinations but for CUDDA.

That's the critical missing component, I think, in terms of this redressability issue is even if this court were to invalidate or strike CUDDA from this state's laws, there is no indication that the physicians in this particular case that determined -- the three physicians that determined that Israel suffered brain death would reverse their determination.

THE COURT: All right. If you want to return to that and wrap up, I believe I understand the parties' positions.

I do have a question about LLDF standing. Are you arguing for all parties, Mr. McReynolds?

MR. MCREYNOLDS: Yes, Your Honor. I can defer to Miss Snyder, though, depending on how detailed the court's questions are.

THE COURT: It is fundamental. I just want some clarification. So an organization can have standing on its own behalf or on behalf of its members.

So am I correct in understanding LLDF is asserting

organizational standing on its own behalf, as opposed to associational standing?

MR. MCREYNOLDS: I believe that it has both, Your Honor. And again, our leading authority for that is the Abigail Alliance case out of the D.C. Circuit. They explain, I think in great detail, both organizational and representational standing.

We have tracked that pretty closely. We've explained, particularly on the organizational side of standing, that LLDF's mission and purposes are frustrated by the Uniform Determinative -- sorry -- the Uniform Determination of Death Act.

We've pled general allegations. LLDF, I'm certain, can get much more specific about the ways in which their purposes are frustrated, but...

THE COURT: Essentially, it -- to the extent it is that original standing -- let's assume both for sake of argument -- organizational standing, its claims track Miss Fonseca's claims, correct?

The causal narrative is the same as Miss Fonseca's?

MR. MCREYNOLDS: The causal narrative is the same, Your Honor.

THE COURT: To the extent it is associational standing, I think I have to read between the lines, is Miss Fonseca a member of LLDF?

I don't see that a member of LLDF is identified in the current complaint.

MR. MCREYNOLDS: That's a keen observation, Your Honor. Legal firms, like LLDF and like ours, for that matter, don't generally have members in the same sense that other organizations do, we have clients. And so I think the clients and members are -- Miss Snyder can correct me on that if I wrong, a membership with LLDF.

But we understand clients and members to be functionally equivalent in the organizational and representational standing equation.

THE COURT: So Miss Fonseca's is a client of LLDF.

MS. SNYDER: That's correct, Your Honor.

THE COURT: Anything to add, Miss Snyder, on that point, organizational versus associational?

MS. SNYDER: Not on that point. But if you'll permit me to go back to the Fonseca case and the cases like that that we have litigated and anticipate litigating, when Israel Stinson was transferred out of Kaiser Hospital, he actually was transferred outside of the country to another hospital that did an EEG, the first EEG he had had that did show brain activity.

He was then transferred to Children's Hospital, and because of California's adoption of the Universal (sic) Declaration of Death Act, that hospital did not believe it had any obligation to do another brain scan or any other tests on this little boy

who four or five months after the initial declaration of death was still -- still had a beating heart, was growing, was healing from infections and, you know, exhibiting signs of life. And yet, because of the statute -- I'm sorry -- because of the statute, his life was terminated without his parents' consent.

In fact, they --

THE COURT: Because the statute, in your view, supported the signing of the death certificate?

MS. SNYDER: That's correct without any further examinations -- medical examinations.

THE COURT: All right. That's because you believe CUDDA does lay out a protocol?

MS. SNYDER: Yes. And that protocol effectively says that if -- if a physician sees no brain activity with that certain protocol, that that patient shall be declared brain dead.

THE COURT: I understand that position of the statute. I understand that position.

I have no further questions --

MS. SNYDER: Okay.

THE COURT: -- so I am prepared to allow final wrap-up argument, and then I'll submit the matter.

So anything you want to add, Miss Norton?

MS. NORTON: Yes, just briefly, Your Honor. I don't

want to just reiterate what's already in the parties' briefing, but I think this distinction is important here.

Even in the absence of CUDDA, there is still going to be physicians who have to make determinations of death based on the medical community's prevailing and accepted standard of care.

Even in the absence of CUDDA, those physicians will also have to sign death certificates determining whether or not an individual has, in fact, passed.

Counsel, just recently mentioned --

THE COURT: There is some exercise of discretion there.

MS. NORTON: Yes. CUDDA is silent on that exercise of discretion. It gives the physicians in this case the decision-making authority. CUDDA does not dictate what tests to run.

Counsel mentioned that, you know, there were not EKGs done. That discretion is vested in the physicians in the medical community. CUDDA does not dictate those determinations. CUDDA does not dictate, even once a physician determines that brain death has occurred, what has to happen next.

When you review the allegations in the complaint, it is obvious that the overriding concern and disagreement is with the recognition of brain death and the subsequent removal from life support. But CUDDA on its face is silent in that regard

and it does not mandate, direct or require a physician or a hospital to make those sorts of life ending determinations.

Again, that discretion is vested in the physicians and what is the accepted and prevailing standard within the medical community.

THE COURT: All right. Mr. McReynolds, Mr. Snider, anything further?

MR. MCREYNOLDS: Yes, Your Honor, just briefly.

There are a number of points in the briefs that I won't repeat. One we haven't gotten to today is the State Endangerment Theory that we put forward, as well as other arguments about how definitions can, in deed, trigger liability.

But I think really the most -- the most important thing is I would just urge the court to look carefully at what the Nevada Supreme Court had to say. They struggled in particular with this notion that hospitals or physicians can do a variety of different tests.

The Nevada Supreme Court was not convinced, at all, that that was consistent with having a uniform determination of death. They were very, very troubled by the differences that are the same kinds of differences we've seen in this case.

THE COURT: But under the Uniform Act.

MR. MCREYNOLDS: Correct.

THE COURT: There are multiple protocols given the --

given that it is up to doctors ultimately to define and apply the accepted medical standards.

MR. MCREYNOLDS: What the court was troubled by was that specifically in that case that there were no confirmatory EEGs done. And that those seemingly were the standard then at the time that UDDA and CUDDA were adopted with no evidence that that's changed in the last 35 years.

But I think more fundamentally, though, we keep talking about whether the statute has directed or required the doctors or physicians to do certain things. I think all of the cases that we've wrestled with, many of which we've briefed, fundamentally come down to whether there was a causal connection, the central second prong in the Lujan equation. Was there a causal connection.

It is something that can be below, direct and even proximate causation. It has to be something that is more than attenuated. I think we have -- we have presented that first Kaiser, then Children's Hospital of Los Angeles, relied upon the statute. We presented that as a factual matter. That's why we believe the motion to dismiss is improper and why the case has to proceed at least through discovery to allow us to identify that.

And just lastly, the cases also note that it is a different level of proof that is required for a motion to dismiss. It feels almost like we're talking about a summary judgment or a

further stage in the litigation that we haven't reached yet. It is a different standard of proof. And so I just respectfully ask the court to be mindful of that in the ruling.

Thank you.

THE COURT: All right. All right. Thank you very much. The matter is submitted. I will let you know my decision in a written order.

MS. NORTON: Thank you, Your Honor.

MS. SNYDER: Thank you, Your Honor.

(Whereupon, the matter was concluded.)

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REPORTER'S CERTIFICATE

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STATE OF CALIFORNIA)
COUNTY OF SACRAMENTO)

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

IN WITNESS WHEREOF, I subscribe this certificate at Sacramento, California.

/S/_Catherine E.F. Bodene_____
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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR; LIFE LEGAL DEFENSE FOUNDATION Plaintiff, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH,** Defendant.	2:16-cv-00889-KJM-EFB **DEFENDANT'S REPLY IN SUPPORT OF MOTION TO DISMISS THIRD AMENDED COMPLAINT** **[Fed.R.Civ.Proc. 12(b)(1), (6)]** Date: August 11, 2017 Time: 10:00 a.m. Dept: 3 Judge: The Honorable Kimberly J. Mueller Trial Date: not set Action Filed: 5/9/2016

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INTRODUCTION

Plaintiffs Fonseca (Fonseca) and Life Legal Defense Foundation (LLDF) (collectively, Plaintiffs) have been given ample opportunity to establish Article III standing and to perfect this Third Amended Complaint (TAC) to state cognizable claims against Defendant Karen Smith, M.D., Director of Public Health (Director). Yet again, Plaintiffs have failed to do so.

It remains that this action should be dismissed for lack of standing. Fonseca makes no showing that the injuries alleged—the loss of Israel's life and the determination that Israel died on April 14—were caused by the Director or CUDDA, rather than the independent medical decisions of non-party doctors. Nor can Fonseca establish redressability, as there is no indication that the physicians who determined Israel's date of death would reach a different conclusion in the absence of CUDDA.

Similarly, LLDF, which works to resist attempts by medical facilities to remove life-support, fails to establish that CUDDA directs such facilities or their physicians to so act. Additionally, LLDF states no facts demonstrating that invalidating CUDDA will impact the medical opinions that individuals have suffered brain death and/or the recommendation that life-support should be withdrawn in those instances.

Nor have Plaintiffs shown that they can state cognizable claims against the Director for any asserted constitutional violation.

Finally, because Fonseca continues to assert "as applied" claims, which aim to reverse the Superior Court's ruling upholding the medical determination that Israel died on April 14, 2016, they are barred by the *Rooker-Feldman* doctrine.

For the reasons set forth below and those stated in the Director's Motion, the TAC should be dismissed without leave to amend.

I. FONSECA LACKS STANDING

A. CUDDA's Enactment Has Not Caused Fonseca's Harm

As stated in the Motion, the Article III standing test requires Fonseca to demonstrate that there is a causal connection between her alleged injuries and the conduct complained of; the injury has to be "fairly traceable to the challenged action of the defendant, and not the result of

the independent action of some third party not before the court." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992) (citations omitted). Accordingly, Fonseca must demonstrate that the injuries alleged—loss of Israel's life and determination that he died on April 14, 2016—stem from compliance with CUDDA. Despite being given repeated opportunities to so state, Fonseca has not sufficiently articulated how CUDDA's enactment ended Israel's life or *compelled* private physicians to act.

Fonseca summarily asserts that the "State bears ultimate culpability for the taking of Israel's life." Opposition to Motion to Dismiss TAC (Opp.), 2:6-11. Fonseca's conclusory opinion, however, does not satisfy her burden to allege facts showing causation. As a threshold matter, Fonseca cannot show causation because CUDDA, by its express terms, defers the actual determination of death to physicians based on medical standards. Cal. Health & Safety Code § 7180 ("A determination of death must be made in accordance with accepted medical standards."). Fonseca's opposition fails to address this shortcoming in her causal claims. Nor has Fonseca alleged any other facts that would show *CUDDA* caused Fonseca's alleged injuries. Indeed, Fonseca concedes that the determination that Israel suffered brain death and the decision to remove life support were made by physicians, and not the result of any mandate by CUDDA. See TAC ¶¶ 23-24, 54, 61. Thus, because Fonseca has not, and cannot, allege that CUDDA directed the decisions at issue, Fonseca cannot sustain her claim that CUDDA caused Israel's death. See *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citing *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 557 (2007) (A complaint does not "suffice if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.'").

Next, Fonseca contends that CUDDA's definition of death, alone, is sufficient to meet her burden. Fonseca cites *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015), for the proposition that definitions can cause injury. Opp. at 2-3. Fonseca's reliance on *Obergefell* is misplaced. The statutes at issue in *Obergefell*—by definition—prohibited officials from issuing marriage licenses to same-sex couples or recognizing same-sex unions that were performed in other states. Quite unlike the statutes at issue in *Obergefell*, CUDDA defers the actual decision making to third parties. It provides that "[a] determination of death must be made in accordance with accepted

medical standards." Cal. Health & Safety Code § 7180(a). Thus, under CUDDA, physicians have discretion to make such determinations in accordance with their medical judgment, and nothing in CUDDA directs or prohibits them from taking the actions that they determine are medically appropriate.

Fonseca also mentions CUDDA's protocols regarding record-keeping, but does not address how these post-death determination protocols have caused her asserted injuries—loss of Israel's life and determination that he died on April 14. These administrative tasks have no bearing on Fonseca's injuries. Simply put, Fonseca has failed to proffer any facts or argument establishing that she has been injured by application of CUDDA.[1]

Finally, Fonseca, relying on *Lujan*, *supra*, argues that she has pled causation because Israel was the object of the challenged statute. Opp. at 5. *Lujan* does not support Fonseca's position. The Plaintiffs in *Lujan* called into question the scope of a federal regulation that required agencies to ensure that any authorized action or funding did not jeopardize endangered species. *Id.* at 558. The Court, in assessing whether the plaintiff environmental group had standing, reasoned that when the plaintiff is the object of the challenged action, "there is little question that the action or inaction has caused him injury." *Id.* at 561-562. Here, however, the action that caused Fonseca's alleged injury is not CUDDA (which is merely definitional), but rather the independent medical decisions of Israel's physicians. CUDDA has not caused Fonseca's injuries.

B. A Favorable Ruling Would Not Provide Fonseca the Relief She Seeks

Fonseca argues that a favorable ruling, i.e., "correcting" the date of death, will remedy the loss of medical insurance coverage and government benefits. Opp., at 7, *see also* TAC ¶ 63. Fonseca, once again, fails to address the fact that Kaiser physicians—who are not named in this action—declared that Israel died on April 14, not CUDDA or the Director. Fonseca speculates that if CUDDA is invalidated, these private physicians will reverse their medical opinions that

[1] Fonseca also cites *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Rounds*, 530 F.3d 724 (8th Cir. 2008) for the proposition that definitions alone cause harm. That case, however, offers no such support. *Planned Parenthood* involved a dispute over the *truthfulness and accuracy* of a statement that the State required be given to all women who sought an abortion. No such issues are involved here.

Israel suffered brain death on April 14. Opp. at 9-10. Fonseca, however, pleads no facts to support this speculative conclusion. As this Court previously recognized, "any pleading directed at the likely actions of third parties would almost necessarily be conclusory and speculative." ECF 79, 12 citing *Levine v. Vilsack*, 587 F.3d 986 (9th Cir. 2009). Such is the case here. Fonseca's injuries cannot be redressed by her claims against the Director.

For these same reasons, invalidating CUDDA will not restore Fonseca's stated loss of dignity caused by the declaration of death. Relying on *Obergefell*, Fonseca states that her and Israel's dignity can be restored by a favorable ruling. Opp. at 8. Once more, Fonseca's arguments fail because third party physicians, and not CUDDA or the Director, made the determination she now wishes to reverse. Fonseca has not met her burden to establish redressability.

II. LLDF Also Lacks Article III Standing Because It Fails to Allege That CUDDA Has Caused Its Injury Or that It Would Be Redressed By This Action

Like Fonseca, LLDF also lacks Article III standing. LLDF fails to establish that CUDDA caused its injury—frustration of its mission—and that the injury will be redressed by this action. LLDF leaves unaddressed the Director's argument that any frustration of LLDF's mission is the result of the independent decisions of medical professionals and hospitals, and not the result of CUDDA's mandate. Instead, LLDF simply reiterates, without facts, that "CUDDA's protocol" frustrates its work. Opp. at 9. Thus, just as in Fonseca's case, LLDF has pled no facts establishing that CUDDA has caused its injury.

LLDF's argument concerning redressability is also unpersuasive. LLDF suggests that invalidating CUDDA will deter physicians from rendering brain death declarations. It argues that this situation is akin to the time when physicians feared prescribing marijuana or assisting patients with end of life options because of the threat of criminal sanction. Opp. at 9-10. There, however, is no basis to conclude that physicians, in this context, fear censure or that they are likely to cease making such medical determinations if CUDDA is invalidated. LLDF has not alleged that—but for CUDDA—the medical community would abandon its recognition of brain death. Moreover, it has no basis to conclude that invalidating CUDDA will likely eliminate or

reduce its need to resist recommendations by physicians and attempts made by medical facilities to cease life-support measures. LLDF's suggestion that physicians will act differently is nothing more than speculation. Such conclusory and speculative statements, without factual allegations, are insufficient to satisfy LLDF's burden here. *Levine*, *supra*, 587 F.3d 997. A judgment against the Director here will not compel the medical community to reverse their medical opinions and protocols. See *Native Vill. of Kivalina v. ExxonMobil Corp.*, 696 F.3d 849, 867 (9th Cir. 2012) (Standing is lacking when the injury is "th[e] result [of] the independent action of some third party not before the court."). LLDF has not sufficiently alleged that invalidating CUDDA will redress its injury.

III. PLAINTIFFS STATE NO COGNIZABLE DUE PROCESS CLAIMS.

A. Plaintiffs Fail to Establish that CUDDA's Procedural Safeguards Are Unconstitutional.

"The fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner." *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976). Here, Plaintiffs' procedural due process challenges, both facial and as applied, fail to state a claim as a matter of law because California law provides—and Fonseca was in fact afforded—the right to challenge the determination of death. Plaintiffs, however, contend that notwithstanding these procedural protections, Fonseca and others similarly situated do not have a "realistic opportunity" to be heard. Opp. at 11. That is incorrect and Plaintiffs' arguments should be rejected.

Foremost, Plaintiffs here offer no response to the Director's argument that Fonseca was afforded the very process they now proclaim does not exist. *See* TAC ¶¶ 43-45. Plaintiffs do not dispute that Fonseca, not only challenged the Kaiser physicians' determination that Israel suffered brain death, but was also afforded the opportunity to secure her own independent assessment. ECF No. 14-2, 14-3, TAC ¶¶ 22-24. Only upon Fonseca's failure to proffer to the court competent medical evidence refuting the Kaiser physicians' determination, did the court dismiss her petition. ECF 14-8, 75:21-76:9, ECF 19-1, 2:5-6. Though Fonseca received several opportunities to be heard and to contest Kaiser's determination, Plaintiffs, citing *Aptheker v. Sec. of State*, 378 U.S. 500, 515 (1954), now dismiss this process solely because it is not expressly

included in CUDDA. Opp. at 12. *Aptheker*, however, does not support Plaintiffs' suggestion that due process requires that all protections have to be derived from the statute. Accordingly, Plaintiffs here fail to establish that judicial review of a brain death determination is not sufficient process.

Second, Plaintiffs' Opposition fails to address the additional safeguards that CUDDA provides as discussed by the Director's Motion. *See* § 7180(a) (requiring that all determinations of death be made in accordance with prevailing medical standards); *see also* § 7181 (requiring that in cases of brain death a single physician's opinion is insufficient; CUDDA requires *independent* confirmation by another physician).

Finally, Plaintiffs fail to identify—or even suggest— what different process they believe is constitutionally required under the circumstances. And, plaintiffs fail to discuss specifically what additional process (if any) Fonseca sought, but did not receive, in this case. Because Plaintiffs have not, and cannot, propose any additional facts that would bolster their First Cause of Action, it should be dismissed with prejudice.

B. Plaintiffs' Substantive Due Process Claims Are Also Without Merit.

Plaintiffs' substantive due process claims fail as a matter of law because CUDDA's enactment does not deprive anyone of life or liberty, and even if it did, the State's interests underlying CUDDA outweigh any individual interests in defining death differently. Motion at 14-16.

Plaintiffs maintain that *CUDDA* has deprived Israel and others of life. Opp. at 7, 10-11. However, CUDDA expressly provides that "[a] determination of death must be made *in accordance with accepted medical standards*." § 7180(a) (emphasis added). In cases of brain death, CUDDA also requires that before a patient is declared deceased "there shall be *independent* confirmation by another *physician*." *Id.*, § 7181 (emphasis added). Thus, CUDDA directs only that determinations of death be made according to accepted medical standards and be confirmed by an independent physician. Because Plaintiffs still fail to state encroachment—that *CUDDA* interfered with Fonseca's or Israel's rights—these claims should be dismissed on this ground alone.

Even if sufficient state involvement is established, Plaintiffs cannot demonstrate a constitutional violation. In her motion, the Director highlights the State's interests underlying CUDDA and argues that they should prevail when balanced against Fonseca's individual interests here. Motion at 15. Plaintiffs, in response, write off the State's interests and assert an unrestricted right to patient self-determination. Opp. at 13 (this "right of self-determination … is not subject to veto by the medical profession or the judiciary"). Plaintiffs argue that this includes the unquestioned right to determine whether to continue life-sustaining support. Opp. at 13. Plaintiffs, however, provide no support for such unfettered authority. Contrary to Plaintiffs' assertion, limits may be imposed by the State where competing legitimate interests are at stake, particularly where public health and safety are concerned. *See Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir. 1980) (no fundamental right to access drugs the FDA has not deemed safe and effective).

The cases cited by Plaintiffs are unpersuasive. Plaintiffs cite *Bartling v. Superior Court*, 163 Cal. App.3d 186 (1984), for the proposition that a person has an unfettered right to direct medical decisions and decisions to prolong life. Opp. at 13. This decision, however, also acknowledges that the asserted fundamental rights are not absolute and must be balanced against the interests of the State. *Bartling*, *supra*, at 195 ("Balanced against [privacy interests] are the interests of the state in the preservation of life, the prevention of suicide, and maintaining the ethical integrity of the medical profession."); see also *Abigail All. for Better Access to Developmental Drugs v. Eschenbach*, 469 F.3d 129, 138 (D.C. Cir. 2006) ("the inherent right of every freeman to care for his own body and health in such way as to him seems 'best' is not 'absolute,' … [citation]").

Additionally, Plaintiffs overstate the scope of parental rights here. Plaintiffs suggest that unless the courts have determined the parents to be incompetent, parents have carte blanche authority to make any and all decisions regarding their children. Opp. at 15-16. Plaintiffs' cited case, *In re AMB*, 248 Mich. App. 144 (2001), is unpersuasive because in that case, the court sought to determine who was empowered to make the decision to withdraw life-support when the parent was incompetent to do so. *In re AMB* does not stand for the proposition that parents

possess limitless decision-making authority; no such authority exists. The "state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare . . . ." *Prince v. Massachusetts*, 321 U.S. 158, 167 (1944). Although parents undoubtedly have a right to the "custody, care and nurture of the child," *id.* at 166; *Troxel v. Granville*, 530 U.S. 57, 65 (2000), the "rights of parenthood are [not] beyond limitation." *Prince*, 321 U.S. at 167.

Plaintiffs have been given many opportunities to support their claims that CUDDA is unconstitutional, yet they still fail to allege any facts demonstrating that CUDDA is arbitrary or unreasoned. ECF No. 48, at 24:17-18 (This court has previously observed that plaintiff provides no facts that "suggest [] CUDDA is arbitrary, unreasoned, or unsupported by medical science."). It remains that Plaintiffs' disagreement with the prevailing definition of death cannot override the State's interests in enacting CUDDA. Plaintiffs' Second Cause of Action fails as a matter of law.

IV. LIKE PLAINTIFFS' FIRST AND SECOND CAUSES OF ACTION, PLAINTIFFS' THIRD CAUSE OF ACTION FOR DEPRIVATION OF LIFE IN VIOLATION OF THE CALIFORNIA CONSTITUTION FAILS.

Plaintiffs allege that CUDDA "deprived Israel of his right to life" in violation of the California Constitution. TAC ¶ 84. As argued herein, the claims based on the loss of Israel's life fail because CUDDA did not cause Israel's death, nor compel Kaiser physicians to run tests and determine that he suffered brain death. Plaintiffs have not addressed these arguments, and thus their claims under the California Constitution should also be dismissed on this ground alone.

Plaintiffs also assert that by defining death, the State encroaches upon one's inalienable right to enjoy and defend life and privacy. Opp. at 17-18. Without factual or legal support, Plaintiffs state that CUDDA is inconsistent with such rights because it gives to medical providers the authority to determine that an individual suffers from brain death. Opp. at 18. That is incorrect. CUDDA does not "authorize" physicians to make determinations against the wishes of parents. Though CUDDA defines death, it is silent as to all aspects of the actual assessment and determination of death. Here, Plaintiffs seem to suggest that CUDDA requires physicians to make brain death determinations. It does not. Nothing in CUDDA requires physicians to act. And, nothing in CUDDA *prevents* physicians from exercising their independent medical

judgment as to whether a patient is deceased, under any definition. As discussed above, CUDDA expressly affords physicians the discretion to so determine.

Plaintiffs also argue that the State has no right to define death in a manner that conflicts with their personal beliefs. Opp. at 18-19. They, however, offer no support for this proposition. It has long been recognized that the "constitutional guaranties of life, liberty, and property are not absolute in the individual, but are always circumscribed by the requirements of the public good." *In re Moffett*, 19 Cal. App. 2d 7, 14 (1937). Thus, an individual possesses no absolute right to be entirely free from state involvement. The court, in determining whether a constitutional violation occurred, must balance the individual liberty interest at stake against the State's interests. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279 (1990) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)); *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1620 (1992). Here, the State's interests are vast, including, among others, the interests in drawing boundaries between life and death, ensuring that citizens receive quality health care, and ensuring that patients are treated with dignity, particularly at the end of their lives. Motion at 16. Plaintiffs have not addressed the State's interests or demonstrated that CUDDA is unreasonable or arbitrary. Accordingly, Plaintiffs have failed to state a claim under the California Constitution.

V. CUDDA DOES NOT VIOLATE THE RIGHT TO PRIVACY AND, THEREFORE, THE FOURTH AND FIFTH CAUSES OF ACTION SHOULD BE DISMISSED

Plaintiffs cannot establish that the State, by enacting CUDDA, has violated Fonseca's or Israel's right to privacy under the state and federal constitutions. It bears repeating that the medical decisions at issue were made by doctors according to prevailing medical standards and were not dictated by CUDDA. Motion at 17. Plaintiffs' argument in response is unavailing. Plaintiffs assert that individuals must have the unquestioned right to control decisions relating to their medical care. Opp. at 19. Yet, Plaintiffs allege no facts that *CUDDA* dictates whether life-sustaining support should continue.

Plaintiffs' claims fare no better even if the court proceeds to balance the interests of the parties. As stated in the Director's Motion, a parent's plenary authority over medical decisions for a child is not without its limits. Motion at 15-16. Plaintiffs offer no discussion or authority

that addresses the situation here: whether the right to dictate medical decisions should prevail once physicians determined that Israel suffered irreversible cessation of brain activity. Plaintiffs' Fourth and Fifth Causes of Action should be dismissed.

VI. THE *ROOKER-FELDMAN* DOCTRINE BARS THE "AS APPLIED" CLAIMS IN THE FIRST AND SECOND CAUSES OF ACTION.

Plaintiffs argue that *Rooker-Feldman* is limited to circumstances where a federal plaintiff alleges state court error and *expressly* seeks relief from the state court judgment. Opp. at 19-20. Plaintiffs also contend that the doctrine does not apply here because this action involves different defendants. *Id.* at 20. The doctrine, however, is not so narrowly limited. The focus is on the issues that were resolved by the state court and those now raised in the federal action, not on the parties. The doctrine precludes the exercise of jurisdiction not only over claims that are de facto appeals of a state court decision but also over suits that raise issues that are "inextricably intertwined" with an issue resolved by the state court. *See D.C. Court of Appeals v. Feldman*, 460 U.S. 462, 483, n. 16 (1983). As the Ninth Circuit has explained: "If claims raised in the federal court action are 'inextricably intertwined' with the state court's decision such that the adjudication of the federal claims would undercut the state ruling or require the district court to interpret the application of state laws or procedural rules, then the federal complaint must be dismissed for lack of subject matter jurisdiction." *Bianchi v. Rylaarsdam,* 334 F.3d 895, 898 (9th Cir. 2003). Such is the case here. In *Israel Stinson v. UC Davis Children's Hospital; Kaiser Permanente Roseville*, Case No. S-CV-0037673, the state court upheld the Kaiser physicians' determination that Israel died on April 14. ECF 14-8, 75:21-76:9, 19-1, 2:5-6. Fonseca here continues to dispute this determination and seeks an order from this Court reversing that determination. TAC ¶ 62, Prayer, ¶ 1. *Rooker-Feldman* bars Fonseca's "as applied" claims.

CONCLUSION

This court should dismiss the Third Amended Complaint without leave to amend.

Dated: August 4, 2017

Respectfully Submitted,

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CERTIFICATE OF SERVICE

Case Name: **Jonee Fonseca v. Kaiser Permanente Medical Center Roseville (CDPH)** No. **2:16-cv-00889-KJM-EFB**

I hereby certify that on August 4, 2017, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

DEFENDANT'S REPLY IN SUPPORT OF MOTION TO DISMISS THIRD AMENDED COMPLAINT

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on August 4, 2017, at Sacramento, California.

J. Hutcherson	/s/ J. Hutcherson
Declarant	Signature

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, LIFE LEGAL DEFENSE FOUNDATION Plaintiffs', v. KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; AND DOES 2-10, INCLUSIVE, Defendants.	2:16-cv-00889-KJM-EFB **OPPOSITION TO DEFENDANT'S MOTION TO DISMISS THIRD AMENDED COMPLAINT** Date: August 11, 2017 Time: 10:00 a.m. Dept.: Courtroom 3 Judge: Hon. Kimberly J. Mueller Date Filed: May 9, 2016 Trial Date: None Set

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INTRODUCTION AND SUMMARY OF THE ARGUMENT

What began as an attempt to save one young, innocent life has now taken on a new purpose of saving many lives by reclaiming the fundamental right to life from a legal fiction that has been used to justify ending lives prematurely. The Court cannot call Israel back from the grave, but it can begin to correct the injustice of his death and prevent future harm to similarly-situated families.

In seeking dismissal of the Third Amended Complaint (TAC), the State's essential position is that it cannot be held responsible for life-and-death harms sanctioned by statutes that it deems merely definitional. The Plaintiffs could not more strongly disagree. On its face, the statutory scheme at issue reaches well beyond definitions. More fundamentally, though, State laws that expressly permit deprivation of constitutional freedoms cannot evade scrutiny of the highest order. It is no defense to argue that the State is merely a bystander to the taking of life.

Through its statutory scheme, the State has endangered the most vulnerable, and medical providers would not prematurely end lives without that power placed in their hands. A determination that the California Uniform Determination of Death Act (CUDDA) is inconsistent with constitutional safeguards of due process, parental rights and privacy would effect a fundamental change that would redress the harms experienced by these plaintiffs.

ARGUMENT

I. THE CONSTITUTIONALITY OF CUDDA IS SQUARELY WITHIN THE JURISDICTION OF THIS COURT.

The threshold issue of Article III standing has taken on new dimensions since the passing of Israel. The Plaintiffs are keenly aware of the need to satisfy the basic formulation of standing as presented in such authorities as *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992). Since there is some overlap among the requirements of injury in fact, causation, and redressability, Plaintiffs will here approach these

elements as follows: 1) demonstrate that statutory definitions can indeed cause harm; 2) explain why the statutory scheme goes far beyond mere definitions; 3) show the causal link between the statutory scheme and the alleged harm; and, 4) identify why invalidating the statutes would indeed alleviate the alleged harm.

a. Defining fundamental rights out of a statutory scheme is indeed a constitutional wrong that demands a remedy.

It is beyond question that Israel and his family suffered harm by his untimely, tragic death, and the first *Lujan* factor is not seriously disputed. The Article III dispute therefore centers around causation and redressability. State Motion to Dismiss ("State's Brief") 1:16-19. Plaintiffs allege that, through the statutory scheme of CUDDA, the State bears ultimate culpability for the taking of Israel's life. TAC ¶63.

CUDDA's foundational definitional provision reads: "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 brain stem, is dead." Health & Safety Code §7180(a).[1] The legislative adoption of the legal fiction in the second half of the provision has the significant effect of defining out of life persons who would have been considered alive at the adoption of the Fifth and Fourteenth Amendments, respectively, due to their continued biological functioning. The State's constricted view of its obligations would take us backwards to a time when states did not protect life or liberty to the degree that all today recognize they must.

Indeed, the State's view that a definitional statute cannot trigger liability ignores the origin of the Fourteenth Amendment. In one of its darkest moments, the Supreme Court accepted just such a theory. "We think ['negroes of African

[1] All statutory references are from the Health & Safety Code.

descent']… were not intended to be included[] under the word 'citizens' in the Constitution, and can therefore claim none of the rights and privileges which that instrument provides for and secures to citizens… ." *Scott v. Sandford*, 60 U.S. 393, 404-05 (1857). Today, the notion that authorities once acquiesced in the deprivation of human beings' most basic liberties by defining them as non-citizens and deferring to private-third-party slave owners shocks the conscience.

We stand 160 years removed from Chief Justice Taney's decision, but not so far removed from the chilling logic. The State drew a line declaring Israel to be no longer a legally-recognized person, regardless of continued biological functioning. The State can no more deflect responsibility for the taking of life onto medical providers than could a State claim that laws permitting slavery were morally neutral, because individual slave owners carried out the actual deprivation of rights. The Fourteenth Amendment was enacted precisely to hold States accountable for laws permitting constitutional deprivations by private-party slave owners.

Fast-forwarding to the present age, and on the other side of the sanctity of life issue, defining life has become a new frontier in the abortion debate. Under the State's logic, jurisdictions like South Dakota should be free to define life to begin at conception, because definitions cause no harm. Yet the federal courts have disagreed. *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Rounds*, 530 F.3d 724, 737 (8th Cir. 2008).

Of course, the definition of marriage has also taken on great significance in the last few years, apart from the specific rights attached to it. The State has argued forcefully – and effectively – that definitions do indeed matter. The Supreme Court agreed in *Obergefell v. Hodges*. The Court held that being defined out of the marriage statute inflicted its own injury, even as to a deceased partner who could no longer become a spouse. *Obergefell v. Hodges*, 135 S. Ct. 2584, 2602 (2015). Note that state law describes qualified candidates for marriage and

provides marriage certificates. But typically a private-third-party (e.g., a minister) officiates the ceremony and executes the certificate. It would provide no defense for a state to assert that it was a priest who caused harm by not conducting the service. In fact, state definitions created the conditions for Article III standing. Defining both the beginning and end of life are essential State functions that carry enormous moral and legal implications. The State's theory that statutory definitions cannot trigger liability is oversimplified and unhelpful to the Article III equation.

Fonseca and LLDF have stated claims linking the CUDDA definitions and other aspects of the statutory scheme to their injuries. TAC ¶63. The Motion to Dismiss should therefore be denied and the validity of the statute put through the crucible of strict scrutiny.

b. CUDDA is much more than merely definitional.

Definitional statutes can be fraught with constitutional deficiencies that demand correction. Sec. 7180 is indeed definitional. But it goes well beyond that. Nor is CUDDA merely about record-keeping, State Mot. to Dismiss at 11; it sets the boundaries between life and death, as the State acknowledges elsewhere when asserting its own interests. *Id.* at 16.

CUDDA's progenitor, UDDA, has its origin in the 1968 Ad Hoc Commission of the Harvard Medical School. The Commission published an article with the goal of changing how death was determined legally and medically. There were two primary reasons put forward: (1) to prevent a waste of medical resources on keeping people alive through modern technologies; and (2) the need to have organs for transplants. Seema K. Shah, *Piercing the Veil: The Limits of Brain Death as a Legal Fiction*, 48 U. Mich. J. L. Reform 301, 320 (2015); The redefining of *death* was not the result of a medical breakthrough. *Id.* 321. The Commission "did not believe that brain death was the equivalent of biological death." *Id.* at 320.

To effectuate these goals, CUDDA prescribes the protocol for confirmation of *death*. Sec. 7181. Under CUDDA, a medical facility must record, communicate with government entities, and maintain records relative to the "irreversible cessation of all functions of the entire brain." Sec. 7183. This includes filling out portions of the Certificate of Death provided by the Department of Public Health within 15 hours after death under (Sec. 102800) and that the medical facility register the death with county officials (Sec. 102775). County officials then jointly issue a death certificate with the State's Department of Vital Records directed by the Defendant, Karen Smith. Ct. doc. 71-1.

At its core, CUDDA represents a profound philosophical shift – with major constitutional implications – by the State. It could not have been carried out by the medical community acting on its own.

The symbiotic relationship is darkly illustrated in the present case. The State-issued Certificate of Death proved to be crucial and self-fulfilling. TAC ¶39.

c. The State, through CUDDA, exposes its most vulnerable citizens to great harm and cannot avoid responsibility by blaming third parties.

The Plaintiffs have further pled causation in that Israel was the object of the challenged regulation, and because the State has created a danger by placing patients like him at the mercy of physicians with the authority to end life.

In *Lujan*, the Court stated that when the plaintiff is the object of the regulation, there is little doubt regarding causation. *Id.* at 562. Grammatically, the subject of CUDDA's definition is the individual whose life hangs in the balance. Sec. 7180(a). The individual is also the focus of Sec. 7181 requiring independent confirmation of brain death. Israel, and by extension his mother, are unequivocally the "objects of the action" under the holding in *Lujan*.

The delegation of essential State functions, and the inadequacy of the accompanying safeguards, is more fully explained below in reference to procedural and substantive due process. For purposes of causation, though, it must be noted that the State cannot create dangers and then blame third parties when those dangers come to fruition.

As Judge Posner memorably put it,

> We do not want to pretend that the line between action and inaction, between inflicting and failing to prevent the infliction of harm, is clearer than it is. If the State puts a man in a position of danger from private persons and then fails to protect him, it will not be heard to say that its role was merely passive. It is as much an active tortfeasor as if it had thrown him into a snakepit. *Bowers v. Devito*, 686 F.2d 616, 618 (7th Cir. 1982).

Placement of the patient in a private facility does not insulate the State, where its policies are ultimately at issue. *K.H. Through Murphy v. Morgan*, 914 F.2d 846, 853 (7th Cir. 1990). And it is no defense to argue that a crime was committed by a third party and not the State, when a state actor places the victim in greater danger than they otherwise would have experienced. *Wood v. Ostrander*, 879 F.2d 583, 594 (9th Cir. 1989) (stranding arrestee's female passenger in high-crime area in the middle of the night). Nor is custody a prerequisite to liability for creation of danger. *L.W. v. Grubbs*, 974 F.2d 119 (9th Cir. 1992) (allowing constitutional claims of correctional employee to proceed, where she had been raped by inmate). One of the primary goals of Sec. 1983 is to provide a remedy for killings unconstitutionally caused *or acquiesced in* by state governments. *Chaudhry v. City of Los Angeles*, 751 F.3d 1096, 1103 (9th Cir. 2014).

The State misses the point by relying on authorities such as *Collins v. Harker Hts.*, 503 U.S. 115 (1992), where the widow of a deceased city employee pursued a failure-to-warn and failure-to train theories of liability. Plaintiffs are not alleging

that the State must better train doctors in ending lives or warn comatose patients that their lives may soon be ended without their consent, but that fundamental rights must be restored to patients and their families from the government-medical complex that is taking away these vital decisions from them.

While the State seeks to deflect responsibility onto doctors, medical providers have done the same toward the State. In Placer County Superior Court, the attorney for Kaiser told the Court, that "under Health and Safety Code [§§] 7180 and 7181, Israel has been found to be dead." Ct-doc. 14-4:38 at lines 9-11.

The attempt to shift responsibility for the most vulnerable patients is nothing new, but it is becoming more acute. Quite recently, this has played out in Sacramento in the form of the County trying to release a comatose inmate, solely to avoid paying for his medical care, and utterly irrespective of what that might mean for his life or death.[2] This trend must be arrested. Neither the State nor local governments can be permitted to absolve themselves of life-and-death decisions as a cost-cutting measure.

d. Invalidating CUDDA will redress the constitutional harm.

Under *Lujan*'s redressability prong, Fonseca a favorable ruling will result in remedying the loss of medical insurance coverage and government benefits to the child and his family. TAC ¶63. Besides the economic consequences that a favorable ruling will address, there are three additional essential points relative to redressability. First, a favorable ruling will redress her own grievances by conferring a degree of dignity similar to that which other constitutional litigants have found meaningful. Second, relief can be granted which will be meaningful to co-plaintiff LLDF's clients. Third, the State's position that redressability is lacking

[2] Hudson Sangree, *Judge won't release inmate in vegetative state because he can't sign paperwork*, Sacramento Bee, July 12, 2017, archived at http://www.sacbee.com/news/local/crime/article161056154.html.

because doctors are unlikely to change their behavior to conform to a change in the law is fallacious. Plaintiffs address these points in that order.

i. Dignity can be restored by a favorable ruling.

The Supreme Court's emphasis on dignity in the constitutional equation carries important implications here. Most recently, in *Obergefell*, the Court felt it was important to extend marriage rights to the plaintiff even though this same-sex partner had died and no further union was possible. *Obergefell*, 135 S. Ct. at 2597 ("The fundamental liberties protected by [the Due Process] Clause include most of the rights enumerated in the Bill of Rights…these liberties extend to certain personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs"). Under the State's theory, *Obergefell* would have been rejected before being decided, as non-redressable. Of course, the State took the opposite view in *Obergefell*, as well as its predecessors, *U.S. v. Windsor*, 133 S.Ct. 2675 (2013), and *Hollingsworth v. Perry*, 133 S. Ct. 2652 (2013). The State cannot have it both ways – either restoration of dignity through invalidation of an onerous statute is redressable, notwithstanding the death of a victim of that statute, or it is not. Consistent with *Obergefell*, Fonseca submits that the wrong inflicted upon Israel continues to be redressable. TAC ¶¶63, 65. To this end, the Prayer for Relief concretely seeks expungement of his erroneous death record. TAC 20:14-17.

ii. LLDF's claims are independently redressable.

The State has set up its standing arguments for both Fonseca and LLDF to rise and fall together, making it superfluous to examine LLDF's standing if Fonseca possesses it, or vice versa. But LLDF has independent grounds for satisfying Article III. The clearest explanation of this principle comes from the D.C. Circuit's decision in *Abigail Alliance*, where the Court found redressability established despite the death of a patient who had been seeking potentially life-saving

treatment. The organization's continuing interest kept the case alive. *Abigail Alliance for Better Access to Deve. Drugs v. Von Essenbach*, 469 F.3d 129, 136-37 (D.C.Cir. 2006). Namely, "the Alliance seeks to enforce the right of terminally ill patients to make an informed decision that may prolong life." *Id.*

The "mission of LLDF focuses on preservation of the lives of the most vulnerable members of society, including the very young and those facing the end of life." TAC ¶4. LLDF closely assisted the family of Israel in the present matter. Sadly, the facts presented in this case are not an outlier for LLDF. The organization attempts to protect members of the public facing withdrawal of life-support from loved ones. Due to the CUDDA protocol, LLDF's work in this regard has been profoundly frustrated. CUDDA causes a significant drain on LLDF's time and resources to address the burdensome undertaking of resisting attempts by medical facilities to remove life-support for members of the public whose loved ones are declared brain dead, though they are not biologically dead." *Id.* This organizational mission ensures that a decision on the constitutionality of CUDDA would have direct impact and would not be advisory. The State seeks to draw the Court into needless conflict with the D.C. Circuit. This invitation, the Court should decline.

iii. The State's claim that the medical community is unlikely to change its behavior even if there is a change in the law lacks credulity.

The State extends its blame-shifting into the realm of redressability in a way that exposes the limits of its logic. Redressability is lacking, claims the State, because doctors as independent actors will not likely change their ways even if CUDDA were invalidated. State's Brief 11:3-12. Two examples from other high-profile policy and medical debates show quite the opposite.

First, as to medical marijuana, courts accept that criminalization produces a chilling effect on doctors that legalization would lift. Prior to California's official acceptance of medical, and now recreational, marijuana, physicians acknowledged

that legislation created a chilling effect that deterred them from even mentioning marijuana to patients that they felt would benefit from it. *Conant v. McCaffrey*, 172 F.R.D. 681, 690 (N.D. Cal. 1997). While the law in California at the time did not explicitly prohibit physicians from merely recommending marijuana, physicians did not want to take any chances. *Id.* Fear of action being taken against them drove physicians to censor themselves. *Id. See also, Conant v. Walters*, 309 F.3d 629, 639 (9th Cir. 2002), *cert denied* 540 U.S. 946 (2003). After the Supreme Court denied certiorari, one of the plaintiff-physicians in the case rejoiced that they could practice without fear once again. Vonn Christenson, *Courts Protect Ninth Circuit Doctors Who Recommend Medical Marijuana Use*, 32 J.L. Med. & Ethics 174, 176 (2004). The notion that physicians do not change their behavior to reflect changes in the law – such as the striking down of CUDDA – is flawed.

A similar fear of the legal consequences for violating state law deters medical practitioners in the context of physician-assisted suicide. In the landmark *Cruzan* case, Nancy Cruzan's family had requested that she be taken off of her artificial hydration and nutrition to end her life. The healthcare facility refused to act absent court authority. *Cruzan by Cruzan v. Harmon*, 760 S.W.2d 408, 410 (Mo. 1988). *See also, Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 280 (1990).

In this Circuit's leading assisted suicide case, *Compassion in Dying v. State of Wash.*, five physicians who regularly treat patients with terminal illnesses wanted to assist their patients in dying, however "they have all been deterred from doing so by the existence of the Washington statute challenged in this case." *Compassion in Dying v. Wash.*, 850 F. Supp. 1454, 1458 (W.D. Wash. 1994), *aff'd* 79 F.3d 790, *rev'd* 51 U.S. 702 (1997).

By design, Sec. 1983 serves as a deterrent to unconstitutional takings of life and liberty. *Chaudhry*, at 1106. In contrast to the State's awkward attempt to minimize the influence of its end-of-life statutes, it should be inferred that removing

the cloak of legitimacy that CUDDA places over certain deprivations of life would most certainly deter physicians from pulling the plug prematurely.

The foregoing analysis of causation and redressability should lead the Court to further assess whether claims have been stated for violations of fundamental constitutional freedoms, as will be discussed next.

II. FONSECA HAS STATED VIABLE CLAIMS FOR BOTH PROCEDURAL AND SUBSTANTIVE DUE PROCESS.

The Fourteenth Amendment declares in relevant part, "No State shall make or enforce any law which shall…deprive any person of life…without due process of law." The heart of Plaintiffs' procedural due process claim is that CUDDA lacks the safeguards necessary to ensure that the State's most vulnerable citizens are not deprived of life. TAC ¶65. The substantive claim is that innocent children like Baby Israel have a fundamental right to life that does not yield to lesser interests such as the need for organ donors or economic efficiency. TAC ¶74, 83.

a. The State-established procedures for brain death are insufficient to prevent deprivation of life without due process of law.

Due process demands that "a person in jeopardy of serious loss [have] notice of the case against him and opportunity to meet it." *Joint Anti-Fascist Comm. v. McGrath*, 341 U.S. 123, 171-172 (1951) (Frankfurter, J., concurring). The degree of deprivation dictates the level of procedures required. *Mathews v. Eldridge*, 424 U.S. 319, 341 (1976). In view of the deprivation of life here, the highest level of procedures must be followed. *Roper v. Simmons*, 543 U.S. 551, 577 (2005).

CUDDA provided no realistic opportunity for Israel's mother to be heard. "The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard." *Goldberg v. Kelly*, 397 U.S. 254, 268-69 (1970).

Deprivation of life must surely be attended with greater process and safeguards than the denial of welfare benefits at issue in *Goldberg*.

CUDDA expedites the determination of *death* by purposefully ignoring whether the person remains biologically alive. This lessoned standard of *death* provides no meaningful process by which the patient's advocate can obtain a different, truly independent medical opinion by the physician of her choosing or even challenge the findings.

This case illustrates the degree to which medical providers are willing to take liberties with even the minimal procedural safeguards that do exist, such as the independence requirement. Section 7181 mandates that, upon a brain death determination "there shall be independent confirmation by another physician."

On its face, CUDDA's independence requirement might be comforting. In actuality, it has proven to be a farce. Noting the holding in *Dority v. Superior Court*, 145 Cal.App.3d 273 (Cal. Ct. App. 4th Dist. 1983), the Honorable Judge Michael Jones asked attorneys for Kaiser: "And, therefore, the parent should not have the opportunity to have an independent evaluation?" The response: "We are the independent [evaluation]." Ct-doc. 14-4 at lines 12-15. The State's fallback position that the statute need not provide additional safeguards, because they have been judicially created, (State's Brief 18:15-26), is remarkable. It is a dubious premise at best that otherwise-deficient statutes can be salvaged by judicial infill. *See Aptheker v. Sec. of State*, 378 U.S. 500, 515 (1964).

Meanwhile, other appellate courts have recognized the disconcerting lack of uniformity with different protocols for declaring brain death. *Gebreyes v. Prime Healthcare Servs., LLC* (*In re Estate of Hailu*), 361 P.3d 524, 529 (Nev. 2015).

The haphazard, uneven and utilitarian-driven rush to declare patients brain dead, ignoring the possibility they might be alive, or the wishes of their family to

keep them alive, is irreconcilable with the principle that the most stringent procedures must be afforded for the greatest deprivations of life and liberty.

b. A patient and his family have significant substantive due process rights, rooted in privacy and self-determination, to resist discontinuation of life support.

The right to life arising under substantive due process is context-specific and resists rigid definition or limitation. *County of Sacramento v. Lewis*, 523 U.S. 833, 834 (1998). "If the right of the patient to self-determination in his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors." *Bartling v. Superior Court*, 163 Cal.App.3d 185, 195 (Cal.Ct. App. 2nd Dist. 1984). "The choice between life and death is a deeply personal decision of obvious overwhelming finality." *Cruzan*, 497 U.S. at 281.

Under this right of self-determination, emanating from the right to privacy, the choice of the patient or his legal surrogate whether to continue life-sustaining measures is not subject to veto by the medical profession or the judiciary. *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 1135 (Cal. Ct. App. 2d Dist. 1986). Stated another way, the patient's vote is not to be overridden. *Id.* at 1137. The State would have the foregoing judicial pronouncements about self-determination turned into wasted breath. The notion that Fonseca cannot maintain a claim on behalf of her now-deceased child against the regime which cut short his life renders these constitutional provisions worse than useless.

Although greater deference is afforded to decisions that deprive the innocent of life, when those decisions are split-second in contexts such as a police chase, *see Lewis, supra at* 853, much less deference should be afforded where the decision is deliberative and made through the legislative process.

There is a popular misconception that the drafters of UDDA, and by extension CUDDA, redefined death based upon medical discoveries resulting in a

new understanding of when death actually occurs. Such a notion is fiction. Shah, Id.; Michael Nair-Collins, *Death, Brain Death, and the Limits of Science: Why the Whole-Brain Concept of Death Is A Flawed Public Policy*, 38 J.L. Med. & Ethics 667, 668 (2010). Persons declared brain dead have living cells. These patients generate new tissue. Shah at 322. They heal if cut and fight infection. *Id.* at 330. They eliminate waste. Nair-Collins, at 670. Children will go into puberty. Shah at 312. Men grow beards. *Id.* 330. Women can continue to gestate a fetus. *Id.*[3] These are consistent with life – not death.

In the present case, the State is striving to head off, through a Motion to Dismiss, consideration by the Court or a jury of the astounding evidence that Israel remained alive after the official Certificate of Death was issued, after he was moved to Guatemala, and after he was brought back to Los Angeles.

In short, the biological basis for brain death is hotly disputed and central to this case. Were this merely a disagreement over treatment options or diagnosis, the Court might be able to defer to erroneous beliefs held by legislators. Since it is a matter of the highest constitutional magnitude, strict scrutiny is required and this case must proceed beyond the 12(b) stage to test the State's interests.

III. FONSECA HAS STATED A COMPELLING CLAIM FOR VIOLATION OF FUNDAMENTAL PARENTAL RIGHTS.

As to her claims for violation of fundamental parental rights, Fonseca's position is that, if such rights are to have any meaning at all, they must give parents a say in the life and death of their child.

[3] In a chilling yet predictable part of the ethical trajectory is the proposal that brain dead women be used as gestational incubators. Jennifer S. Higgins, *Not of Woman Born: A Scientific Fantasy*, 62 Case W. Res. 399, 407 (Winter 2011).

Typically, a fit parent has plenary authority over medical decisions for a small child. *In re Baby K*, 832 F. Supp. at 1030. Fonseca felt a moral and spiritual duty to give her child every benefit of the medical doubt as to whether he could improve with additional treatment. TAC ¶36.

The Supreme Court has maintained that fundamental parental rights include educational decision-making such as whether to send their child to public or private school. *Pierce v. Socy. of Sisters*, 268 U.S. 510, 534 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 403 (1923); *Wisconsin v. Yoder*, 406 U.S. 205, 234 (1972). Surely, this Fourteenth Amendment liberty interest cannot mean parents have educational decision-making rights while lacking life-and-death decision-making rights for their child. *See, Chaudhry*, at 1106. Thus, courts in this state have upheld withdrawal of life support where all of the family is in agreement. *Barber v. Super. Ct.*, 147 Cal.App.3d 1006, 1021 (Cal. Ct. App. 2d 1983).

By asserting that Fonseca cannot even state, much less prove, such a claim, the State goes too far. This leaves the Court with the unappealing choice whether to agree that parents have no constitutional option but to watch in horror (or more likely, be physically restrained) as their child's breathing is deliberately stopped.

Fortunately, there is another way. The State ignores as it must the path laid out by the Michigan Court of Appeals in a similar case, *Family Independence Agency v. A.M.B.* (*In re AMB*), 248 Mich. App. 144 (Mich Ct. App. 2001). There, the appellate court conducted an extensive post-mortem of the circumstances surrounding the withdrawal of life support from Baby Allison. The appellate court found serious due process violations in the manner that the decision to end Baby Allison's life was taken away from her parents, all of their shortcomings notwithstanding. The Family Court had authorized the termination of life support after a doctor testified by telephone that being on the ventilator was not in the child's best interests. *Id.* at 160. The appellate court focused in on the

presumption that to establish incompetency for the parent who would otherwise have a Fourteenth Amendment liberty interest in making medical decisions for their child, the evidence must be clear and convincing. *Id*. at 204-5. Thus, the court held that, even though circumstantial evidence pointed to the parents' inability to make life-and-death decisions for their child, much more formal adjudication of the parents' incompetence was required to take away the decision from them. *Id.*

Liberty demands no less in the present case. Fonseca's fitness was not in question and the State, through its statutory scheme, nevertheless took away her ability to make this monumental decision for her child. There was a medical dispute as to whether Israel was alive. TAC ¶62. As it turned out, Fonseca's decision to err on the side of continuing life support was justified. TAC ¶26. Physicians in Guatemala ran two EEG tests and found that Israel was not only not biologically dead, but was also not brain dead. Drs. Ruben Posadas and Francisco Montiel determined that Israel was in a "persistent vegetative state." TAC ¶47.

But because Kaiser already acted under the CUDDA protocol, the medical providers at Children's Hospital would not accept the results of the two EEG tests, would not perform their own brain death examination, and would not allow the parents to bring in an eminent professor from UCLA's medical school to conduct an examination. TAC ¶57. That Israel was alive under any definition of death was an inconvenient truth. Instead of accepting that scientific reality, attorneys for Children's Hospital filed ex parte the death certificate signed by Kaiser and the death certificate from the Defendant's Department of Vital Records with the Superior Court in Los Angeles. TAC ¶¶58-59. Children's Hospital's intent was to convert the death certificate into a death warrant. As a direct result of the death certificate issued through the CUDDA protocol, the Superior Court lifted a temporary restraining order that the mother had secured in pro per and did not give even a 24 hour reprieve to seek emergency relief from a higher court. TAC ¶60.

By the authority vested in them by the State, before the close of business that day, Children's Hospital medical staff entered Israel's room, and disconnecting his life support, they killed him. TAC ¶61.

The State's diminished view of fundamental parental rights moves dangerously close to the conscience-shocking drama that has recently been playing out across the Atlantic.[4] Taking the facts as true, the disturbing deprivation of parental rights effectuated here cannot be waved off under FRCP 12(b).

IV. THE STATE TOO HASTILY WRITES OFF ITS OWN CONSTITUTION.

The State offers little on the California constitutional causes of action, contenting itself to note that the analysis follows the federal claims. The State's minimization of its own charter belies both the greater specificity of the state provisions, and the fact that they have been invoked to bolster the corollary federal claims. Set forth prominently in Article I §1, the State's Constitution provides for a "Declaration of Rights." The relevant language provides, "[a]ll people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life…and privacy[5]." CA Const. Art. I §1. Liberties afforded by the California Constitution exist with independent force, not depending upon any provision of the federal Constitution's Bill of Rights. *People v. Pettingill*, 21 Cal.3d 231, 248 (1978). The Declaration of Rights dates back to 1849, nineteen years before the Fourteenth Amendment attached the liberties enumerated in the Bill of Rights to the citizens of each state.

[4] Aria Bendix, *British Hospital Declines Vatican's Offer to Treat Charlie Gard*, The Atlantic, July 5, 2017, archived at https://www.theatlantic.com/news/archive/2017/07/british-hospital-declines-vaticans-offer-to-treat-charlie-gard/532719/.

[5] The right to privacy as an inalienable right was added to the Constitution by proposition in 1974.

Interpretation of CA Const. Art. I §1 begins with the face of the text. *Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652, 1658 (2017). The *life* provision provides for both its enjoyment and defense. Though perhaps not in contrast, but as seen as a difference, the Fifth and Fourteenth Amendments speak in terms of the deprivation of life without due process of law. The State's provisions of *enjoying* and *defending* life carry a more robust connotation than due process. Note that Art. I §7(a) has a due process clause that mirrors the federal provisions. "A person may not be deprived of life…without due process of law… ." The State's position that the Art. I §1 claim in the TAC should receive identical analysis with the Fifth and Fourteenth Amendment claims is in error for two reasons.

First, it conflates Art. I §§1 and 7(a). The use of different language for the respective sections means that the drafters intended different things for each. Otherwise, reading the two sections as the same renders section 1 as mere surplusage. A cardinal principle of statutory construction is that "a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant." *TRW v. Andrews*, 534 U.S. 19, 31 (2001).

In related error, the State fails to address the scope of the California Constitution on its own terms. Art. I §1 identifies the right to enjoying and defending life as *inalienable*. The difference between the liberties set forth in the federal Bill of Rights and an *inalienable right* provided in the Declaration of Rights is that the former cannot be abridged by a state actor while the latter cannot be abridged by anyone. *Hill v. NCAA*, 7 Cal.4th 1, 19 (1994).

Here CUDDA is inconsistent with the inalienable right to the enjoyment and defense of life (as that term was understood in 1849) because it gives to medical providers the authority to declare a biologically living child as brain dead against the wishes of a fit parent. The ordinary meaning of *life* – and by extension *death* –

in 1849 tracked the first definition found in CUDDA, i.e., "irreversible cessation of circulatory and respiratory functions." In contrast, those who drafted and ratified the inalienable right to the enjoyment and defense of *life* in the Declaration of Rights could not have contemplated a definition of *death* as the "irreversible cessation of all functions of the entire brain, including the brain stem." Attempts to square the original understanding of Art. I §1 with the second part of CUDDA is simply an anachronism.

Turning to the right to privacy, Art. I §1 has been interpreted more expansively than the federal Constitution in such privacy decisions as *Hill v. NCAA*. The *Bartling* court grounded its understanding of patient self-determination in the right to privacy found in both state and federal constitutions. *Bartling*, at 195. *See also, People v. Adams*, 216 Cal.App.3d 1431, 1448 (Cal. Ct. App. 3d Dist. 1990) (based on the right to privacy in Art. I, §1, adults have the fundamental right to control decisions relating to their own medical care). Of particular relevance, such decisions have blurred the lines between private and state action that the State seeks to assert via its Article III arguments.

While state interests in preserving life and self-determination in medical decisions rooted in privacy share much in common with federal interests, as not identical they require independent evaluation. The State has not offered nearly enough to demonstrate that Fonseca and LLDF cannot state state-based claims.

V. *ROOKER-FELDMAN* DOES NOT APPLY.

The State reasserts the *Rooker-Feldman* doctrine. The reality is that the doctrine has been limited to the facts of the two cases from which it is derived, *Rooker v. Fid. Trust Co.*, 263 U.S. 413 (1923) and *D.C. Ct. of App. v. Feldman*, 460 U.S. 462 (1983).

The Ninth Circuit has explained that *Rooker-Feldman* "applies only when the federal plaintiff both asserts as her injury legal error…by the state court *and* seeks

as her remedy relief from state court judgment." *Kougasian v. TMSL, Inc.*, 359 F.3d 1136 (9th Cir. 2004) (emphasis in original).

The original two defendants in the respective Superior Court cases that were filed on an emergency basis to prevent termination of life support were Kaiser Permanent Roseville Medical Center and Children's Hospital Los Angeles. Those two entities are not named as defendants in the current action, making the requested relief materially different than that which had been sought against them.

CONCLUSION

The State would have us believe that CUDDA played no role in the death of Baby Israel, or for that matter other vulnerable patients declared to be brain dead and thereby cut off from all fundamental and constitutional rights. The TAC pleads causes of action demonstrating that the State's role is pervasive, and that it lacks constitutionally-required safeguards. With the addition of LLDF as co-plaintiffs, the TAC ensures that relief will inure not only to Fonseca, but to countless other Californians who are currently at risk for deprivation of their most basic right – the right to life – with only a perfunctory process. The Motion to Dismiss should therefore be denied.

Respectfully submitted this Twenty-Seventh day of July, 2017.

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, Plaintiff, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA,** Defendant.	2:16-cv-00889-KJM-EFB **NOTICE OF MOTION AND MOTION TO DISMISS THIRD AMENDED COMPLAINT** Date: August 11, 2017 Time: 10:00 a.m. Courtroom: 3 Judge: Hon. Kimberly J. Mueller Trial Date: Action Filed: May 9, 2016

TO ALL PARTIES, THEIR COUNSEL OF RECORD, AND THE CLERK OF THE COURT:

PLEASE TAKE NOTICE THAT on August 11, 2016 at 10:00 a.m., or as soon thereafter as the matter may be heard before the Honorable Judge Kimberly Mueller in Courtroom 3 of the United States District Court for the Eastern District of California, located at 501 I Street, Sacramento, California 95814, defendant Karen Smith, M.D., Director of the California

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Department of Public Health, will move this Court to dismiss without leave to amend plaintiffs' third amended complaint, pursuant to Federal Rules of Civil Procedure 12(b)(1) and (6).

This motion to dismiss is brought on the grounds that plaintiffs do not have standing to pursue this matter; therefore, the court lacks jurisdiction to hear plaintiffs' complaint. The motion is also brought on the ground that plaintiffs fail to state a claim for relief. This motion is based on this Notice and the Memorandum of Points and Authorities filed in support of this motion, the papers and pleadings on file in this action, and upon such matters as may be presented to the Court at the time of the hearing.

Pursuant to the honorable Judge Mueller's standing orders, defendant has conferred with plaintiffs regarding the underlying merits of defendant's motion to dismiss. The parties have conferred regarding the merits of plaintiffs' claims and the date of hearing in this matter on several occasions. On July 8, 2016, and again on August 26, 2016, the parties met and conferred telephonically and by electronic mail. On April 26, 2017, and again on May 17, 2017, defendant notified plaintiffs that it planned to file a motion to dismiss, addressing the same issues raised by the motion to dismiss the prior complaint. Plaintiffs have not committed to address the numerous deficiencies outlined in defendant's motion to dismiss. As such, defendant is forced to bring this motion to dismiss.

Dated: May 19, 2017

Respectfully Submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR; LIFE LEGAL DEFENSE FOUNDATION, Plaintiffs, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,** Defendant.	2:16-cv-00889-KJM-EFB **MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO DISMISS PLAINTIFFS' THIRD AMENDED COMPLAINT FOR EQUITABLE RELIEF** Date: August 11, 2017 Time: 10:00 a.m. Dept: 3 Judge: The Honorable Kimberly J. Mueller Trial Date: not set Action Filed: 5/9/2016

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MEMORANDUM OF POINTS AND AUTHORITIES
INTRODUCTION

One year ago, Plaintiff Jonee Fonseca (Fonseca) sought to enjoin Kaiser, the hospital where her son, Israel, was being cared for, from removing him from life support. Fonseca maintained that Israel was alive in spite of physicians' declarations to the contrary, and their pronouncement that he suffered irreversible brain death on April 14, 2016. Fonseca also joined to the action, Karen Smith, M.D., Director of the California Department of Public Health (Director) and alleged that the California Uniform Determination of Death Act (CUDDA), the statute that defines death, was unconstitutional.

In August 2016, Israel was removed from life support and, thus, there remained no dispute that he was deceased. Fonseca, however, continued with her challenge to CUDDA to secure a declaration that Israel died on August 25, the day the life-sustaining support was removed, and not April 14, the date stated on the death certificate and as declared by Kaiser physicians. The Director filed a motion to dismiss asserting, among other arguments, that Fonseca did not have standing to pursue her action.

In its order granting Director's motion, this Court stated that Fonseca's Second Amended Complaint (SAC) did not satisfy the causation and redressability prongs of Article III standing. In particular, the Court concluded that the alleged injury—the determination of when Israel died—was not caused by CUDDA. Additionally, this court found that Fonseca did not establish that her desired relief—invalidation of CUDDA—would redress her injury. Fonseca, however, was given leave to amend her Complaint.

Notwithstanding the court's ruling, Fonseca and now Life Legal Defense Foundation (LLDF) (collectively "plaintiffs") filed essentially the same complaint as in the previous action.[1] In this Third Amended Complaint (TAC), plaintiffs continue to maintain that CUDDA is unconstitutional. Plaintiffs allege that CUDDA caused physicians to declare that Israel died on

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[1] Life Legal Defense Foundation is an organization focused on resisting attempts by medical facilities from removing individuals from life-support. Third Amended Complaint, ¶ 4.

April 14, 2016 and that its protocols deprive patients—in this case, Israel—of life.[2] Plaintiffs, however, offer no new allegations that would cure the lack of standing discussed in this Court's earlier ruling. Fonseca makes no showing that the determination that Israel died on April 14, 2016, was caused by the Director or by operation of CUDDA, rather than the independent medical decisions of non-party doctors. The same goes for Fonseca's assertion that CUDDA ended Israel's life. Nor can she establish redressability, as there is no indication that the physicians who determined Israel's date of death would reach a different conclusion in the absence of CUDDA.

LLDF lacks standing for similar reasons, as it fails to allege sufficient facts that CUDDA directs physician's medical opinions or that these physicians would act differently in the absence of CUDDA.

Standing remains a bar to this action.

Finally, even if plaintiffs could establish standing, they have not alleged cognizable claims against the Director for any constitutional violation. The First, Second and Third Causes of Action contend that CUDDA deprived Israel of life and Fonseca of her right to make decisions on his behalf. Again, because CUDDA is definitional only, and the decisions at issue are made by physicians in accordance with accepted medical standards, plaintiffs cannot demonstrate that the Director — via CUDDA— deprived Israel of life or Fonseca of any liberties secured by the United States or California Constitutions. Additionally, plaintiffs fail to allege facts showing that CUDDA is facially unconstitutional or that Fonseca has been denied any process due under the circumstances.

Further, the Fourth and Fifth claims for violation of privacy are also without merit. When balanced against the competing state interests, Fonseca's assertion that she, as Israel's proxy, was entitled to dictate medical decisions under the circumstances fails as a matter of law.

[2] Fonseca appears to allege that she (on behalf of Israel) has been injured in two respects: (1) physicians determined that Israel died on April 14, the date that is recorded on official documents and (2) CUDDA's protocols deprived Israel of life. The TAC is primarily focused on the alleged mistaken determination of death on April 14, 2016. TAC p. 1:6-10; ¶¶ 39-41, 62-63-73, 83, Prayer ¶ 1). Plaintiffs also sporadically allege that CUDDA actually deprived Israel of life. *Id.* ¶¶ 65, 74, 84.

Plaintiffs, though provided ample opportunity, have failed to assert a viable cause of action. Because plaintiffs' claims cannot be cured by any further amendment, this TAC should be dismissed with prejudice.

LEGAL AND FACTUAL BACKGROUND

I. THE CALIFORNIA UNIFORM DETERMINATION OF DEATH ACT[3]

CUDDA defines death as occurring when an individual has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem. Cal. Health & Safety Code § 7180(a).[4] "A determination of death must be made in accordance with accepted medical standards." *Ibid.*

CUDDA also contains a number of patient protections. It requires "independent confirmation by another physician" when an individual is pronounced dead by determining that the individual has sustained irreversible cessation of brain function. § 7181. In the event that organs are donated, the physician making the independent confirmation may not participate in the procedures for removing or transplanting the organs. § 7182. Additionally, complete medical records shall be "kept, maintained, and preserved" with respect to the determination of brain death. § 7183. And, following determinations of death under CUDDA, families must receive a reasonable period of accommodation. § 1254.4.

If a disagreement exists concerning the determination of death, judicial review is available by filing a petition with the superior court. See *Dority v. Superior Court*, 145 Cal.App.3d 273, 280 (1983) ("The jurisdiction of the court can be invoked 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."). Additionally, a person may seek to correct errors stated in a registered certificate of death by complying with the process contained in § 103225 et seq.

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[3] CUDDA was enacted in 1982 to conform to the Uniform Determination of Death Act that was approved by the National Conference of Commissioners on Uniform State Laws. 14 Witkin, Summary 10th Wills § 11, p. 69 (2005). The Court previously recognized that California is one of thirty-three states that have formally adopted the Act. ECF No. 48, p. 24:25-28.

[4] All further references are to the Health and Safety Code unless otherwise specified.

II. FACTUAL BACKGROUND

On April 1, 2016, Israel suffered a severe asthma attack and was taken to Mercy General Hospital where he was placed on a breathing machine. TAC ¶ 7. He was eventually transferred to University of California, Davis Medical Center (UC Davis). *Id.* After a series of tests, physicians at UC Davis concluded on April 10, that Israel suffered brain death. TAC ¶ 20. The following day, Israel was transferred to Kaiser Permanente Roseville Medical Center (Kaiser). *Id.* ¶ 21. Kaiser physicians, following all procedures recommended by the American Academy of Pediatrics and the Society of Critical Care Medicine, determined that Israel was brain dead. *Id.* ¶¶ 22-24. Israel's attending physician, Dr. Michael Steven Myette, completed the physician's certification portion of the death certificate attesting that as of April 14, 2016, Israel was deceased. *Id.* ¶ 39.

On May 21, 2016, Israel was flown to a facility in Guatemala for examination and treatment. TAC ¶ 45. On August 6, 2016, Israel returned to the United States and was admitted to Children's Hospital of Los Angeles (CHLA). *Id.* ¶ 52. On August 25, 2016, Israel was removed from life support. *Id.* ¶ 61.

III. OVERVIEW OF STATE AND FEDERAL COURT PROCEEDINGS

A. Placer County Superior Court

Following Dr. Myette's determination that Israel was deceased, Fonseca initiated *Stinson v. UC Davis Children's Hospital; Kaiser Permanente Roseville*, Case No. S-CV-0037673. TAC ¶43; ECF No. 14-2. Styled as an application for a temporary restraining order directed at Kaiser, Fonseca requested time to find a physician to conduct an independent medical examination pursuant to § 7181. ECF No. 14-2. Fonseca asserted that in accordance with *Dority*, "the court has jurisdiction over whether a person is 'brain dead' or not pursuant to [CUDDA]." *Id.*, 5:13-15. The court issued a temporary restraining order (TRO) requiring Kaiser to maintain life support. ECF No. 14-3. The TRO was extended over two weeks to afford Fonseca time to secure an independent examination or relocate Israel. See ECF. No. 14-5, 14-7, 14-11.

The matter was reconvened on April 29, 2016, during which the court concluded that "a determination of death [] has been made in accordance with accepted medical standards under

[Section] 7181…." ECF 14-8, 75:21-76:9. The court determined that CUDDA had been complied with and ordered the petition dismissed. ECF 19-1, 2:5-6. Fonseca did not appeal.

B. Eastern District and the Ninth Circuit Court of Appeals

On April 28, 2016, Fonseca filed this action against Kaiser alleging claims under the federal Constitution, the federal Rehabilitation Act, and the Americans with Disabilities Act. ECF No. 1. The court granted a temporary restraining order. ECF No. 23.

However, on May 2, 2016, the court dismissed Fonseca's complaint. ECF No. 23. The following day, Fonseca amended the complaint to include the Director and asserted five claims: Deprivation of Life in Violation of Due Process (against all defendants); Deprivation of Parental Rights in Violation of Due Process (against all defendants); violation of the Emergency Medical Treatment and Active Labor Act (42 U.S.C § 1395dd et seq.) (against Kaiser); and violation of the right privacy under the United States Constitution and in violation of the California Constitution (against all defendants). ECF No. 29. The complaint sought, among other things, an order preventing Kaiser from removing life-sustaining support and a declaration that CUDDA is unconstitutional on its face. *Id*. at 17-18.

On May 6, 2016, Fonseca filed a motion for preliminary injunction against Kaiser seeking an order restraining Kaiser from removing ventilation from Israel. ECF No. 33. Kaiser opposed the motion and the matter was heard on May 11, 2016. The court issued an order denying the motion on May 13, 2016. ECF No. 48.

Fonseca filed a notice of interlocutory appeal on May 14, 2016 seeking relief from the Order denying the motion for preliminary injunction. ECF No. 49. Fonseca also requested an order requiring Kaiser to continue the life support until she could locate another facility to care for Israel. See *id*. No. 55. The Ninth Circuit stayed dissolution of this court's TRO to afford it time to review the matter. *Id.* Days later, Fonseca withdrew the motion as Israel was flown to a facility out of the country. ECF 60, TAC ¶ 45. The appeal was thereafter dismissed.

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C. Los Angeles Superior Court

On August 6, 2016, Israel returned to the United States and was admitted to CHLA.[5] TAC, ¶ 52. On August 16, 2016, Fonseca was informed that the hospital intended to remove Israel's ventilator. *Id.*, at ¶ 54. On August 18, 2016, plaintiff initiated *Stinson v. Children's Hospital Los Angeles, Los Angeles County* Superior Court Case No. BS164387, alleging that CHLA violated CUDDA by failing to obtain or permit an independent evaluation. ECF No. 68-3, Ex. C. The court issued a TRO requiring the CHLA to refrain from removing Israel from the ventilator and to cooperate with Fonseca to facilitate an independent evaluation of Israel. *Id.*, Ex. D, p. 2.

On August 25, 2016, the court dissolved its TRO. ECF No. 68-3, Ex. E. CHLA subsequently removed Israel from the ventilator eliminating any dispute that Israel is deceased.

D. The SAC and TAC

1. Fonseca's SAC

Following Kaiser's dismissal, Fonseca amended her complaint for the second time. The SAC asserted five claims against the Director as the sole defendant: (1) Deprivation of Life in Violation of Due Process under the Fifth and Fourteenth Amendments; (2) Deprivation of Parental Rights in Violation of Due Process of Law under the Fifth and Fourteenth Amendments; (3) Deprivation of Life under the California Constitution; (4) Violation of Privacy Rights under the United States Constitution; and (5) Violation of Privacy Rights under the California Constitution. ECF No. 64.

The Director filed a Motion to Dismiss and on March 28, 2017, the Court granted the Director's motion. ECF No. 79. The Court determined that Fonseca's allegations were insufficient to establish that CUDDA caused her injury—the Kaiser physician's determination that Israel had died—or, that invalidating CUDDA would redress that injury. *Id.* 11-13. Because it found that Fonseca did not have standing, the Court declined to address the Director's other arguments for dismissal. *Id.*, at p. 13. The Court gave Fonseca leave to amend. *Ibid.*

[5] The court previously took judicial notice of the state court filings from *Israel Stinson v. Children's Hospital, Los Angeles*, Los Angeles Superior Court Case No. BS164387. See ECF No. 79 (March 28, 2017, Order at p. 2); ECF No. 68-2, 68-3, Ex. C. The Director also relies on these previously noticed state court filings.

2. Plaintiffs' TAC

Fonseca, along with LLDF, filed the TAC that alleges that CUDDA is unconstitutional. In spite of the court's ruling, the TAC alleges the exact same causes of action and is nearly identical to the SAC, the notable difference being that plaintiffs updated the allegations to include the events that took place after Israel's return to the United States, and his eventual removal from life support. See TAC ¶¶ 45-61.

Plaintiffs here seek extraordinary relief: (1) an injunction directing Director to expunge all records that state that Israel died on April 14, 2016; (2) an injunction directing that all records be amended to reflect that Israel died on August 25, 2016; and (3) a judicial declaration that CUDDA is unconstitutional on its face and as applied. ECF No. 80, Prayer ¶¶ 1-3.

The allegations of the TAC focus on the alleged mistakes made by third party physicians in determining that Israel died on April 14, and not on CUDDA itself. TAC ¶¶ 18-28, 35-36, 42, 44-50. LLDF, without providing any specific facts, alleges that its efforts to resist attempts made by "medical facilities to remove life support" have been significantly impacted by CUDDA. TAC ¶ 4.

STANDARD

Federal Rule of Civil Procedure 12(b)(1) authorizes a motion to dismiss for "lack of subject-matter jurisdiction."

As the Supreme Court has "repeatedly said: 'Federal courts are courts of limited jurisdiction.'" *Rasul v. Bush*, 542 U.S. 466, 489 (2004) (citations omitted). "A federal court is presumed to lack jurisdiction in a particular case unless the contrary affirmatively appears." *Stock West, Inc. v. Confederated Tribes*, 873 F.2d 1221, 1225 (9th Cir. 1989). A plaintiff bears the burden to establish that subject matter jurisdiction is proper. *Kokkonen v. Guardian Life Ins. Co. of America*, 511 U.S. 375, 377 (1994).

The purpose of a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) "is to test the legal sufficiency of the complaint." See *North Star Int'l v. Ariz. Corp. Comm'n*, 720 F.2d 578, 581 (9th Cir. 1983). "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v.*

Iqbal, 556 U.S. 662, 678 (2009) (citations and quotations omitted). The court accepts as true all material allegations in the complaint and construes those allegations in the light most favorable to the plaintiff. See *Lazy Y Ranch Ltd. v. Behrens*, 546 F.3d 580, 588 (9th Cir. 2008). But the court is not required to "assume the truth of legal conclusions merely because they are cast in the form of factual allegations." *Fayer v. Vaughn*, 649 F.3d 1061, 1064 (9th Cir. 2011) (per curiam) (citations and quotations omitted). Mere "conclusory allegations of law and unwarranted inferences are insufficient to defeat a motion to dismiss." *Adams v. Johnson*, 355 F.3d 1179, 1183 (9th Cir. 2004).

Dismissal without leave to amend is appropriate when deficiencies in the complaint could not possibly be cured by amendment. See *Watison v. Carter*, 668 F.3d 1108, 1117 (9th Cir. 2012).

ARGUMENT

I. FONSECA HAS NOT SATISFIED THE CAUSATION AND REDRESSABILITY PRONGS OF ARTICLE III STANDING

A. Fonseca Has Not Sufficiently Alleged that CUDDA Caused Her Harm.

Standing is a jurisdictional requirement, and a party invoking federal jurisdiction has the burden of establishing standing. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992). The Article III standing test requires Fonseca to demonstrate that there is a causal connection between her alleged injury and the conduct complained of; the injury has to be "fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court." *Id.* at 560 (citations omitted).

Fonseca brings this constitutional challenge to CUDDA because she believes that Israel died on August 25, 2016, and not on April 14, 2016 as determined by Kaiser's physicians. TAC, p. 1:1-10, ¶¶ 62-63. As previously recognized by this Court, to sustain this action, Fonseca's injury—determination of death— must be "fairly traceable to the challenged action of the defendant," rather than the result of "the independent actions of some third party not before the court." ECF No. 79, 10:6-9 citing *Ass'n of Pub. Agency Customers v. Bonneville Power Admin.*, 733 F.3d 939, 953 (9th Cir. 2013). Accordingly, here, Fonseca must demonstrate that the medical

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determination that Israel died on April 14 stems from compliance with CUDDA and was not the result of conduct of some third party not before the court. Fonseca has not met her burden.

Fonseca has not established that CUDDA caused or was the reason why Kaiser physicians determined that Israel died on April 14. Fonseca alleges in conclusory fashion that CUDDA directs physicians to make a declaration of death even in situations where the brain injury is reversible. TAC ¶ 64. Fonseca's allegations, however, are belied by the plain text of CUDDA, which defines death as the "irreversible cessation" of all brain activity. Cal. Health & Safety Code § 7181. Thus, as a matter of law, an individual with *reversible* injuries would not meet CUDDA's definition of death. Moreover, any determination of death must be made according to accepted medical standards and, in the case of brain death, confirmed by an independent medical opinion, thus again ensuring that the determination is consistent with medical certainty. §§ 7180, 7181. Fonseca, by targeting CUDDA, continues to miss the point. The determination that Israel died on April 14 was not directed by CUDDA or the Director. That medical determination was made by third party physicians and in accordance with accepted medical standards.

Additionally, Fonseca cannot establish that CUDDA ended Israel's life. CUDDA does not direct physicians or hospitals to remove life-sustaining support. Nothing in CUDDA requires that life-sustaining support be removed once a determination of death is made. Thus, any decision to remove life-support is left to the physicians, hospitals, and the patient's family.

Moreover, to the extent Fonseca asserts that the Kaiser physicians were mistaken about their determination that Israel suffered brain death, nothing in CUDDA prevented her from securing an independent medical assessment of Israel. In fact, Fonseca requested and was afforded that very opportunity by the Placer County Superior Court in April 2016. TAC 43, ECF, Nos. 14-2, 14-5, 14-7, 14-11. It remains that Fonseca has not and cannot show that the determination by third party physicians that Israel died on April 14 was caused by the Director or CUDDA.

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B. Fonseca Has Not Alleged That Her Dispute Concerning Israel's Date of Death Can Be Redressed By A Favorable Decision.

Fonseca has not alleged that her injury can be redressed by a favorable decision, namely, that the medical determination that Israel died on April 14 would be reversed if she prevailed in this case. See *Wolfson v. Brammer*, 616 F.3d 1045, 1056 (9th Cir. 2010). The medical determination that Israel died on April 14 is redressable only by challenging the independent medical decisions of the physicians who assessed Israel. A judgment against the Director will not compel these physicians to reverse their medical opinions. See *Native Vill. of Kivalina v. ExxonMobil Corp.*, 696 F.3d 849, 867 (9th Cir. 2012) (Standing is lacking when the injury is "th[e] result [of] the independent action of some third party not before the court."). A favorable decision by this court will not invalidate the prevailing medical standards of the medical community or the medical opinions of the three physicians who determined that Israel died.

Even if this court were to invalidate CUDDA, Fonseca has not alleged that the physicians who rendered the determination that Israel died on April 14 would reverse their medical opinion. As this Court previously noted courts consistently find that "any pleading directed at the likely actions of third parties would almost necessarily be conclusory and speculative" absent supporting factual allegations. ECF No. 79, citing *Levine v. Vilsack*, 587 F.3d 986, 997 (2009). Fonseca has not pled here that the medical determination would be reversed if she prevailed in this case. Simply put, Fonseca has sued the wrong party to affect the change she wants.

Because Fonseca has failed to assert any additional facts that would establish Article III standing here, this action must be dismissed without leave to amend.

II. LLDF ALSO LACKS ARTICLE III STANDING BECAUSE IT FAILS TO ALLEGE THAT CUDDA HAS CAUSED ITS INJURY OR THAT IT WOULD BE REDRESSED BY THIS ACTION

LLDF joins this challenge to CUDDA and asserts that, due to CUDDA's protocols, its mission has been frustrated and its time and resources have been drained. TAC ¶ 4. LLDF is an organization that "focuses on preservation of the lives of the most vulnerable members of society, including the very young and those facing the end of life." *Ibid.* An organization, such as LLDF, must meet the same Article III test that applies to individuals. *Havens Realty Corp. v. Coleman*,

455 U.S. 363, 378–79 (1982). Accordingly, LLDF must also establish that CUDDA caused its injury—frustration of its mission—and that the injury will be redressed by this action. Like Fonseca, LLDF has not met its burden.

LLDF contends that due to CUDDA's "protocols," its work in protecting members of the public from withdrawal of life-support is frustrated. TAC ¶ 4. LLDF asserts CUDDA is a barrier to LLDF's ability to ensure that life-sustaining support is continued. *Ibid*. These allegations are insufficient and will not satisfy standing because CUDDA has not caused LLDF's alleged harm. Again, nothing in CUDDA prescribes how or when a physician must issue its medical determination that a person has died. Nor does it direct physicians and hospitals to remove life-sustaining support. Instead, CUDDA defers to the medical community requiring that any determination of death be made in "accordance with accepted medical standards," and in the event of a brain death diagnosis, confirmed by an independent physician. See §§ 7180(a), 7181. Accordingly, any frustration of LLDF's mission is the result of the independent decisions of medical professionals and hospitals, and not the result of CUDDA's mandate.

To the extent LLDF asserts CUDDA's post death protocols have frustrated its mission, these protocols have no effect on the alleged injury. CUDDA's mandate that records be maintained (§ 7183) and the State's requirement that a death certificate be completed and registered (Cal. Health & Saf. Code §§ 102775, 102800), do not direct or affect the physician's medical opinion that a person has died, and have no bearing on whether an individual remains on life-support. Accordingly, it remains that LLDF has not shown that CUDDA caused its alleged injury.

Finally, LLDF cannot show that invalidating CUDDA will affect the change it desires. LLDF believes that brain death is not death and works to prevent physicians and hospitals from removing individuals from life-support. TAC ¶ 4. Thus, to satisfy standing, LLDF must show that invalidating CUDDA will likely eliminate or reduce its need to resist attempts made by medical facilities to cease life-support measures. LLDF has not sufficiently alleged that invalidating CUDDA will impact this mission.

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While LLDF maintains that CUDDA is the root of its frustrated purpose, the actual decisions that are at issue are *medical determinations* made by *medical professions* in response to the prevailing medical and ethical standards of the medical community. Thus, the relief that LLDF seeks depends entirely on independent decisions of third parties, not before this court. Where redressability hinges on the choices of independent actors, a plaintiff must show that those actors will change course and act in a manner that affords the relief requested. See *Levine*, *supra* at p. 993. LLDF has not met that burden. LLDF has not established that if CUDDA were eliminated, the medical community could cease recognizing brain death as death. Nor has it alleged that this action will force a change in the hospitals' polices and decisions regarding life-support.

Here, LLDF lacks standing to pursue this action because CUDDA has not caused LLDF's purported injuries, nor has LLDF alleged that CUDDA's invalidation will affect the change it desires.

III. THE FIRST AND SECOND CAUSES OF ACTION FAIL TO STATE A CLAIM AGAINST THE DIRECTOR AND SHOULD BE DISMISSED

Even if plaintiffs had standing, the complaint should still be dismissed because it fails to state any claims against the Director as a matter of law. Plaintiffs' First and Second Causes of Action allege generally that CUDDA deprived Israel of life and Fonseca of parental rights in violation of the due process clauses of the Fifth and Fourteenth Amendments. Though not entirely clear, plaintiffs appear to allege (1) a procedural due process claim that CUDDA provides no process or procedures by which a patient or advocate can challenge the determination of death, TAC ¶¶ 72, 78, and (2) a substantive due process claim that CUDDA provides an incorrect definition of death and "removes the independent judgment of medical professionals as to whether a patient is dead." TAC ¶ 72. As explained below, both contentions fail to state a claim as a matter of law.

A. California's Procedures Are Constitutionally Sufficient.

"No single model of procedural fairness, let alone a particular form of procedure, is dictated by the Due Process Clause." *Kremer v. Chemical Const. Corp.*, 456 U.S. 461, 483 (1982).

Instead, the "fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner." *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976) (citations omitted). Under California law, the procedures concerning determinations of death are constitutionally adequate and Fonseca has received all the process to which she is due.

1. Plaintiffs' facial challenge lacks merit.

To mount a successful facial challenge to CUDDA, plaintiffs "must establish that no set of circumstances exists under which the Act would be valid." *U.S. v. Salerno*, 481 U.S. 739, 745 (1987). A statute is facially unconstitutional if "it is unconstitutional in every conceivable application, or it seeks to prohibit such a broad range of protected conduct that it is unconstitutionally overbroad." *Foti v. City of Menlo Park*, 146 F.3d 629, 635 (9th Cir. 1998) (internal quotation marks omitted). Where, however, a statute has "a plainly legitimate sweep," the challenge must fail. *Hoye v. City of Oakland*, 653 F.3d 835, 857 (9th Cir. 2011) (quoting *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008)). Plaintiffs cannot meet their burden and the facial challenge to CUDDA fails.

While CUDDA itself does not expressly set forth procedures to challenge a determination of death, such procedures are provided under California law. *See Dority v. Superior Court*, 145 Cal. App. 3d 273, 280 (1983) ("The jurisdiction of the court can be invoked 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."); *see also* ECF No. 48, at 26-28 (in ruling on plaintiffs' preliminary injunction motion, this court noted that the "state court has jurisdiction to hear evidence and review physician's determination that brain death has occurred"). Indeed, plaintiffs have invoked these procedures to challenge the doctors' determinations that Israel is deceased on two separate occasions, filing suits in Placer County Superior Court to challenge Drs. Myette's and Maselink's determination, in case No. S-CV-0037673, and more recently filing suit in Los Angeles County Superior Court to challenge CHLA's physicians' determination in case no. BS164387.

Further, CUDDA itself provides certain preliminary procedures that must be followed at the time of the initial determination of death. First, all determinations of death must be made by

physicians in accordance with prevailing medical standards. § 7180(a). Second, in cases of brain death a single physician's opinion is insufficient; CUDDA requires *independent* confirmation by another physician. *Id.*, § 7181.[6] These procedures and the right to contest a determination of death in the superior court, *see Dority*, *supra*, are more than sufficient to satisfy all constitutional procedural due process requirements.

2. Plaintiffs' "as applied" challenge fails.

Plaintiffs' "as applied" challenge meets the same fate. Plaintiffs cannot demonstrate that CUDDA, as applied to the facts of this case, is unconstitutional. *See Hoye*, *supra*, at 857. Here, three physicians performed the requisite tests and independently concluded that Israel suffered irreversible brain death. TAC ¶¶ 20-24. Following the third pronouncement, Fonseca contested the determination by initiating the Placer County Superior Court action. *Id.*, 43-44; *see also* ECF 14-2. Fonseca was given a full evidentiary hearing. She was given time to secure her own independent examination by a qualifying physician, as well as the opportunity to cross-examine Dr. Myette, Israel's attending physician. After considering the evidence before it, the court concluded that there was no basis to question the medical determination that Israel was deceased. *See* ECF No. 19-1. Given these facts, plaintiffs have not, nor can they, demonstrate that these procedures are constitutionally inadequate.

B. Plaintiffs' Substantive Due Process Allegations Fail to State a Claim.

Plaintiffs' substantive due process allegations also fail to state a claim as a matter of law. As this Court has previously noted, the Due Process Clause of the Fourteenth Amendment prohibits states from making or enforcing laws that deprive a person of life, liberty, or property without due process. ECF 48, 21:22-24; U.S. Const. amend, XIV, section 1. The substantive due

[6] CUDDA provides a number of additional procedural protections. For example, § 7182 forbids physicians involved in the determination of death from participating in any procedures to remove or transplant the deceased person's organ; § 7183 requires the hospital to keep, maintain and preserve patient medical records in the case of brain death; § 1254.4(a) requires hospitals to "adopt a policy for providing family or next of kin with a reasonably brief period of accommodation . . ."; § 1254.4 (b) requires the hospital to provide the patient's family with a written statement of the policy regarding a reasonably brief accommodation period; and § 1254.4(c)(2) requires the hospital to make reasonable efforts to accommodate a family's religious and cultural practices and concerns

process right "protects individual liberty against 'certain government actions regardless of the fairness of the procedures used to implement them.'" *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992) (quoting *Daniels v. Williams*, 474 U.S. 327, 331 (1986)). It "provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). Inherent in this protection is the notion that a state by law or enforcement actually *deprives* a person of life, liberty, or property.

As a preliminary matter, Plaintiffs' claim that CUDDA actually deprived Israel of life fails. Plaintiffs cannot establish that the Director or *CUDDA* deprived Israel of life. The determination that Israel died was made by third party physicians. Similarly, the decision to remove life-sustaining support was made by third parties not before this court. CUDDA did not direct or require these third parties to remove the support which ultimately lead to the cessation of all bodily function.

Next, Plaintiffs contend that under CUDDA an advocate for a patient is not allowed to bring in their own physician to contest the findings, TAC ¶¶ 72, 78, and that CUDDA prevents a physician from exercising his or her independent judgment as to whether a patient is dead, TAC ¶ 72. Both allegations are incorrect as a matter of law.

Nothing in CUDDA prevents physicians from exercising their independent medical judgment as to whether a patient is deceased or precludes an advocate from seeking an independent opinion. As discussed above, CUDDA expressly provides that "[a] determination of death must be made *in accordance with accepted medical standards*. § 7180(a) (emphasis added). In cases of brain death, CUDDA also requires that before a patient is declared deceased "there shall be *independent* confirmation by another physician." *Id.*, § 7181 (emphasis added). Accordingly, the statute, by its plain terms, defers to the medical judgment of doctors. Nothing in CUDDA dictates or directs any physician concerning when an inquiry of death should ensue, which tests to perform, or whether an actual declaration of death should be made. It provides a general definition of brain death, but leaves the ultimate determination to the discretion of doctors "in accordance with accepted medical standards." *Id.*, § 7180(a). Moreover, the statute does not

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state which physicians are permitted to examine the patient. Thus, *CUDDA*, does not prevent advocates from securing their own medical opinions.

Even if plaintiffs could allege sufficient governmental encroachment (which they cannot), plaintiffs' substantive due process claim still fails. Whether the constitutional rights at stake have been violated is determined by balancing them against the "relevant state interests." *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 279 (1990) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)). As this court previously noted, California "has a broad range of legitimate interests in drawing boundaries between life and death." ECF No. 48, at 24:4-16 (recognizing the state's interest in the context of criminal law, probate and estates law, and general healthcare and bioethics). The State also has a compelling interest in the quality of health and medical care received by its citizens. ECF No. 48, at 24:14-15 (citing *Varandani v. Bowen*, 824 F.2d. 307, 311 (4th Cir. 1987)). Similarly, the State seeks to ensure that patients are treated with dignity, particularly during their end of life. *See* Cal. Prob. Code § 4650 (b) (The "prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person."); *id.*, § 4735 (health care provider "may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution"). And it is well settled that the State has a legitimate interest in securing the public safety, peace, order, and welfare. *See Wisconsin v. Yoder*, 406 U.S. 205, 230; *Carnohan v. United States*, 616 F.2d 1120, 1122 (1980) (no fundamental right to access drugs the FDA has not deemed safe and effective).

As this court previously observed, Fonseca provides no facts that "suggest [] CUDDA is arbitrary, unreasoned, or unsupported by medical science." ECF No. 48, at 24:17-18. CUDDA's definition of death is substantively identical to the definition agreed upon by the American Medical Association and the American Bar Association, which has been "uniformly accepted throughout the country." ECF No. 48, at 24:22-28 (quoting *In re Guardianship of Hailu*, 361 P.3d 524, 528 (Nev. 2015)). Plaintiffs here have not alleged any additional facts to sustain this

claim. It remains that plaintiffs' disagreement with the prevailing definition of death cannot override the State's interests in enacting CUDDA. The substantive due process claim fails as a matter of law.

IV. THE COMPLAINT'S THIRD CAUSE OF ACTION FOR DEPRIVATION OF RIGHT TO LIFE IN VIOLATION OF THE CALIFORNIA CONSTITUTION ALSO FAILS TO STATE A CLAIM

Identical to the first claim, plaintiffs, in support of the third claim, asserts that CUDDA deprived Israel of his right to life. TAC ¶ 84. The California Constitution also protects persons from deprivation of life, liberty, or property without due process of law and is "identical in scope with the federal due process clause." *Sanchez v. City of Fresno*, 914 F. Supp. 2d 1079, 1116 (E.D. Cal. 2012) citing *Owens v. City of Signal Hill*, 154 Cal.App.3d 123, 127 n. 2, (1984). Accordingly, for the reasons articulated above as to First and Second Causes of Action, plaintiffs' Third Cause of Action should also be dismissed.

V. CUDDA DOES NOT VIOLATE FONSECA'S RIGHT TO PRIVACY AND THEREFORE THE FOURTH AND FIFTH CAUSES OF ACTION SHOULD BE DISMISSED

Plaintiffs allege that health care decisions are part of the right to personal autonomy and privacy, and that CUDDA violated these rights by allegedly denying plaintiffs the right to make medical decisions on Israel's behalf. TAC ¶¶ 87-89, 92-94. This claim fails because the medical decisions in question were not dictated by CUDDA but rather made by doctors, using their medical judgment, and plaintiff had the right to challenge those medical decisions through appropriate avenues.

Article I, section 1 of the California Constitution provides: "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, *and privacy*." (Emphasis added.) The federal Constitution does not expressly mention the right to privacy but recognizes a realm of personal liberties upon which the government may not intrude. *Roe v. Wade*, 410 U.S. 113, 152 (1973). However, this right is not absolute; one's right to dictate medical treatment may be outweighed by supervening public concerns. *Roe*, *supra*, at 155. Thus, as with the due process claims, the court is charged with balancing the liberty at stake against the State's interests in limiting that right.

In the complaint, plaintiffs contend that Fonseca's right to dictate medical decisions and treatment on behalf of her son is boundless. TAC ¶¶ 87, 89, 92, 94. Plaintiffs are mistaken. As articulated above, the State's interests in defining death and limiting a parent's right to make medical decisions are vast. *See infra.*, Part, III.B. In the case at bar, the right to dictate medical decisions gave way once three physicians determined that Israel suffered irreversible cessation of brain activity and is, therefore, deceased. Additionally, though Fonseca was provided ample opportunity to refute that determination, she did not do so. In light of these facts, and the competing state interests, plaintiffs cannot demonstrate that CUDDA violated Israel's right to continued privacy as afforded by the California or United States Constitutions. The Fourth and Fifth Causes of Action should be dismissed.

VI. "AS APPLIED" CLAIMS IN THE FIRST AND SECOND CAUSES OF ACTION ARE BARRED BY THE *ROOKER-FELDMAN* DOCTRINE[7]

The *Rooker-Feldman* doctrine precludes this court from considering Fonseca's "as applied" challenges to the constitutionality of CUDDA in the First and Second Causes of Action. In April 2016, Fonseca expressly challenged the determination of death in state court alleging that the brain death declaration was wrong. After affording Fonseca time to secure her own medical opinion, the court upheld the determination of death. Fonseca did not appeal the trial court's decision. Instead, she filed a series of complaints, the latest of which directly challenged the physician's determination of death. Fonseca's newly asserted "as applied" claims are nothing more than an impermissible challenge to the state trial court's decision.

"Stated plainly, *Rooker–Feldman* bars any suit that seeks to disrupt or 'undo' a prior state-court judgment, regardless of whether the state-court proceeding afforded the federal-court plaintiff a full and fair opportunity to litigate her claims." *Bianchi v. Rylaarsdam*, 334 F.3d 895, 900 (9th Cir. 2003) (citation omitted). Unlike res judicata, the *Rooker–Feldman* doctrine is not limited to claims that were actually decided by the state courts, but rather it precludes review of

[7] The court, in its March 28, 2017, order on the Director's motion to dismiss the SAC, determined that the Rooker-Feldman doctrine is inapplicable to this case. ECF No. 79, 8:25. The Director reasserts this argument for purposes of preserving this issue on appeal.

all state court decisions. *Id.* The doctrine "applies even though the direct challenge is anchored to alleged deprivations of federally protected due process and equal protection rights." *Allah v. Superior Court*, 871 F.2d 887, 891 (9th Cir.1989), superseded by statute on other grounds as stated in *Schroeder v. McDonald*, 55 F.3d 454, 458 (9th Cir.1995); *Worldwide Church of God v. McNair*, 805 F.2d 888, 891 (9th Cir.1986) ("This doctrine applies even when the challenge to the state court decision involves federal constitutional issues.").

The *Rooker–Feldman* doctrine precludes the exercise of jurisdiction not only over claims that are de facto appeals of a state court decision but also over suits that raise issues that are "inextricably intertwined" with an issue resolved by the state court. *See Feldman*, 460 U.S. at 483 n. 16; *Noel v. Hall*, 341 F.3d 1148, 1158 (9th Cir. 2003). As the Ninth Circuit has explained: "If claims raised in the federal court action are 'inextricably intertwined' with the state court's decision such that the adjudication of the federal claims would undercut the state ruling or require the district court to interpret the application of state laws or procedural rules, then the federal complaint must be dismissed for lack of subject matter jurisdiction." *Bianchi, supra*, at 898. In determining whether a plaintiff's federal claims are "inextricably intertwined" with a state court decision, "a court must do more than simply 'compare the issues involved in the state-court proceeding to those raised in the federal-court plaintiff.'" *Id.* at 900 (quoting *Kenmen Engineering v. City of Union*, 314 F.3d 468, 476 (10th Cir.2002)). Rather, it must "'pay close attention to the relief sought by the federal-court plaintiff.'" *Id.*

In this newly amended action, Fonseca expressly asserts an "as applied" challenge to CUDDA. TAC ¶¶ 62, 64-65, 73, 78. Identical to Fonseca's state court petition, the First and Second Causes of Action allege there is a medical dispute of fact as to whether Israel was dead or alive between April 14 and August 25, 2016. *See* TAC ¶¶ 62, 73. Additionally, the remedy Fonseca seeks reveals that this action is a direct challenge to the determination of death and the superior court's order upholding the determination. Prayer, ¶ 1 (Fonseca seeks "[a]n order expunging all records … which state or imply that Israel died on April 14, 2016 . . ."). This most recent complaint is simply an effort to set aside the determination that Israel died on April 14, a matter already adjudicated by the Placer County Superior Court. Thus, Fonseca is barred from

seeking what in substance would be appellate review of a state judgment in federal district court, even if she contends the state judgment violated her federal rights.

CONCLUSION

This court should dismiss the Third Amended Complaint without leave to amend.

Dated: May 19, 2017

Respectfully Submitted,

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CERTIFICATE OF SERVICE

Case Name: ***Jonee Fonseca v. Kaiser Permanente Medical Center Roseville (CDPH)*** Case No. ***2:16-cv-00889-KJM-EFB***

I hereby certify that on May 19, 2017, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

- **NOTICE OF MOTION AND MOTION TO DISMISS THIRD AMENDED COMPLAINT**
- **MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO DISMISS PLAINTIFFS' THIRD AMENDED COMPLAINT FOR EQUITABLE RELIEF**

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on May 19, 2017, at Sacramento, California.

Bryn Barton	***/s/ Bryn Barton***
Declarant	Signature

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Life Legal Defense Foundation, Plaintiffs, v. Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendant.	Case No.: 2:16-cv-00889-KJM-EFB **Third Amended Complaint for Equitable Relief** **REQUEST FOR JURY TRIAL**

INTRODUCTION

A toddler, Israel Stinson, was declared brain dead pursuant to the California Uniform Determination of Death Act ("CUDDA" or "Act") on April 14, 2016. In fact, the child remained alive until life-support was removed on August 25, 2016, by medical providers at Children's Hospital of Los Angeles ("Children's Hospital") in reliance on a death certificate signed under the requisites of CUDDA. This action is brought through his mother to expunge all records archived or under the control of the Director of the California Department of Public Health that state that the child died on April 14, 2016. To this end, the Plaintiffs challenge the constitutionality of the Act.

JURISDICTION

1. This Court has federal question jurisdiction over Plaintiff's claims arising under the Fifth and Fourteenth Amendments of the United States Constitution and 42 U.S.C. §1983. Jurisdiction is therefore proper under 28 U.S.C. §1331. This Court has supplemental jurisdiction over Plaintiff's claims arising under the Constitution of the State of California pursuant to 28 U.S.C. §1337.

VENUE

2. Venue is proper in the United States District Court for the Eastern District of California, pursuant to 28 U.S.C. sections 84 and 1391. The events that gave rise to this complaint occurred primarily in Sacramento and Placer Counties, in the State of California, and the Defendant has her principal place of business in Sacramento, California.

PARTIES

3. Plaintiff, JONEE FONSECA ("Ms. Fonseca"), a resident of the State of California. She is the mother of Israel Stinson ("Israel") and the healthcare decision maker for him. Ms. Fonseca is a devout Christian and believes in the healing power

of God. She also believes that life does not end until the cessation of biological functioning. In all interactions with medical providers as described more fully below, she consistently requested that her son not be removed from life support. She believed that removing him from such would be tantamount to ending his life.

4. Life Legal Defense Foundation ("LLDF") is organized under section 501(c)(3) of the Internal Revenue Code. The mission of LLDF focuses on preservation of the lives of the most vulnerable members of society, including the very young and those facing the end of life. LLDF closely assisted the family of Israel in the present matter. Sadly, the facts presented in this case are not an outlier for LLDF. The organization attempts to protect members of the public facing withdrawal of life-support from loved ones. Due to the CUDDA protocol described herein, LLDF's work in this regard has been profoundly frustrated. CUDDA has caused a significant drain on LLDF's time and resources to address the burdensome undertaking of resisting attempts by medical facilities to remove life-support for members of the public whose loved ones are declared brain dead, though they are not biologically dead. This includes counseling the families, negotiating with hospitals, litigation, and raising funds for these purposes.

5. Defendant, KAREN SMITH, M.D., serves as the Director of the California Department of Public Health. The Department which she heads has supervisorial, regulatory and enforcement roles over California hospitals. Further, the Department issues death certificates, requires compliance by hospitals and physicians in the manner in which death certificates are filled out and recorded. Dr. Smith's Department enforces the requirement that hospitals, physicians, and coroners use California's definition of death and that the determination of death be performed in a manner consistent with the State's statutory protocol. The definitions and protocol are part of CUDDA. The Department that she heads has created and dispatched to physicians and hospitals, a mandatory form known as a

Certificate of Death – State of California. Acting pursuant to the Act, she requires that medical doctors and hospitals use the operational definition of death found in Health & Safety Code §7180 and that procedures are followed under Health & Safety Code §7181 and that recordation be provided on the Certificate of Death. Pursuant to Health & Safety Code §7183 she requires that medical providers maintain records, in accordance to regulations that her Department adopts, regarding individuals who have been pronounced dead under the definition of death found in CUDDA. Further, her Department also requires that medical providers fill out the Certificate of Death within 15 hours after death under (Health & Safety Code §102800) and that medical providers register the death with local officials (Health & Safety Code §102775). All of the conduct is done under color of law. Dr. Smith is sued in her official capacity.

6. Plaintiff is ignorant of the true names and capacities of defendants sued herein as Does 2 through 10, inclusive, and therefore sue these defendants by such fictitious names and capacities. Plaintiff is informed and believes and thereon alleges that each fictitiously named defendant is responsible in some manner for the occurrences herein alleged, and that Plaintiff's injuries as herein alleged were proximately caused by the actions and/or in-actions of said Doe defendants. Plaintiff will amend this complaint to include the true identities of said doe defendants when they are ascertained.

FACTS

7. On April 1, 2016, Ms. Fonseca took her son to Mercy General Hospital ("Mercy") with symptoms of an asthma attack. The medical personnel in the emergency room examined him and placed him on a breathing machine. He underwent x-rays. Shortly thereafter he began shivering, his lips turned purple, his eyes rolled back and he lost consciousness. He had an intubation performed on him. Doctors then told Ms. Fonseca they had to transfer her son to the University of

California Davis Medical Center in Sacramento ("UC Davis") because Mercy did not have a pediatric unit. He was then taken to UC Davis via ambulance and admitted to the pediatric intensive care unit.

8. The next day, the tube was removed from the child at UC Davis. The respiratory therapist said that the patient was stable and that they could possibly discharge him the following day, Sunday April 3. The doctors at UC Davis put him on albuterol for one hour, and then wanted to take him off albuterol for an hour. About 30 minutes later while off the albuterol, Ms. Fonseca noticed that he began to wheeze and have trouble breathing. The nurse came back in and put him on the albuterol machine. Within a few minutes the monitor started beeping. The nurse came in and repositioned the mask, then left the room. Minutes after the nurse left the room, the child started to shiver and went limp in his mother's arms. He suffered a bronchospasm (squeezing of the airway, preventing air from passing). Ms. Fonseca pressed the nurses' button, and screamed for help, but no one came to the room. A different nurse entered, and Ms. Fonseca asked to see a doctor.

9. The doctor, Stephanie Meteev, came to the room and said she did not want to intubate the child to see if he could breathe on his own without the tube. The child was not breathing on his own.

10. Ms. Fonseca had to leave the room to compose herself. When Ms. Fonseca came back into the room five minutes later, the doctors were performing CPR on him. The doctors dismissed Ms. Fonseca from the room again while they continued to perform CPR. The doctors were able to resuscitate him. Dr. Meteev told Ms. Fonseca that the child was "going to make it" and that he would be put on Extracorporeal Membrane Oxygenation ("ECMO") machine to support his heart and lungs. Initially, doctors thought the patient might have a lung blockage, but no such blockage was found by the pulmonologist who examined him.

11. Dr. Meteev then indicated that there was a possibility that the child will

have brain damage. Israel was sedated twice due to his blood pressure being high, and was placed on an ECMO machine and a ventilator machine.

12. Two tests were performed on April 3 and 4 respectively. The tests included touching his eye with a Q-tip, striking his knee, shining a light in his eye, flushing cold water down his ear, and inserting a stick down his throat to check his gag reflexes.

13. On Sunday April 3, 2016, a brain test was conducted to determine the possibility of brain damage while Israel was hooked up to the ECMO machine.

14. On April 4, 2016, the same tests were performed when he was taken off the ECMO machine.

15. Prior to the first brain death examination, a UC Davis nurse contacted an organ donor company.

16. California Health and Safety Code §7180, which was in force and effect at all times material to this action, provides that "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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." Section 7180 is part of CUDDA and UC Davis medical staff conducted the tests for death pursuant to that section.

17. California Health and Safety Code §7181 provides that an individual can be pronounced dead by a determination of "irreversible cessation of all functions of the entire brain, including brain stem." CUDDA requires "independent" confirmation by another physician. Section 7181 is also part of the Act.

18. On April 6, 2016, the child was taken off the ECMO machine because his heart and lungs were functioning on their own. The next day, a radioactive test was performed to determine blood flow to the brain.

19. On April 7 a radionuclide test was performed to determine the blood flow to the brain; doctors claimed the test showed very little uptake of oxygen or nutrients in the child's brain.

20. On April 10 a magnetic resonance imaging ("MRI") and computed tomography ("CT") scan were performed on the patient; doctors asserted the MRI and CT scan confirmed "diffused brain swelling," "severe global injury," and transforaminal herniation across the foramen of the brain stem. As a result of these tests, physicians at UC Davis found that the patient's condition was consistent with brain death.

21. On April 11, 2016, Israel was transferred via ambulance from UC Davis to Defendant Kaiser Permanente Roseville Medical Center – Women and Children's Center ("Kaiser") for additional treatment. Upon his arrival at Kaiser, another reflex test was done, in addition to an apnea test. On April 14, 2016, a further reflex test was performed for determination of brain death in conjunction with protocol directed by the State of California and enforced by Defendant Smith's Department.

22. Dr. Myette of Kaiser testified in Superior Court that the hospital followed all procedures recommended by the American Academy of Pediatrics, the Society of Child Neurology, and the Society of Critical Care Medicine. This included regulating Israel's body temperature and sodium levels prior to testing.

23. The apnea test lasted for seven and a half minutes, and Israel was on 100 percent oxygen; the carbon dioxide level in his blood at the beginning of the test ranged between 35 and 45, and at the end of the test his carbon dioxide level was 85. In court, Dr. Myette testified that such a level would cause "anybody with any function of their brain stem" to breath. Dr. Myette testified that no brain activity was found, and had he "discovered that there was some activity in [the patient's] brain" doctors would not have declared him dead.

24. Dr. Myette testified that a second confirmatory exam was performed by his colleague Brian Masselink. (The Physician in Chief, Shelly Garone, was present along with the child's great aunt and one of his grandmothers). Dr. Masselink is a pediatric neurologist. Medical records state that Dr. Masselink found no evidence of any brain function. However, no Kaiser physician performed electroencephalogram ("EEG") tests to see if Israel had brain waives. (Ct. doc. 14-4, p. 17-36).

25. That same day, April 14, 2016, a Certificate of Death was issued. The Certificate of Death reveals that in fact Israel was last seen alive on April 12, 2016 (Ct. doc. 43-3, #114), a date *after* he was transferred to Kaiser from UC Davis.

26. That notwithstanding, at the time of the issuance of the Certificate of Death, with pulmonary support provided by the ventilator, the child's heart and other organs functioned well, and continued to function until August 25, 2016. He also began moving his upper body in response to his mother's voice and touch.

27. After signing the Certificate of Death, Dr. Myette gave testimony in the Superior Court for the County of Placer in support of an attempt to remove life-support from the child. Dr. Myette testified that "in situations where families wish organ donation, often when someone has been declared brain dead, we, intensivists, as a bridge to get these organs to transplant, will work very hard to keep a patient alive…" (Ct. doc. 43-2, 33:6-10). He then said, "Scratch that…to keep a patient's organs functioning and keep a heart beating." Id.

28. Ms. Fonseca has knowledge of other patients who had been diagnosed as brain dead, using the same criteria as in her son's case. In some of those cases, where the decision makers were encouraged to consent to the withdrawal of life support, the patients emerged from legal brain death to where they had cognitive ability and some even fully recovering. Such cases are fully medically documented.

29. Plaintiff is a Christian with firm religious beliefs that as long as the heart is beating, her child is alive. These religious beliefs involve providing all

treatment, care, and nutrition to a body that is living, treating it with respect and seeking to encourage healing.

30. Kaiser informed Ms. Fonseca that it intended to disconnect the ventilator that her son was relying upon to breathe claiming that he was brain dead pursuant to California Health and Safety Code §7180.

31. Kaiser claimed that, since its medical doctors have declared the child as brain dead, his mother had no right to exercise any decision making authority relative to maintaining her son on a ventilator.

32. Ms. Fonseca contacted Paul Byrne, a board certified neonatologist, pediatrician, and Clinical Professor of Pediatrics at University of Toledo, College of Medicine. However, Kaiser would not allow Dr. Byrne to examine Israel or even be present during an examination, as he is not a California licensed physician. In other words, his independence from Kaiser was the reason that Dr. Byrne was prevented from examining the child.

33. Ms. Fonseca repeatedly asked Kaiser's medical staff that her child be given nutrition, including protein and fats. She also asked that he be provided nutritional feeding through a nasal-gastric tube or gastric tube to provide him with nutrients as soon as possible. She further requested that care be administered to her son to maintain his heart, tissues and organs. Kaiser refused to provide such treatment stating that they do not treat or feed brain dead patients. Dr. Myette stated that any attempt to feed Israel would be "catastrophic." Because of this Kaiser denied her ability to make decisions over the health care of her son. Ms. Fonseca therefore sought alternate placement of her son, outside a Kaiser facility.

34. Ms. Fonseca vehemently opposed the efforts to exclude her from the decision-making regarding her son and Kaiser's insistence that she has no right concerning the decision to disconnect the ventilator that provides oxygen necessary for her son's heart to beat and his organs to be kept profuse with blood. She

expressly forbad the hospital from removing life support. Kaiser refused her requests for nutritional support and the placement of a tracheostomy tube and a gastric tube stating that she has no rights to request medical care for her son as he is brain dead. Kaiser's position is that under California law, the removal of mechanical life support does not require consent by the patient's advocate – the parent in this case – if there has been a declaration of brain death under CUDDA.

35. Two weeks after Kaiser declared Israel brain dead, Israel began moving his upper body in response to his mother's voice and touch. Ms. Fonseca also observed fluctuations in Israel's rate of respiration, indicating that Israel was taking breaths over the ventilator.

36. Despite these developments, Kaiser continued its insistence that Israel was dead. Dr. Byrne was in the child's room and observed Israel moving in response to his voice. He communicated to the parents that the child was alive. In view of her child's movements and a physician's opinion that the boy was alive, Ms. Fonseca believed that she had a moral and spiritual obligation to give her child the benefit of the medical doubt.

37. The State definition of death is the "irreversible cessation of all functions of the entire brain, including the brain stem." This definition of "dead" is in stark and material difference to the religious beliefs of Ms. Fonseca. She believes that the disconnection of life support would be tantamount to killing her son.

38. The State of California, acting by and through the Department of Public Health, has not authorized physicians to exercise independent professional judgment regarding determination of death. The State specifically defines *brain death* and declares such as *death*. This requires physicians to practice medicine in accordance to that definition, regardless of medical opinion or evidence to the contrary.

39. In accordance to the definition of death under CUDDA, on April 14, 2016, Dr. Myette filled out and signed a Certificate of Death which declared that

Israel was deceased. (Ct. doc. 43-3) The Certificate of Death was provided by the California Department of Public Health. Additionally, the Certificate of Death was subsequently submitted to the Department of Vital Statistics, which is a subdivision of the Department of Public Health and under the supervision of Defendant, Dr. Smith.

40. Per the requirements of the laws of California, Kaiser communicated to the Placer County Coroner's office that Israel was dead.

41. Despite an official determination that Israel was dead, subsequent to that declaration, the child showed movement in direct response to the voice and touch of his mother.

42. Since the issuance of the Certificate of Death, three physicians, independent of Kaiser and UC Davis, gave their medical judgment that Israel was in fact alive.

43. Because Kaiser insisted that Israel was dead according to the Act, Kaiser sought to remove life support from him. On April 14, in an act of desperation, Ms. Fonseca filed – in pro per – papers in the Superior Court, in and for the County of Placer, in which she pleaded with the Court to spare the life of her child.

44. The Superior Court granted temporary relief. However, based upon the testimony of Dr. Myette, the Superior Court determined that all medical protocols were met and the child was dead pursuant to the definition of brain death under CUDDA.

45. Ms. Fonseca retained new counsel and filed this action in this Court. She received temporary relief in this Court against Kaiser, but her request for a preliminary injunction was denied. This Court granted her a stay while emergency relief was sought in the Ninth Circuit Court of Appeals. Days later, the Ninth Circuit granted an emergency stay and requested further briefing by the parties.

While the emergency motion was still under review, Ms. Fonseca communicated with a pediatric specialist, Juan Zaldana, at Sanatorio Nuestra Señor del Pilar in Guatemala City, Guatemala. Dr. Zaldana agreed to admit Israel. Israel was flown to the facility for examination and treatment on May 21, 2016. This resulted in the withdrawal of the emergency motion to the Ninth Circuit.

46. A tracheotomy was performed and a feeding tube inserted at the facility. Kaiser physicians refused to provide this very treatment because they claim it unethical to treat a dead person and further asserted that Israel's digestive system was dead. That proved to be untrue. Israel stabilized and gained weight.

47. Dr. Zaldana and a pediatric neurologist, Dr. Francisco Montiel, performed numerous examinations on Israel including an EEG. The EEG revealed that he had brain waves. The presence of brain waves is inconsistent with brain death. Physicians informed the parents that Israel was not dead, but was in a persistent vegetative state. The results were confirmed by another physician, Dr. Rubén Posadas.

48. The parents remained with Israel in Guatemala for approximately 2½ months.

49. After treatment, Israel began to increasingly have more purposeful movements. In addition to the prior movements that he had at Kaiser in April, he began to move his arms, hands, legs and toes. Further, these movements were not random. They occurred primarily in response to voices and music. As a song that the child knew was played, he would begin to move at the sound of the music.

50. He was placed on a portable ventilator and increasingly would begin to take breaths off of the ventilator.

51. In July, Ms. Fonseca was told that Children's Hospital of Los Angeles consulted with Dr. Zaldana regarding Israel's condition. After speaking with medical professionals from Children's Hospital, Children's Hospital agreed to

accept Israel as a transfer patient for treatment.

52. On August 6, 2016, Israel was transported by air ambulance from Guatemala City and was admitted to Children's Hospital the following day.

53. Over the next few days, Israel's face and torso became increasingly red and swollen. Ms. Fonseca was told that medical staff stopped feeding Israel because of his sodium levels.

54. On August 16, Children's Hospital informed Ms. Fonseca of their intent to remove Israel's ventilator.

55. Because of this, Ms. Fonseca filed, in pro per, an ex parte petition for a temporary restraining order ("TRO") in the Superior Court, in and for the County of Los Angeles, to keep Israel on life-support. The order was granted and a preliminary injunction hearing was scheduled for September 9.

56. Ms. Fonseca began to make plans for Israel at home. Patients with severe brain injuries are often transferred to home care with a portable ventilator. Israel was a good candidate for home care, as he required very little medical intervention apart from the ventilator and feeding tube.

57. Ms. Fonseca also requested that the hospital allow her to bring in a neurologist to conduct an independent examination. She had made arrangements for Dr. Alan Shewmon, a neurologist at UCLA Medical Center, to examine Israel. Children's Hospital refused.

58. Armed with the Certificate of Death signed by Kaiser, attorneys for Children's Hospital filed a request to dissolve the TRO. Attorneys for Children's Hospital objected to the evidence from physicians in Guatemala proving that Israel was alive. They further objected to allowing Dr. Shewmon from examining the child.

59. Seeing the death certificate, the Judge of the Superior Court declined to entertain any evidence that Israel was alive or to allow the neurologist from UCLA

to examine the child in order to ensure that an innocent life would not be taken.

60. On August 25, 2016, based solely on the Certificate of Death issued pursuant to CUDDA, the Superior Court granted the request to dissolve the TRO.

61. After the hearing, Ms. Fonseca called the undersigned and informed him of the situation. A frantic effort was made by attorneys to file papers in the California Court of Appeal. Unlike the Ninth Circuit, there is no mechanism in place to get an emergency stay, e.g., lawyers assigned by the appellate court to handle emergencies by accepting calls and directing e-filing. Tragically as the emergency writ was being filed that afternoon, medical personnel entered Israel's room, stood next to his bed, disconnected his ventilator – and they killed him.

62. There is an actual dispute between the parties. California officially certified that Israel died on April 14. Plaintiff asserts that he was alive until August 25, 2016. This is a dispute of fact.

63. The continued existence of government documents that certify that Israel died on April 14 causes actual injury. This results in the loss of medical insurance coverage and government benefits to the child and his family.

64. The definition of brain death is fallacious. In essence, the presupposition is that the cessation of all functions of the entire brain – including the brain stem – is per se irreversible. However, brain waves return in rare cases after having disappeared. Nonetheless, California law directs that such a person be deemed dead. CUDDA requires independent confirmation by another physician. But that confirmation is exclusively confined to the definition of brain death in the statute. Hence it is a tautology. On its face and as applied, under CUDDA an advocate for a patient is not allowed to bring in their own physician to contest the findings. In this case, Kaiser used two of its own doctors for the tests. As such, it asserted in Superior Court that it is the independent evaluation under CUDDA. Ct. doc. 14-4, 36:12-24.

65. In the alternative, Plaintiff alleges that even if hypothetically the definition of brain death under CUDDA is correct as understood in the branch of natural science of biology, the medical protocol at times results in a misdiagnosis of brain death. The Act, either on its face or under its application, does not provide for an advocate of the patient to retain a doctor, at the advocate's own expense, to examine the patient and contest the findings. This deprives a patient of life without the safeguards necessary to satisfy the federal and state constitutional requirements.

66. Seeking an emergency writ of mandate in Superior Court is not generally a viable option when hours matter and the family cannot leave the bedside of the loved one lest life support be removed while rushing to court.

67. CUDDA states that brain death is to be declared according to accepted medical standards. The Act does not delineate such standards. There are multiple types of protocols for brain death used in the medical community. The determination of brain death can differ from patient to patient depending on the protocol chosen. As a result, the law subjects persons to a loss of life based upon medical standards that are not universally recognized within the medical community. For example, the Nevada Supreme Court reviewed a statute nearly identical to CUDDA. The State's high court found that the Harvard Criteria for brain death and the American Association of Neurology Guidelines were not the same. See, *Gebreyes v. Prime Healthcare Servs., LLC (In re Estate of Hailu)*,361 P.3d 524 (Nev. 2015).

68. *Biology* is a branch of natural science. This branch has identified certain basic characteristics of living organisms such as nutrition (the process by which organisms obtain energy and raw materials from nutrients such as proteins, carbohydrates and fats); respiration (release of energy from food substances in all living cells); movement; excretion (the cells get rid of waste products); growth; reproduction; and sensitivity. Death is the cessation of biological life. CUDDA's

definition of brain death stands in defiance of these universally agreed upon criteria for life. In other words, the accepted medical standards define brain death such that it can be coextensive with biological life. This matters because *life* is a legal right. The understanding of *life* recognized at the time the Declaration of Independence was signed (1776), the Fifth and Fourteenth Amendments were ratified (1791 and 1868) had a meaning which was more expansive than the definition of brain death found in CUDDA.

69. There is verifiable evidence that persons who have been declared brain dead have in fact not died. Some have recovered.

70. The aforementioned conduct was done under color of state law and by state actors. Such includes the implementation and enforcement of CUDDA.

FIRST COUNT

Deprivation of Life and Liberty in Violation of Due Process of Law under the Fifth and Fourteenth Amendments (42 U.S.C. §1983)

71. The Plaintiff incorporates by reference as if fully set forth herein the foregoing paragraphs.

72. Under the Fifth and Fourteenth Amendments, a citizen cannot be deprived of life or liberty without due process of law. Historically, death has been defined as the cessation of breath and the beating of the heart. Such understanding was true at the ratification of said Amendments. The State of California has defined death in a matter that is broader than the historical definition. The State's statutory scheme related to the definition of death and how it is determined have provided no procedures or process by which a patient or their advocate can independently challenge the findings of death. Further, the statutory scheme removes the independent judgment of medical professionals as to whether a patient is dead.

73. Under the facts described herein, there is a medical dispute of fact as to whether Israel Stinson was dead or alive on April 14, 2016. On this Earth, there can

be few rights more precious than the liberty interest in life. Life is a fundamental right that finds explicit protection in the U.S. Constitution.

74. The enactment and enforcement of CUDDA deprived Israel of his right to life without due process of law. The Act defines brain death and requires that physicians declare a person as dead when the conditions found in the definition are met. In essence, the Act speaks death into existence – and the patient out of existence – when biologically the individual is alive. But because a patient is declared brain dead by California, the patient does not become biologically dead. Death is the cessation of biological functioning. By State action, the Act requires a declaration that a person is deceased at a point in time earlier than the cessation of biological functioning. This is what happened to Israel. Through the use of *brain death*, lawmakers have created a legal fiction. Such a premature official certification of death deprives an individual of the liberty interest in life in a manner that is inconsistent with the Fifth and Fourteenth Amendments.

SECOND COUNT

Deprivation of Parental Rights in Violation of Due Process of Law under the Fifth and Fourteenth Amendments (42 U.S.C. §1983)

75. Plaintiffs incorporate by reference as if fully set forth herein the foregoing paragraphs.

76. As the fit parent of Israel, Ms. Fonseca has plenary authority over medical decision relative to her 2-year-old child.

77. In addition to the natural profound bounds of affection between parent and child, Ms. Fonseca believes that she has a moral and spiritual obligation to give her child every benefit of the medical doubt before disconnecting life support.

78. On its face and as applied the Act provides no due process for a parent to contest the medical findings by bringing in her own physician for a second opinion. Because as a fit parent she is completely cut off under the State's protocol,

she is being deprived of her parental rights.

79. In addition and in the alternative, there is a close nexus between the conduct of Kaiser, Dr. Myette and the State of California. The child was deprived of medical treatment because medical professionals at Kaiser asserted that treating a dead person allegedly violates medical ethics. In essence, based on CUDDA deeming brain death as legal death, Israel was denied treatment. There was a direct and proximate cause between the denial of treatment to Israel – who was biologically alive – and CUDDA which doctors relied on to declare him legally dead.

THIRD COUNT

Deprivation of Life

CA Const. Art. I §1

80. Plaintiff incorporates, herein by reference, the foregoing paragraphs.

81. This count arises under the right to life enumerated in the California Constitution which provides as follows: "[a]ll people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life… ." CA Const. Art. I §1.

82. The State of California has defined death in a matter that is broader than the historical definition. The State's statutory scheme related to the definition of death and how it is determined have provided no procedures or process by which a patient or their advocate can independently challenge the findings of death. Further, the statutory scheme removes the independent judgment of medical professionals as to whether a patient is dead.

83. Under the facts described herein, there is a medical dispute of fact as to whether Israel died on April 14, 2016. Life is a fundamental right that finds explicit protection in the California Constitution.

84. The enactment and enforcement of CUDDA deprived Israel of his right

to life. The Act defines death and requires that physicians declare a person as dead when the conditions found in the definition are met. But because a patient is declared dead does not make the patient become biologically dead when in fact the person was and is alive. By State action, the Act requires a declaration that a person is deceased at a point in time earlier than the cessation of biological functioning.

FOURTH COUNT

Violation of Privacy Rights

(42 U.S.C. §1983)

85. Plaintiff incorporates, herein by reference, the foregoing paragraphs.

86. This count arises under the right to privacy protected by the United States Constitution.

87. Under the penumbra of rights guaranteed under the United States Constitution, health care decisions are part of the right to personal autonomy and privacy. As a fit parent, Ms. Fonseca had plenary authority over the health care decisions of her child.

88. As a direct and proximate cause of compliance with the Act, health care treatment was denied to Israel because he was declared dead.

89. His mother was deprived of the rights of privacy that she enjoys and seeks to exercise on behalf of her child, relative to medical decisions.

FIFTH COUNT

Violation of Privacy Rights

CA Const. Art. I §1

90. Plaintiff incorporates, herein by reference, the foregoing paragraphs.

91. This count arises under the right to life enumerated in the California Constitution which provides as follows: "[a]ll people are by nature free and independent and have inalienable rights. Among these are… privacy." CA Const. Art. I §1.

92. Under the California Constitution, health care decisions are part of the right to personal autonomy and privacy. As a fit parent, Ms. Fonseca had plenary authority over the health care decisions of her child. She possesses a reasonable expectation of exercising personal autonomy and privacy on behalf of her son.

93. As a direct and proximate cause of the compliance with the Act, health care treatment was denied to Israel because he was declared dead.

94. A fallacious declaration of death constitutes a serious invasion of the liberty interest in privacy. As such, Ms. Fonseca was deprived of the rights of privacy that she enjoyed and sought to exercise on behalf of her child relative to medical decisions.

PRAYER

Wherefore, Plaintiffs pray for judgment against the Defendants as follows:

1. An order expunging all records archived by Defendant, or persons and entities under her control or authority, which state or imply that Israel Stinson died on April 14, 2016, and that an order issue that all records reflect the date of death as August 25, 2016, *nunc pro tunc*;

2. A declaration that the California Uniform Determination of Death Act is unconstitutional on its face;

3. A declaration that the California Uniform Determination of Death Act is unconstitutional as applied;

4. Any and all other appropriate relief to which the Plaintiff may be entitled including all "appropriate relief" within the scope of F.R.C.P. 54(c); and,

5. Costs and attorney fees.

Dated: April 14, 2017

/S/ Kevin Snider
Kevin T. Snider
Attorney for Plaintiffs

REQUEST FOR A JURY TRIAL

Plaintiff hereby respectfully requests a jury trial.

S/_Kevin Snider_____
Kevin T. Snider
Attorney for Plaintiffs

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA,

Plaintiff,

v.

KAREN SMITH, M.D., in her official capacity as Director of the California Department of Public Health,

Defendant.

No. 2:16-cv-00889-KJM-EFB

ORDER

This matter comes before the court again following the tragic death of young Israel Stinson. Plaintiff is Israel's mother, Jonee Fonseca. Defendant is Karen Smith, M.D., whom plaintiff is suing in her official capacity as Director of the California Department of Health. On August 31, 2016, defendant filed a motion to dismiss plaintiff's second amended complaint. ECF No. 68. Plaintiff opposes. ECF No. 70. On October 7, 2016, the court heard arguments, in which Kevin Snider appeared on behalf of plaintiff and Ashante Norton appeared on behalf of defendant. Oct. 7, 2016 Hr'g Mins., ECF No. 77. For the reasons stated below, defendant's motion to dismiss is GRANTED.

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I. JUDICIAL NOTICE

Defendant requests the court take judicial notice of the following documents:

> Exhibit A: documents from the Assembly Health Committee Analysis of Senate Bill 2004;
>
> Exhibit B: a copy of the Uniform Determination of Death Act drafted by the National Conference of Commissioners on Uniform State Laws;
>
> Exhibit C: plaintiff's Ex Parte Petition for a Temporary Restraining Order/Injunction and Request for Order of Independent Neurological Exam, filed August 18, 2016, in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case No. BS164387;
>
> Exhibit D: a copy of the Temporary Restraining Order and Order to Show Cause Re Preliminary Injunction filed August 18, 2016, in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case No. BS164387; and
>
> Exhibit E: Order on Ex Parte Application to Dissolve Temporary Restraining Order filed August 25, 2016, in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case No. BS164387.

Def.'s Req. for Judicial Notice ("RJN"), ECF No. 68-2.

Although legislative history is properly a subject of judicial notice, *Anderson v. Holder*, 673 F.3d 1089, 1094 n.1 (9th Cir. 2012), the court declines to take judicial notice of Exhibits A and B because they are not relevant to the court's decision on the pending motion. The court does take judicial notice of Exhibits C through E, as state court filings and orders also are properly subjects of judicial notice, and they are relevant to the court's decision. *See Holder v. Holder*, 305 F.3d 854, 866 (9th Cir. 2002) (taking judicial notice of a state court opinion and briefs filed in that proceeding).[1]

[1] The court previously took judicial notice of the state court filings relevant to this case as of May 13, 2016. *See* May 13, 2016 Order at 4 n.2, ECF No. 48 (taking judicial notice of the state court filings attached to ECF No. 14). The court relies on these previously noticed state court filings insofar as they are not duplicative of the exhibits filed with the instant motion.

II. FACTUAL AND PROCEDURAL BACKGROUND

On April 1, 2016, Israel Stinson suffered a severe asthma attack and was taken to Mercy General Hospital, where he was intubated. Second Am. Compl. ("SAC") ¶ 6, ECF No. 64. Israel was eventually transferred to University of California Davis Medical Center in Sacramento ("UC Davis") and admitted to the pediatric intensive care unit. *Id.* On April 10, after performing a series of tests, including a magnetic resonance imaging ("MRI") and computed tomography ("CT") scan, doctors at UC Davis concluded Israel had suffered brain death. *Id.* ¶ 19.

The next day, on April 11, Israel was transferred to Kaiser Permanente Roseville Medical Center – Women and Children's Center ("Kaiser"). *Id.* ¶ 20. On April 14, doctors performed further tests that confirmed Israel had suffered brain death. *See id.* ¶¶ 20–23. That day a doctor at Kaiser, Dr. Myette, filled out and signed a Certificate of Death that declared Israel deceased, *id.* ¶ 36, and Kaiser sought to remove him from life support, *id.* ¶ 40. Also on that day, the Placer County Superior Court granted plaintiff's application for a temporary restraining order requiring Kaiser to maintain life support. *Id.* ¶¶ 40–41. After the Superior Court found on April 27, 2016 that Kaiser had satisfied all medical protocols in determining Israel's death, plaintiff filed this action in federal court. *Id.* ¶¶ 41–42; Ex. G, April 27, 2016 Hr'g Mins., ECF No. 14-8.

On April 28, plaintiff's original complaint in this case named Kaiser and Dr. Myette, alleging violation of, *inter alia*, plaintiff's right to privacy as guaranteed by the Fourteenth Amendment. ECF No. 1. On May 2, the court heard arguments and granted plaintiff's request for a temporary restraining order requiring Kaiser to maintain life support. ECF No. 22.

On May 3, plaintiff filed an amended complaint in which she added as a defendant Karen Smith, M.D., in her official capacity as Director of the California Department of Public Health, alleging, *inter alia*, defendants violated plaintiff's right to due process as guaranteed by the Fifth and Fourteenth Amendments. First Am. Compl. ("FAC"), ECF No. 29. Plaintiff also sought a declaration that the California Uniform Determination of Death Act ("CUDDA"), a statute that defines death in California, is unconstitutional on its face. FAC Prayer ¶ 3.

On May 6, plaintiff filed a motion for a preliminary injunction against Kaiser, seeking to enjoin Kaiser from removing Israel from life support pending trial. ECF No. 33. On May 13, the court issued an order denying plaintiff's motion for a preliminary injunction; however, the court allowed the temporary restraining order to remain in place until May 20 to give plaintiff time to appeal. ECF No. 48.

On May 14, plaintiff filed a notice of interlocutory appeal to the Ninth Circuit. ECF No. 49. On May 20, the Ninth Circuit stayed dissolution of this court's temporary restraining order to afford the Circuit time to review the matter. ECF No. 55. Days later, a medical facility outside the United States admitted Israel as a patient, SAC ¶ 42, and plaintiff withdrew her Ninth Circuit appeal, ECF No. 59.

On June 8, plaintiff stipulated to the dismissal of Kaiser and Dr. Myette as defendants in this case. ECF No. 60. On July 1, plaintiff filed the operative second amended complaint. *See* SAC. Plaintiff's second amended complaint names only one defendant: Karen Smith, M.D., in her official capacity as Director of the California Department of Health. *Id.* As Director of the California Department of Health, Karen Smith, M.D., has a supervisorial, regulatory, and enforcement role over California hospitals, and her Department issues death certificates. *Id.* ¶ 4. The second amended complaint includes five claims, all stemming from California's definition of death under CUDDA: (1) Deprivation of Life and Liberty in violation of Due Process under the Fifth and Fourteenth Amendments (42 U.S.C. § 1983); (2) Deprivation of Parental Rights in violation of Due Process under the Fifth and Fourteenth Amendments (42 U.S.C. § 1983); (3) Deprivation of Life (Cal. Const. Art. I § 1); (4) violation of federal Privacy Rights (42 U.S.C. § 1983); and (5) violation of state Privacy Rights (Cal. Const. Art. I § 1). *Id.* Plaintiff also seeks a declaration that CUDDA is unconstitutional on its face and as applied to the facts in this case. SAC Prayer ¶¶ 2–3.

Following July 1, the following events have taken place and are referenced in the motion to dismiss; they also are relevant to whether plaintiff should be granted leave to amend. On August 6, 2016, plaintiff transported Israel back to the United States, where he was admitted to Children's Hospital of Los Angeles ("Children's Hospital"). Ex. C, Def.'s RJN at 29, ECF No.

68-3. On August 16, Children's Hospital informed plaintiff it intended to remove Israel from life support. *Id.* at 30. Two days later, the Los Angeles County Superior Court granted plaintiff's request for a temporary restraining order that required Children's Hospital to maintain life support. Ex. D, Def.'s RJN at 43–44.

On August 25, the Los Angeles County Superior Court dissolved the temporary restraining order. Ex. E, Def.'s RJN at 46. Children's Hospital subsequently removed Israel from life support. Plaintiff's position is that it was on this date that Israel died. *See* Oct. 7, 2016 Hr'g Mins.

On August 31, defendant filed a motion to dismiss plaintiff's second amended complaint based on Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6), arguing plaintiff's as applied claims are barred by the *Rooker-Feldman* doctrine, as they amount to a collateral attack on the Los Angeles state court's judgment upholding the physicians' determination of death, and that plaintiff generally lacks standing. *See* Def.'s Mot. to Dismiss ("MTD") 13–15, ECF No. 68. Plaintiff opposes, Pl.'s Opp'n, ECF No. 70, and defendant replied, Def.'s Reply, ECF No. 73.

III. LEGAL STANDARDS

A. Rule 12(b)(1)

A motion to dismiss under Federal Rule of Civil Procedure 12(b)(1) challenges the court's subject-matter jurisdiction. *See, e.g.*, *Savage v. Glendale Union High Sch.*, 343 F.3d 1036, 1039–40 (9th Cir. 2003). The Federal Rules of Civil Procedure mandate that "[i]f the court determines at any time that it lacks subject-matter jurisdiction, the court must dismiss the action." Fed. R. Civ. P. 12(h)(3).

"The Article III case or controversy requirement limits federal courts' subject matter jurisdiction by requiring, inter alia, that plaintiffs have standing." *Chandler v. State Farm Mut. Auto. Ins. Co.*, 598 F.3d 1115, 1121–22 (9th Cir. 2010) (citing *Allen v. Wright*, 468 U.S. 737, 750 (1984)). As "an essential and unchanging part of the case-or-controversy requirement of Article III," *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992), "[s]tanding is the threshold issue of any federal action," *Employers-Teamsters Local Nos. 175 & 505 Pension Trust Fund v. Anchor Capital Advisors*, 498 F.3d 920, 923 (9th Cir. 2007). "The party asserting federal subject

matter jurisdiction bears the burden of proving its existence." *Chandler*, 598 F.3d at 1122 (citing *Kokkonen v. Guardian Life Ins. Co.*, 511 U.S. 375, 377 (1994)). However, "[a]s the Supreme Court has noted, the evidence necessary to support standing may increase as the litigation progresses." *Barnum Timber Co. v. U.S. E.P.A.*, 633 F.3d 894, 899 (9th Cir. 2011) (citing *Lujan*, 504 U.S. at 561). "Where standing is raised in connection with a motion to dismiss, the court is to 'accept as true all material allegations of the complaint, and construe the complaint in favor of the complaining party.'" *Levine v. Vilsack*, 587 F.3d 986, 991 (9th Cir. 2009) (quoting *Thomas v. Mundell*, 572 F.3d 756, 760 (9th Cir. 2009)).

B. Rule 12(b)(6)

Under Federal Rule of Civil Procedure 12(b)(6), a party may move to dismiss a complaint for "failure to state a claim upon which relief can be granted." The motion may be granted only if the complaint "lacks a cognizable legal theory or sufficient facts to support a cognizable legal theory." *Hartmann v. Cal. Dep't of Corr. & Rehab.*, 707 F.3d 1114, 1122 (9th Cir. 2013). Although a complaint need contain only "a short and plain statement of the claim showing that the pleader is entitled to relief," Fed. R. Civ. P. 8(a)(2), in order to survive a motion to dismiss this short and plain statement "must contain sufficient factual matter . . . to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). A complaint must include something more than "an unadorned, the-defendant-unlawfully-harmed-me accusation" or "'labels and conclusions' or 'a formulaic recitation of the elements of a cause of action.'" *Id.* (quoting *Twombly*, 550 U.S. at 555). Determining whether a complaint will survive a motion to dismiss for failure to state a claim is a "context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Id.* at 679. Ultimately, the inquiry focuses on the interplay between the factual allegations of the complaint and the dispositive issues of law in the action. *See Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984).

In making this context-specific evaluation, this court must construe the complaint in the light most favorable to the plaintiff and accept its factual allegations as true. *Erickson v. Pardus*, 551 U.S. 89, 93–94 (2007). However, "'conclusory allegations of law and unwarranted

inferences' cannot defeat an otherwise proper motion to dismiss." *Schmier v. U.S. Court of Appeals for Ninth Circuit*, 279 F.3d 817, 820 (9th Cir. 2002) (quoting *Associated Gen. Contractors of Am. v. Metro. Water Dist. of S. California*, 159 F.3d 1178, 1181 (9th Cir. 1998)).

IV. DISCUSSION

Plaintiff's claims in this case stem from her assertion that she was harmed when doctors determined her son had died, following the definition and procedures set forth in CUDDA. *See* SAC ¶ 49. CUDDA defines death 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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

Cal. Health & Safety Code § 7180(a). CUDDA also requires an "independent confirmation by another physician" after an individual is pronounced dead. *Id.* § 7181.

Defendant contends this court lacks jurisdiction under the *Rooker-Feldman* doctrine over plaintiff's as applied challenges to CUDDA, and plaintiff generally lacks standing. The court analyzes these two arguments in turn.

A. *Rooker-Feldman* Doctrine

Defendant argues plaintiff's as applied claims are precluded by the *Rooker-Feldman* doctrine, which "bars any suit that seeks to disrupt or 'undo' a prior state-court judgment." *Bianchi v. Rylaarsdam*, 334 F.3d 895, 901 (9th Cir. 2003) (citation omitted). Specifically, defendant contends plaintiff's first two claims are an improper appeal from the state court's April 2016 decision to uphold the physicians' determination that Israel was dead. Def.'s MTD at 19.

Rooker-Feldman is a narrow doctrine that "applies only in 'limited circumstances' where a party in effect seeks to take an appeal of an unfavorable state-court decision to a lower federal court." *Lance v. Dennis*, 546 U.S. 459, 466 (2006) (quoting *Exxon Mobil Corp. v. Saudi Basic Indus. Corp.*, 544 U.S. 280, 291 (2005)). This is because "Congress . . . vests the United States Supreme Court, not the lower federal courts, with appellate jurisdiction over state court

judgments." *Cooper v. Ramos*, 704 F.3d 772, 777 (9th Cir. 2012). "The doctrine bars a district court from exercising jurisdiction not only over an action explicitly styled as a direct appeal, but also over the 'de facto equivalent' of such an appeal." *Cooper*, 704 F.3d at 777 (citing *Noel v. Hall*, 341 F.3d 1148, 1155 (9th Cir. 2003)). To determine whether the federal action functions as a de facto appeal, courts "must pay close attention to the *relief* sought by the federal-court plaintiff." *Bianchi*, 334 F.3d at 900 (emphasis in original) (quotation and citation omitted).

The court previously addressed this issue, after the Placer County Superior Court's ruling, and found the first amended complaint was not an attempt to appeal the state court's decision. *See* ECF No. 48. Here too, plaintiff's current action before this court, filed before the Los Angeles court ruled, is not an appeal of a state court ruling. Unlike in her first state action, plaintiff in this case challenges CUDDA's constitutionality generally. *See D.C. Court of Appeals v. Feldman*, 460 U.S. 462, 486 (1983) (allowing plaintiffs to proceed in federal court on claims questioning the constitutionality of a rule, so long as plaintiffs did not seek review of the rule's application in plaintiffs' particular case, which had been decided in state court). In this case, neither plaintiff's constitutional claims nor her non-constitutional claims were presented to the Placer County Superior Court. *See* Exs. A–G and J–K, ECF No. 14 (briefs, orders, and transcripts from plaintiff's April 2016 proceedings in state court). Additionally, the defendants in the federal and state actions are wholly different: the sole remaining defendant in this action is Karen Smith, M.D., in her capacity as Director of the California Department of Public Health, whereas the only defendants in the Placer County state action were U.C. Davis Children's Hospital and Kaiser Permanente Roseville Medical Center. *See* Ex. A, Pl.'s April 14, 2016 Petition, ECF No. 14. *See also Lance*, 546 U.S. at 466 (cautioning against using principles of privity in the *Rooker-Feldman* analysis); *Marks v. Tennessee*, 554 F.3d 619, 623 (6th Cir. 2009) (noting, in part, that *Rooker-Feldman* did not apply because the federal and state actions involved different defendants). The *Rooker-Feldman* doctrine is inapplicable to this case.

B. Standing

Defendant also argues plaintiff lacks standing because CUDDA did not cause plaintiff's alleged injury; rather only the third party doctors can properly be identified as the

cause. Def.'s MTD at 8. Thus, defendant argues plaintiff lacks standing because the doctors' determination was made in accordance with prevailing medical standards, and the relief sought by plaintiff would not redress her alleged injury. *Id.*

> To establish standing in this case, plaintiff must satisfy a three part test:
>
> First, [plaintiff] must suffer an "injury in fact"—a "concrete and particularized" and "actual or imminent" harm to a legally protectable interest. Second, plaintiff[ ] must demonstrate a "causal connection between the injury and the conduct complained of" such that the injury is "fairly traceable" to the defendant's actions. Third, it must be "likely" that [plaintiff's] injury will be redressed by a favorable court decision.

Harris v. Bd. of Supervisors, Los Angeles Cty., 366 F.3d 754, 760 (9th Cir. 2004) (quoting *Lujan*, 504 U.S. at 560–61).

1. Injury

"The party who seeks to invoke federal jurisdiction has the burden of establishing that it has suffered an injury in fact, 'an invasion of a legally-protected interest' that is concrete and particularized, and actual or imminent, not conjectural or hypothetical." *Didrickson v. U.S. Dep't of Interior*, 982 F.2d 1332, 1340 (9th Cir. 1992) (quoting *Lujan*, 504 U.S. at 560). In this case, plaintiff alleges she was injured when doctors declared her son was dead under California law when in her view, and informed by her religious faith, he was not "biologically dead" since he was still breathing and his heart was still breathing, albeit while connected to life support. *See* SAC ¶ 56. Before doctors removed Israel from life support on August 25, 2016, the threat of injury from doctors removing Israel from life support was concrete, particularized, and imminent because, plaintiff contends, Israel was biologically alive. *See Harris*, 366 F.3d at 761 (observing that "threatened rather than actual injury can satisfy Article III standing requirements" (quotations omitted)). Thus, even without amending her complaint to reflect Israel's death after he was removed from life support, plaintiff has pled sufficient facts to establish the injury prong of the standing inquiry.

2. Causation

As for causation, plaintiff alleges CUDDA caused her harm because the definition of death in CUDDA "is broader than the historical definition [of death]." SAC ¶ 54. Plaintiff also argues CUDDA is "more than merely definitional" because it "prescribes the protocol for confirmation of death." Pl.'s Opp'n at 6.

To have standing, plaintiff must show her "alleged injury [is] 'fairly traceable to the challenged action of the defendant,' rather than [the result of] 'the independent actions of some third party not before the court.'" *Ass'n of Pub. Agency Customers v. Bonneville Power Admin.*, 733 F.3d 939, 953 (9th Cir. 2013) (quoting *Lujan*, 504 U.S. at 560). To satisfy this requirement, plaintiff must show "that there are no independent actions of third parties that break the causal link between" the conditions set forth in CUDDA and plaintiff's harm. *See id.* "The line of causation between the defendant's action and the plaintiff's harm must be more than attenuated. However, a causal chain does not fail simply because it has several links, provided those links are not hypothetical or tenuous and remain plausible." *Native Vill. of Kivalina v. ExxonMobil Corp.*, 696 F.3d 849, 867 (9th Cir. 2012) (citations, quotations, and brackets omitted). But "[i]n cases where a chain of causation involves numerous third parties whose independent decisions collectively have a significant effect on plaintiff's injuries, . . . the causal chain [is] too weak to support standing at the pleading stage." *Maya v. Centex Corp.*, 658 F.3d 1060, 1070 (9th Cir. 2011) (quotations and citations omitted).

Plaintiff contends CUDDA's definition of death caused her harm because "brain waves return in rare cases after having disappeared." SAC ¶ 49. However, CUDDA defines death as the "irreversible cessation of all functions of the entire brain." Cal. Health & Safety Code § 7180(a)(2). Thus, plaintiff's contention is inconsistent with the plain language of CUDDA, for if the cessation of all brain functions is irreversible, brain functions would by definition not return, not even in rare cases.

Plaintiff also contends she could amend her complaint to allege physicians in Guatemala, who cared for Israel when he was outside the United States, ran independent tests and found Israel was not brain dead. Pl.'s Opp'n at 11–14; *see* SAC ¶¶ 44–45. In other words,

plaintiff contends doctors at Kaiser originally misdiagnosed Israel as brain dead when in fact he was in a "persistent vegetative state." Pl.'s Opp'n at 12. As a result of this misdiagnosis, plaintiff argues, CUDDA harmed her as follows:

> [B]ecause Kaiser already acted under the CUDDA protocol, the medical providers at Children's Hospital would not accept the results of the two EEG tests [performed by doctors in Guatemala], would not perform their own brain death examination, and would not allow the parents to bring in an eminent professor from UCLA's medical school to conduct an examination.

Id.

CUDDA mandates that "[a] determination of death must be made in accordance with accepted medical standards." Cal. Health & Safety Code § 7180(a). Nothing in CUDDA prevented Children's Hospital from performing its own independent examinations or required the Hospital take account of the EEG tests. *See San Diego Cty. Gun Rights Comm. v. Reno*, 98 F.3d 1121, 1130 (9th Cir. 1996) (finding plaintiffs who claimed Crime Control Act restricted supply of assault weapons, thereby raising prices, could not establish causation because "nothing in the Act directs manufacturers or dealers to raise the price of regulated weapons"). Plaintiff's allegations are therefore not sufficient to show CUDDA is the cause of her injuries.

3. Redressability

Finally, in order to establish standing, plaintiff "must show a substantial likelihood that the relief sought would redress the injury." *Mayfield v. United States*, 599 F.3d 964, 971 (9th Cir. 2010) (citation omitted). At the motion to dismiss stage, "a court's obligation to take a plaintiff at its word . . . in connection with Article III standing issues is primarily directed at the injury in fact and causation issues, not redressability." *Levine*, 587 F.3d at 996–97 (citing *Lujan*, 504 U.S. at 561). To satisfy the redressability prong of the standing analysis, plaintiff in this case must plead facts demonstrating that invalidating CUDDA will reverse or otherwise impact the medical opinion that Israel died on April 14, when doctors at Kaiser determined Israel was dead. *See Levine*, 587 F.3d at 997 ("Even accepting the allegations in the [complaint] as true, [plaintiff] did not plead any facts demonstrating that [defendant] would act" differently but for the challenged administrative rule.). Plaintiff has not so pled.

Courts consistently find that "any pleading directed at the likely actions of third parties would almost necessarily be conclusory and speculative" absent supporting factual allegations. *Levine*, 587 F.3d at 997. For instance, in *Simon v. E. Kentucky Welfare Rights Org.*, indigent plaintiffs sued Department of Treasury officials to challenge provisions allowing favorable tax treatment to a non-profit hospital where plaintiffs were denied service. 426 U.S. 26, 43 (1976). Due to the attenuated chain of causation, the Supreme Court concluded that plaintiffs lacked standing, as there was no evidence that eliminating the challenged tax break would result in the hospital's changing its practices in treating the plaintiffs. *Id.* Similarly, in this case plaintiff has pled no facts suggesting the elimination of CUDDA would have resulted in physicians determining Israel was still alive on and after April 14, 2016.

Likewise, in *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, plaintiffs were prescription drug plan participants who brought suit against a benefits management company under ERISA, alleging breach of fiduciary duty. 465 F.3d 1123, 1124 (9th Cir. 2006). Plaintiffs argued that if the court found in their favor, the plan's drug costs, contributions, and co-payments would decrease. *Id.* at 1125. The Ninth Circuit found that the alleged injury was not redressable because the court's judgment would not compel the defendants to increase their disbursement of benefits payments. *Id.* The court then held plaintiffs lacked standing under Article III because, as with the doctors in the case presently before this court, "any prospective benefits depend on an independent actor who retains broad and legitimate discretion the courts cannot presume either to control or predict." *Id.* (internal citations omitted).

Unlike in *Simon* and *Glanton ex rel.*, in *Stormans, Inc. v. Selecky*, pharmacy owners brought a Free Exercise Clause challenge against a regulation requiring pharmacists to stock and dispense a type of emergency contraception called Plan B. 586 F.3d 1109, 1120 (9th Cir. 2009). In holding that the pharmacy owners had Article III standing, the Ninth Circuit found that their injury would be redressed by a judgment that the regulation was unconstitutional. *Id.* at 1121–1122. Unlike in the case presently before this court, the connection in *Stormans* was direct because the regulation required the pharmacists to perform actions that they would not have to perform if the regulation were invalidated. *Id.*

The court finds plaintiff has failed to plead facts sufficient to show her desired relief would redress her injury.

V. CONCLUSION

The court finds plaintiff's second amended complaint does not satisfy the causation and redressability prongs of the Article III standing inquiry. Having found plaintiff lacks standing, the court declines to address defendant's other arguments for dismissal at this time. The court therefore GRANTS defendant's motion to dismiss.

Federal Rule of Civil Procedure 15(a)(2) provides that "[t]he court should freely give [a party leave to amend its pleading] when justice so requires," and the Ninth Circuit has "stressed Rule 15's policy of favoring amendments." *Ascon Properties, Inc. v. Mobil Oil Co.*, 866 F.2d 1149, 1160 (9th Cir. 1989). In light of plaintiff's arguments in her briefing and the events that have transpired since the filing of the second amended complaint, suggesting amendment may be possible, plaintiff is granted leave to amend her complaint within twenty-one (21) days of the date of this order.

IT IS SO ORDERED.

DATED: March 27, 2017.

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **PLAINTIFF'S OPPOSITION TO DEFENDANT'S OBJECTION TO PLAINTIFF'S REQUEST FOR JUDICIAL NOTICE** **Date:** October 7, 2016 **Time:** 2:30 p.m. **Ctrm:** 3 **Hon.:** Kimberly J. Mueller **Trial Date:** none set

[1] *Counsel of record*

[2] The papers are the verified petition and declaration in support of the application for a temporary restraining order filed by Fonseca.

Comes now Plaintiff (or "Fonseca") who submits this opposition to the Defendant's Objection to the Plaintiff's Request for Judicial Notice. Defendant ("Director") objects to Superior Court filings in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case no. BS164387. Namely, the Director objects to the medical opinions of Drs. Ruben Posadas and Francisco Montiel.

But the Director has requested judicial notice of papers filed from that very case. (Ct. doc. 71). Indeed, two of the documents ("TRO documents")[2] filed by the Director specifically reference the physicians' statements for which Fonseca requests judicial notice. Def. RJN, Exh. C (Ct. doc. 68-3, p. 28:20 to 29:12 & 38:19-24). The opinions of Drs. Posadas and Montiel were attached as exhibits to the TRO documents. Id. It is mystifying why the Director would seek judicial notice of two incomplete TRO documents from the Superior Court case, yet object when Fonseca seeks to include the exhibit attached to those same TRO documents. By requesting judicial notice of the TRO documents, the statements and supporting exhibits in those TRO documents were put at issue by the Director.

In any event, as this Court noted in its prior opinion, it may take judicial notice of the filings in the state case. *Fonseca v. Kaiser Permanente Medical Center Roseville*, 2016 U.S.Dist.LEXIS 63698, citing Fed. R. Evid. 201(b) and *Asdar Group v. Pillsbury, Madison & Sutro*, 99F.3d 289, 290 n.1 (9th Cir. 1996) (Ct. doc. 48, p. 4, n. 2).

Respectfully submitted,

S/ Kevin Snider
Attorney for Plaintiff

[2] The papers are the verified petition and declaration in support of the application for a temporary restraining order filed by Fonseca.

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, Plaintiff, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA,** Defendant.	2:16-cv-00889-KJM-EFB **DEFENDANT'S OBJECTION TO PLAINTIFF'S REQUEST FOR JUDICIAL NOTICE** Date: October 7, 2016 Time: 10:00 a.m. Courtroom: 3 Judge: Hon. Kimberly J. Mueller Trial Date: none set Action Filed: May 9, 2016

Defendant Karen Smith, M.D., in her official capacity as Director of the California Department of Public Health objects to plaintiff's request that this court take judicial notice of the Medical Evaluations of Drs. Ruben Posadas and Francisco Montiel, which plaintiff collectively identifies as Exhibit 1.

Plaintiff fails to satisfy the requirements for judicial notice. Judicial notice is appropriate where the fact is not subject to reasonable dispute because it is capable of accurate and ready determination by resort to sources "whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b)(2). Here, the documents themselves cannot be readily authenticated. Moreover, the purported facts contained within these documents are disputed and cannot be "readily

determined." Finally, the medical opinions of Doctors Posadas and Montiel are immaterial to the issues raised by the Director's motion to dismiss.

CONCLUSION

For the foregoing reasons, the Director respectfully requests that the Court deny plaintiff's request to take judicial notice of the above referenced documents.

Dated: September 30, 2016

Respectfully submitted,

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/s/ Ashante L. Norton

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CERTIFICATE OF SERVICE

Case Name: ***Jonee Fonseca v. Kaiser Permanente Medical Center Roseville (CDPH)*** Case No. ***2:16-cv-00889-KJM-EFB***

I hereby certify that on September 30, 2016, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

Defendant's Objection to Plaintiff's Request for Judicial Notice

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on September 30, 2016, at Sacramento, California.

Bryn Barton	***/s/ Bryn Barton***
Declarant	Signature

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12451105.doc

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JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, Plaintiff, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEATH,** Defendant	2:16-cv-00889-KJM-EFB **DEFENDANT'S REPLY IN SUPPORT OF MOTION TO DISMISS SECOND AMENDED COMPLAINT** **[Fed.R.Civ.Proc. 12(b)(1), (6)]** Date: October 7, 2016 Time: 10:00 a.m. Dept: 3 Judge: The Honorable Kimberly J. Mueller Trial Date: not set Action Filed: 5/9/2016

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INTRODUCTION

Because there now is no dispute that Israel is deceased, no case or controversy remains and the matter should be dismissed. Plaintiff, however, desires to continue on in hopes of establishing that the Kaiser physicians were wrong and she wants to amend the relief to include a declaration that Israel died on August 25, the day the life-sustaining support was removed, instead of April 14, the date stated on the death certificate and as declared by Kaiser physicians. In so doing, plaintiff hopes to resolve a hypothetical dispute concerning the medical bills incurred while Israel was on life sustaining support. Plaintiff also seeks to add as co-plaintiff, Life Legal, the organization assisting plaintiff in this litigation. These amendments will not cure the defects raised by the Director's motion and the complaint should be dismissed without leave to amend.

The only controversy that remains is between plaintiff and the physicians who rendered the medical determination that Israel died on April 14. Thus, the matter remains moot and the mootness exception "likely of repetition yet evading review" does not apply.

Standing also remains a bar to plaintiff's complaint. Indeed, plaintiff largely fails to address the Director's standing arguments, and makes no showing that the injury alleged—the determination that Israel died on April 14, 2016—was caused by the Director or CUDDA, rather than the independent medical decisions of non-party doctors. Nor can plaintiff establish redressability, as there is no indication that the physicians who determined Israel's date of death would reach a different conclusion in the absence of CUDDA.

Nor has plaintiff shown that she can state cognizable claims against the Director for any constitutional violation.

Finally, plaintiff has not shown, and cannot show, that her "as applied" claims raise different issues than those already adjudicated in her state court action. Accordingly, they are barred by the *Rooker-Feldman* doctrine Accordingly, plaintiff's claims must be dismissed without leave to amend.

I. PLAINTIFF'S CLAIMS REMAIN MOOT.

As the Director argued in her motion, plaintiff's claims in the Second Amended Complaint are moot because it is now undisputed that Israel is deceased. *See* Motion at 9-10.

In response, plaintiff does not dispute that her current claims are moot, but instead asserts that her proposed further amendments to the complaint would revive the controversy between the parties; or alternatively, that the court should retain jurisdiction because her claims present important questions of law that are capable of repetition yet evading review. Opposition at 1-4. Plaintiff is wrong on both accounts.

Foremost, the amendments proposed by plaintiff do not present a justiciable claim. Plaintiff's claim that she may be financially responsible for Israel's medical care costs after Medi-Cal ceased coverage is too speculative and remote and is therefore unripe. A case or controversy exists justifying declaratory relief only when "the challenged government activity ... is not contingent, has not evaporated or disappeared, and, by its continuing and brooding presence, casts what may well be a substantial adverse effect on the interests of the petitioning parties." *Headwaters, Inc. v. Bureau of Land Management, Medford Dist.*, 893 F.2d 1012, 1015 (9th Cir. 1990) (citing *Super Tire Engineering Co. v. McCorkle*, 416 U.S. 115, 122 (1974)). The adverse effect, however, must not be "so remote and speculative that there [is] no tangible prejudice to the existing interests of the parties." *Headwaters, supra*, at 1015. The parties must have adverse legal interests "of sufficient *immediacy and reality* to warrant issuance of a declaratory judgment." *Biodiversity Legal Found. v. Badgley*, 309 F.3d 1166, 1174–75 (9th Cir. 2002) (emphasis added). Plaintiff's concerns about her potential financial liability based on Israel's date of death are not sufficiently concrete to state a ripe, justiciable claim.

Further, plaintiff's proposed amendments would suffer from the same standing and merits flaws as her current claims, as she is still suing the Director to challenge the validity of CUDDA when it is not CUDDA, but the independent medical decisions of non-party physicians, that determined Israel's date of death. The only controversy that remains is between plaintiff and the medical community, parties whom are not before this Court.

Moreover, the repetition-yet-evading-review exception doctrine cannot save plaintiff's action. Under this exception, the court may exercise jurisdiction over otherwise moot matters in which "[1] the challenged action [is] in its duration too short to be fully litigated prior to its cessation or expiration, and [2] there [is] a reasonable expectation that the *same complaining*

party would be subjected to the same action again." *Headwaters, Inc., supra*, 893 F.2d at 1016 (emphasis added). The exception is a narrow one and applies in only exceptional circumstances. *Id*.

Plaintiff has not shown that this is a type of case that necessarily evades review. Plaintiff, relying on *Roe v Wade*, 410 U.S. 113 (1973), argues that the doctrine is "a classic fit." Not so. The *Roe* Court reasoned that both the short gestation period and the fact that "[p]regnancy often comes more than once to the same woman" were cause to apply the narrow exception. *Id*. at 125.

While plaintiff dismisses the availability of stays and injunctions as "not the best way" to litigate these claims, the fact remains that they are available. In this very case, plaintiff's ability to initiate several cases and successfully obtain stays from several courts while she pursued her claims proves that this is not a type of case that necessarily evades review.

Finally, plaintiff has not shown that there is a reasonable probability that *she* will again be faced with contesting a brain death declaration.

Plaintiff's reliance on *Bartling v. Superior Court*, 163 Cal. App.3d 186 (1984), is not persuasive. Unlike the "case-or-controversy" limitation imposed by Article III on federal court jurisdiction, there is no similar requirement in the California Constitution. *Jasmine Networks, Inc. v. Superior Court*, 180 Cal. App. 4th 980, 990 (2009). Accordingly, state courts, like the court in *Bartling*, are "empowered to adjudicate any 'cause' brought before it." *Id*.

Plaintiff has not demonstrated that the remaining issue—whether Israel died on April 14 or August 25—will have any impact beyond this complaint. Nor can plaintiff demonstrate that she will again have cause to challenge CUDDA. This matter remains beyond the court's reach.

II. PLAINTIFF STILL FAILS TO ESTABLISH STANDING; THE DIRECTOR HAS NOT CAUSED PLAINTIFF HARM NOR WILL A FAVORABLE OUTCOME REDRESS PLAINTIFF'S ALLEGED INJURY

Plaintiff cannot establish the causation or redressability required for standing against the Director because the injury plaintiff alleges—the determination that Israel died on April 14—resulted from the independent medical decisions of non-party doctors, and not from CUDDA or any actions of the Director. Motion at 10-12. Further, an order invalidating CUDDA would not redress plaintiff's injury, as the date of death would still be determined by the medical

professionals, and plaintiff has not shown any likelihood that the doctors would reach a different conclusion in CUDDA's absence. *Id*. at 11-12. Plaintiff does not directly address these arguments.

A. Plaintiff Has Not Sufficiently Alleged That CUDDA's Enactment Has Caused the Injury At Issue

As stated in the Motion, plaintiff must show that the injury—determination of death—stems from compliance with CUDDA. Motion at 11. The only remaining "injury" is the determination that Israel died on April 14. Opposition at 5. Plaintiff contends that CUDDA is responsible because it defines death and imposes certain post-death requirements on the hospital. Opposition at 6. This will not satisfy standing because plaintiff fails to state any facts demonstrating that CUDDA *directs the medical determination* that Israel suffered brain death on April 14. Moreover, CUDDA's post death protocols have no effect on the alleged injury. CUDDA's mandate that records be maintained (§ 7183) and the State's requirement that a death certificate be completed and registered (Cal. Health & Saf. Code §§ 102775, 102800) do not direct or affect the physician's medical opinion that Israel suffered brain death. Accordingly, it remains that plaintiff has not shown that CUDDA caused plaintiff's alleged injury. Plaintiff lacks standing.

B. Even Considering The Proposed Amendments, The Alleged Injury Cannot Be Redressed By Challenging CUDDA

Plaintiff disputes Kaiser physician's determination that Israel died on April 14 and she contends that her injury would be redressed if the Court were to "order the Defendant to change the date of the death certificate from April 14 to August 24, 2016." Opposition at 5. But as a matter of law the State does not determine the date of death, but instead only records the date of death as determined by the appropriate medical professionals. (Cal. Health & Saf. Code, §§ 102800, 102775.) Fundamentally, plaintiff cannot show how invalidating CUDDA will reverse the medical opinion that Israel died on April 14. Plaintiff wholly fails to address the fact that the medical determination at issue is made in response to the prevailing medical and ethical standards of the medical community. Invalidating CUDDA will not affect the change plaintiff desires. If plaintiff seeks to change the date of death, she must seek relief from the doctors who determined

the date of death, and she lacks standing to seek such relief from the Director, who did not cause the allegedly erroneous determination of death and cannot redress it. Simply put, plaintiff has sued the wrong party.

III. PLAINTIFF HAS NOT ALLEGED FACTS OR PROVIDED LEGAL AUTHORITY TO SUPPORT HER DUE PROCESS CLAIMS.

A. Plaintiff Has Not Addressed the Director's Arguments Concerning Her Procedural Due Process Claim; The First Cause of Action Should be Dismissed

Plaintiff's procedural due process challenges, both facial and as applied, fail to state a claim as a matter of law because California law provides—and plaintiff was in fact afforded—the right to challenge a determination of death in state superior court. Motion at 13-14.[1] Plaintiff contends that notwithstanding these procedural protections, she did not have a "realistic opportunity" to be heard. Opposition at 8-10. That is incorrect.

Though plaintiff alleges that CUDDA precludes a patient advocate from securing her own opinion, she acknowledges that she was afforded the very process she proclaims does not exist. *See* SAC ¶¶ 21-23, 40-42. Plaintiff filed a petition with the superior court upon learning that Kaiser physicians determined that Israel suffered irreversible brain death. ECF No. 14-2. The petition expressly sought an opportunity to secure an independent opinion. *Id*. The state court granted plaintiff's petition and provided her two weeks to have Israel evaluated. ECF No. 14-3. Only upon plaintiff's failure to proffer to the court competent medical evidence refuting the Kaiser physicians' determination, did the court dismiss plaintiff's petition. ECF 14-8, 75:21-76:9, ECF 19-1, 2:5-6. Plaintiff provides no factual or legal authority for why this process is insufficient.

Additionally, plaintiff fails to address the additional safeguards that CUDDA provides. *See* § 7180(a) (requiring that all determinations of death be made in accordance with prevailing medical standards); *see also* § 7181 (requiring that in cases of brain death a single physician's opinion is insufficient; CUDDA requires *independent* confirmation by another physician).

[1] Like the complaint, plaintiff's opposition does not distinguish between her facial and "as applied" challenges to CUDDA.

In discussing her procedural due process claims, plaintiff raises arguments arising from her *substantive* beliefs concerning biological death, citing several articles that discuss biological life and various disagreements with brain death diagnosis. Opposition at 8-10. These arguments are irrelevant to plaintiff's procedural due process claims as they do not address the Director's arguments, nor do they demonstrate that the procedural due process challenge has merit. Because plaintiff has not, and cannot, propose any additional facts that would bolster her First Cause of Action, it should be dismissed with prejudice.

B. Plaintiff's Substantive Due Process Claim Is Also Without Merit and The Second Cause of Action Should be Dismissed.

Plaintiff's substantive due process claims fail as a matter of law because CUDDA does not deprive anyone of life or liberty, and even if it did, the State's interests underlying CUDDA outweigh any individual interests in defining death differently. Motion at 15-16.

Plaintiff asserts that CUDDA has deprived Israel of life. Opposition at 7, 10-11. However, CUDDA expressly provides that "[a] determination of death must be made *in accordance with accepted medical standards*." § 7180(a) (emphasis added). In cases of brain death, CUDDA also requires that before a patient is declared deceased "there shall be *independent* confirmation by another physician." *Id.*, § 7181 (emphasis added). Thus, CUDDA directs only that determinations of death be made according to accepted medical standards and be confirmed by an independent physician. Because plaintiff still fails to show state encroachment—that CUDDA interfered with her or Israel's rights— her claims should be dismissed on this ground alone.

Even if sufficient state involvement is established, plaintiff cannot demonstrate a constitutional violation. In her motion, the Director highlights the State's interests underlying CUDDA and argues that they should prevail when balanced against plaintiff's individual interests here. Motion at 16. Plaintiff, in response, writes off the State's interests and assert an unrestricted right to patient self-determination. Opposition at 10-11 (children like Israel "have a fundamental right to life that does not yield to countervailing interests …" and this "right of self-determination … is not subject to veto by the medical profession or the judiciary"). She argues that this includes the unquestioned right to determine whether to continue life-sustaining support.

Opposition at 10. Plaintiff, however, provides no support for such unfettered authority. Contrary to plaintiff's assertion, limits may be imposed by the State where competing legitimate interests are at stake, particularly where public health and safety are concerned. See *Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir. 1980) (no fundamental right to access drugs the FDA has not deemed safe and effective).

The cases cited by plaintiff are also unpersuasive. Plaintiff cites *Abigail All. for Better Access to Developmental Drugs v. Eschenbach*, 469 F.3d 129, 138 (D.C. Cir. 2006) and *Bartling*, *supra*, for the proposition that a person has an unquestioned right to direct medical decisions and decisions to prolong life. Opposition at 14. These decisions, however, also acknowledge that the asserted fundamental rights are not absolute and must be balanced against the interests of the State. *Bartling*, *supra*, at 195 ("Balanced against [privacy interests] are the interests of the state in the preservation of life, the prevention of suicide, and maintaining the ethical integrity of the medical profession."); *Abigail*, *supra*, at 138 ("the inherent right of every freeman to care for his own body and health in such way as to him seems 'best' is not 'absolute,' … [citation]".)

Additionally, plaintiff overstates the scope of parental rights here. The "state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare . . . ." *Prince v. Massachusetts*, 321 U.S. 158, 167 (1944). Although parents undoubtedly have a right to the "custody, care and nurture of the child," *id.* at 166; *Troxel v. Granville*, 530 U.S. 57, 65 (2000), the "rights of parenthood are [not] beyond limitation." *Prince*, 321 U.S. at 167.

Plaintiff has been given ample opportunity to support her claims that CUDDA is unconstitutional, yet she still fails to allege any facts demonstrating that CUDDA is arbitrary. ECF No. 48, at 24:17-18 (This court has previously observed that plaintiff provides no facts that "suggest [] CUDDA is arbitrary, unreasoned, or unsupported by medical science."). It remains that plaintiff's disagreement with the prevailing definition of death cannot override the State's interests in enacting CUDDA. Plaintiff's second cause of action fails as a matter of law.

IV. LIKE PLAINTIFF'S FIRST AND SECOND CAUSES OF ACTION, PLAINTIFF'S THIRD CAUSE OF ACTION FOR DEPRIVATION OF LIFE IN VIOLATION OF THE CALIFORNIA CONSTITUTION FAILS.

As the Director argued in her motion, the analysis of plaintiff's third cause of action is substantively identical to the analysis of her first and second causes of action, and thus it fails to state a claim for the same reasons. Motion at 17. In response, plaintiff contends that the analysis is not the same, and that here claims for deprivation of life in violation of the California Constitution are "more expansive" than her federal due process claims. Opposition at 14. That is incorrect.

First, the protections are the same. The California Constitution protects persons from deprivation of life, liberty, or property without due process of law. It "prevents government from enacting legislation that is 'arbitrary' or 'discriminatory' or lacks 'a reasonable relation to a proper legislative purpose.'" *Kavanau v. Santa Monica Rent Control Bd*., 16 Cal.4th 761, 771 (1997); *California Rifle & Pistol Assn. v. City of W. Hollywood*, 66 Cal. App. 4th 1302, 1330 (1998); Cal. Const., Art. I, § 7. The federal Due Process Clause likewise imposes constraints on governmental decisions which deprive an individual's right to be deprived of life, liberty, or property only by the exercise of lawful power. *J. McIntyre Mach., Ltd. v. Nicastro*, 564 U.S. 873, 879 (2011). Additionally, both Constitutions require that the affected parties be afforded procedural protections – the "right to be heard at a meaningful time and in a meaningful manner." *D & M Fin. Corp. v. City of Long Beach*, 136 Cal. App. 4th 165, 175 (2006) (citations omitted); *Mathews v. Eldridg*e, 424 U.S. 319, 333 (1976).

Second, the analysis is the same. The court, in determining whether a constitutional violation occurred, must balance the individual liberty interest at stake against the State's interests. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279 (1990)(quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982); *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1620 (1992); see also *People v. Ramirez*, 25 Cal.3d 260, 264 (court must assess what procedural protections are constitutionally required in light of the governmental and private interests at stake).

Even under the more "expansive view" advocated by plaintiff, her claims still fail. Plaintiff relies on *Donaldson, supra*, for support that there is an unqualified interest in preserving life. Opposition at 14. Plaintiff overreaches. There the court considered the State's interests in

preserving life as *balanced against* an individual's right to medical self-determination. *Donaldson* at 1620. As the Director argued in her motion, the State's interests are vast, including, among others, the interests in drawing boundaries between life and death, ensuring that citizens receive quality health care, and ensuring that patients are treated with dignity, particularly at the end of their lives. Motion at 16. Plaintiff has not addressed the State's interests or demonstrated that CUDDA is unreasonable or arbitrary. Furthermore, plaintiff has received all the process due to her under these circumstances. See Motion at 13-14. Accordingly, it remains that plaintiff has failed to state a claim under the California Constitution and the Third Cause of Action should also be dismissed.

V. CUDDA DOES NOT VIOLATE PLAINTIFF'S RIGHT TO PRIVACY AND THEREFORE THE FOURTH AND FIFTH CAUSES OF ACTION SHOULD BE DISMISSED

Plaintiff cannot establish that the State by enacting CUDDA has violated her right to privacy under the state and federal constitutions. It bears repeating that the medical decisions at issue were made by doctors according to prevailing medical standards and were not dictated by CUDDA. Motion at 17. Plaintiff's arguments in response are unavailing. Plaintiff complains that Kaiser physicians did not conduct EEG tests and her requests to continue life support were not respected. Opposition at 11-12. Yet, she alleges no facts that *CUDDA* directs physicians concerning which examinations to conduct or that *CUDDA* dictates whether life-sustaining support should continue. Plaintiff's inability to demonstrate that CUDDA is responsible for the alleged injury cannot be overcome.

Plaintiff's claims fare no better even if the court proceeds to balance the interests of the parties. As stated above, a parent's plenary authority over medical decisions for a child is not without its limits. *See infra*, Part III.B. Plaintiff offers no discussion or authority that address why her right to dictate medical decisions should prevail once three physicians determined that Israel suffered irreversible cessation of brain activity. Plaintiff's fourth and fifth causes of action should be dismissed.

VI. PLAINTIFF'S PROPOSED AMENDMENTS FURTHER HIGHLIGHT THAT THE *ROOKER FELDMAN* DOCTRINE BARS PLAINTIFF'S "AS APPLIED" CLAIMS IN THE FIRST AND SECOND CAUSES OF ACTION.

In *Israel Stinson v. UC Davis Children's Hospital; Kaiser Permanente Roseville*, Case No. S-CV-0037673, the court declared that a proper determination of death had been made in accordance with accepted medical standards. ECF 14-8, 75:21-76:9, 19-1, 2:5-6. Accordingly, the court affirmed the medical opinion that Israel died on April 14. Plaintiff continues to dispute this determination and seeks to amend the relief sought to include an order from this Court that Israel died on August 25, and not on April 14 as Kaiser physicians determined and the state court upheld. If there was any doubt that *Rooker-Feldman* bars plaintiff's "as applied" claims, none should remain.

In response, plaintiff denies asking this Court to reverse the state court's determination. Opposition at 15. However, this is precisely what plaintiff requests. *See* Opposition at 5 ("the remedy would be for the Court to order the Defendant to change the date of the death certificate from April 14 to August 24 [sic], 2016, …"). The *Rooker-Feldman* doctrine bars these claims.

VII. FINALLY, ADDING LIFE LEGAL WILL NOT SATISFY ARTICLE III STANDING OR CURE THE ISSUES CONCERNING IN THE MERITS OF THE COMPLAINT

Plaintiff suggests adding Life Legal as co-plaintiff to this action. Plaintiff generally alleges that Life Legal will continue to be affected by CUDDA, including working to maintain life support for members of the public. Opposition at 6. Life Legal, however, cannot establish standing. The same analysis used in the context of an individual plaintiff is also used to determine whether an organizational plaintiff meets the threshold requirements (which must be met in addition to the particular requirements for organizational standing) for standing in a particular case. *La Asociacion de Trabajadores de Lake Forest v. City of Lake Forest*, 624 F.3d 1083, 1088 (9th Cir. 2010). Accordingly, joining Life Legal will not salvage this action. Moreover, even if Life Legal were joined, the claims remain the same. Each of plaintiff's claims is deficient and cannot be cured by amendment. Adding another plaintiff to this action will not transform the claims or resolve the deficiencies raised by the Director's motion.

CONCLUSION

This court should dismiss the Second Amended Complaint without leave to amend.

Dated: September 30, 2016

Respectfully Submitted,

KAMALA D. HARRIS
Attorney General of California
ISMAEL A. CASTRO
Supervising Deputy Attorney General

/s/ Ashante L. Norton

ASHANTE L. NORTON
Deputy Attorney General
Attorneys for Defendant

SA2016102013
12451283.doc

CERTIFICATE OF SERVICE

Case Name: ***Jonee Fonseca v. Kaiser Permanente Medical Center Roseville (CDPH)*** Case No. ***2:16-cv-00889-KJM-EFB***

I hereby certify that on September 30, 2016, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

Defendant's Reply in Support of Motion to Dismiss Second Amended Complaint

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on September 30, 2016, at Sacramento, California.

Bryn Barton	***/s/ Bryn Barton***
Declarant	Signature

SA2016102013
12451090.doc

Kevin T. Snider, State Bar No. 170988[1]
Michael J. Peffer, State Bar. No. 192265
Matthew B. McReynolds, State Bar No. 234797
PACIFIC JUSTICE INSTITUTE
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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **PLAINTIFF'S REQUEST FOR JUDICIAL NOTICE IN OPPOSITION TO DEFENDAN'S MOTION TO DISMISS; DECLARATION OF KEVIN SNIDER** **Date:** October 7, 2016 **Time:** 3:30 p.m. **Ctrm:** 3 **Hon.:** Kimberly J. Mueller **Trial Date:** none set

[1]*Counsel of record*

Pursuant to Rule 201 of the Federal Rules of Evidence, Plaintiff Jonee Fonseca respectfully requests that the Court take judicial notice of the document listed below.

Judicial notice is appropriate where the fact is not subject to reasonable dispute because it is "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b)(2). Federal courts routinely take judicial notice of state court records. *Harris v. County of Orange*, 682 F.3d 1126, 1132 (9th Cir. 2012); *Cachil Dehe Band of Wintun Indians v. California*, 547 F.3d 962, 968 n. 4 (9th Cir. 2008) (taking judicial notice of state records); *United States v. Black*, 482 F.3d 1035, 1041 (9th Cir. 2007) (noting that a court "may take notice of proceedings in other courts, both within and without the federal judicial system, if those proceedings have a direct relation to matters at issue"); *Reyn's Pasta Bella, LLC v. Visa USA, Inc*., 442 F.3d 741, 746 n. 6 (9th Cir. 2006) (taking judicial notice of pleadings, memoranda, and other court filings); *Asdar Group v. Pillsbury, Madison & Sutro*, 99 F.3d 289, 290 n. 1 (9th Cir. 1996) (court may take judicial notice of pleadings and court orders in related proceedings).

Defendant has requested judicial notice of the Verified Ex Parte Petition for Temporary Restraining Order/Injunction: Request for Order of Independent Neurological Exam filed August 18, 21016, in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case no. BS164387. See Defendant's Exhibit C. Plaintiff also requests judicial notice of a portion of the filings in said case. Namely, portions of two exhibits (2 and 3) filed by attorneys for Children's Hospital Los Angeles in support of the Ex Parte Application to Dissolve Temporary Restraining Order. Exhibit 2 to the Ex Parte Application is the Death Certificate of Israel Stinson issued by the California Department of

Vital Records and the County of Placer. Exhibit 3 to the Ex Parte Application includes the medical evaluations by a Guatemalan neurologist (Dr. Ruben Posadas) and another physician (Dr. Francisco Montiel). These documents are marked as Exhibit 1.

Date: September 21, 2016

Respectfully submitted,

S/ Kevin Snider
Attorney for Plaintiff

DECLARATION OF KEVIN SNIDER

I, Kevin T. Snider, hereby declare, that I am one of the attorneys for the Plaintiff in the above-encaptioned action, and that if called upon, I could, and would, truthfully testify of my own personal knowledge, as follows:

1. On September 19, 2016, I searched the Online Services of the California Superior Court, County of Los Angeles' website for the papers filed in the case *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case no. BS164387. I did this after reading Exhibit C (Ct. doc. 68-3, p. 26-46) of the Defendant's Request for Judicial Notice and seeing that it consisted of a number of documents filed in that case.

2. Exhibit 1 of Plaintiff's Request for Judicial Notice are true and correct copies of filings from the same case which I downloaded from the Superior Court's website. These documents are as described in Plaintiff's Request for Judicial Notice filed concurrently herewith.

3. In addition to downloading the item in Exhibit 1, I also reviewed the list of documents in that case. Neither the Petitioner nor the Respondent filed objections to the respective exhibits filed by either party.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct as to my own personal knowledge. Executed this twenty-third day of September, 2016, in the County of Sacramento, City of Sacramento, State of California.

S/ Kevin Snider
Attorney for Plaintiff

EXHIBIT 1

CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY
RICHARD D. CARROLL (SBN 116913)
DAVID P. PRUETT (SBN 155849)
111 West Ocean Boulevard, 14th Floor
Post Office Box 22636
Long Beach, California 90801-5636
Telephone No. (562) 432-5855 / Facsimile No. (562) 432-8785

Attorneys for Respondent, CHILDREN'S HOSPITAL LOS ANGELES

FILED
Superior Court of California
County of Los Angeles
AUG 25 2016
Sherri R. Carter, Executive Officer/Clerk
By Nancy N. DiGiambattista Deputy
N. DiGiambattista

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ISRAEL STINSON, a minor, by Jonee Fonseca his mother,

Petitioner,

vs.

CHILDREN'S HOSPITAL LOS ANGELES

Respondent.

CASE NO.: BS164387

EX PARTE APPLICATION TO DISSOLVE TEMPORARY RESTRAINING ORDER; DECLARATIONS OF DAVID P. PRUETT, BARRY MARKOVITZ, M.D., AND CHERYL LEW, M.D.

DATE: August 25, 2016
TIME: 8:30 a.m.
DEPT: 86

ASSIGNED FOR ALL PURPOSES TO:
JUDGE AMY D. HOGUE
DEPARTMENT 86

TO THE COURT AND JONEE FONSECA, MOTHER OF ISRAEL STINSON AND COURT-APPOINTED "GUARDIAN AD LITEM":

PLEASE TAKE NOTICE that on August 25, 2016, at 8:30 a.m., in Department 86 of the Los Angeles Superior Court, located at 111 North Hill Street, Los Angeles, California, respondent Children's Hospital Los Angeles will be heard on its ex parte application to for an order to dissolve the temporary restraining order entered by the Court on August 18, 2016 and to permit Children's Hospital Los Angeles to take actions, including withdrawal of mechanical support of the physical body of Israel Stinson, based upon the fact that Israel Stinson has been

CITY CASE# BS164387
LEAP REF#
RECEIPT #: 0015207208
DATE PAID: 08/25/16 08:22 AM
PAYMENT: $60.00
RECEIVED: $60.00
CHARGE: $0.00
CASH: $0.00
CHECK: $0.00
CARD: $0.00

CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY
RICHARD D. CARROLL (SBN 116913)
DAVID P. PRUETT (SBN 155849)
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Attorneys for Respondent, CHILDREN'S HOSPITAL LOS ANGELES

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ISRAEL STINSON, a minor, by Jonee Fonseca his mother,

Petitioner,

vs.

CHILDREN'S HOSPITAL LOS ANGELES

Respondent.

CASE NO.: BS164387

DECLARATION OF DAVID P. PRUETT IN SUPPORT OF EX PARTE APPLICATION TO DISSOLVE TEMPORARY RESTRAINING ORDER

DATE: AUGUST 25, 2016
TIME: 8:30 A.M.
DEPT: 86

ASSIGNED FOR ALL PURPOSES TO:
JUDGE AMY D. HOGUE
DEPARTMENT 86

DECLARATION OF DAVID P. PRUETT

1. I am an attorney licensed to practice law in the State of California. I am a certified appellate specialist. I am a partner with the firm of Carroll, Kelly, Trotter, Franzen, McKenna & Peabody, attorneys for Children's Hospital Los Angeles in the above-captioned action pertaining to Israel Stinson. I am making this declaration in support of the ex parte application of Children's Hospital Los Angeles to dissolve the temporary restraining order of August 18, 2016.

2. On August 23, 2016, at 8:41 a.m. I left a voicemail for Jonee Fonseca, at (707)450-6900, the telephone number on her "Verified Ex Parte Petition for Temporary Restraining Order," and at 9:06 a.m. I sent to her an email to her address at joneefonseca@yahoo.com, give you notification that Children's Hospital Los Angeles will make an ex parte application to the Court, at 8:30 a.m. on August 25, 2016, in Department 86 of the Los Angeles Superior Court, located at 111 North Hill Street, Los Angeles, California, for an order to dissolve the temporary restraining order entered by the Court on August 18, 2016 and to permit Children's Hospital Los Angeles to take actions, including withdrawal of mechanical support of the physical body of Israel Stinson, based upon the fact that Israel Stinson has been medically and legally determined to be dead. Alternatively, Children's Hospital Los Angeles will seek an order expediting the proceedings, to hear the issue of whether the Court should enter a preliminary injunction, to be heard by the Court on August 29, 2016, or as soon thereafter as the matter can be heard. A copy of my email is submitted as Exhibit "X."

3. On August 24, 2016, at about 10:30 a.m., I spoke to Ms. Fonseca, and she informed me that she or an attorney would appear at the ex parte hearing. Later that day, at about 2:30 p.m., I received a call from attorney Dan Woodard, stating that he would be appearing at the ex parte hearing. He gave me phone numbers of (626)485-3589 and (626)584-8000, and email of djw@woodardlaw.net.

4. True and correct copies of documents have been submitted with this declaration and the ex parte application, including:

- Exhibit 1: Temporary Restraining Order of August 18, 2016;

- Exhibit 2: Verified Ex Parte Petition For Temporary Restraining Order/Injunction: Request For Order Of Independent Neurological Exam; Request For Order To Maintain Level Of Medical Care, filed August 18, 2016;
- Exhibit 3: Copy of Certificate of Death, which I obtained from the State of California on August 12, 2016;
- Exhibit 4: Order Of Dismissal of the Placer County Superior Court, dated April 29, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889;
- Exhibit 5: Order of United States District Court, Eastern District of California, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 13, 2016, dissolving temporary restraining order and denying preliminary injunction, obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system;
- Exhibit 6: Order of Ninth Circuit, Fonseca v. Kaiser Permanente, Case: 16-15883 (appealing District Court Case 2:16-cv-00889), filed May 26, 2016, obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system;
- Exhibit 7: Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California;
- Exhibit 8: The declaration of Michael S. Myette, M.D., filed with Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California;
- Exhibit 9: The transcript of Placer County Superior Court testimony of Michael S. Myette, M.D., filed with Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889,

filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California;

- Exhibit 10: Certificate of Death documentation prepared by Michael S. Myette, M.D., filed with Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California.

5. Exhibits 5 through 19 are true and correct copies of the documents described in the declarations of Barry Markovitz, M.D. and Cheryl D. Lew, M.D.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 25th day of August 2016, in Long Beach, California.

DAVID P. PRUETT

EXHIBIT 2

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

OFFICE OF THE CLERK-RECORDER

COUNTY OF PLACER

AUBURN, CALIFORNIA

INFORMATIONAL
NOT A VALID DOCUMENT
TO ESTABLISH IDENTITY

CERTIFICATE OF DEATH

30320161392139 — 32016310020021

1. NAME OF DECEDENT – FIRST	ISRAEL
2. MIDDLE	-
3. LAST (FAMILY)	STINSON
4. DATE OF BIRTH (mm/dd/yyyy)	10/05/2013
5. AGE (Last Birthday)	2
6. SEX	M
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	CA
8. SOCIAL SECURITY NUMBER	[redacted]
9. EVER IN U.S. ARMED FORCES?	NO
10. MARITAL STATUS	NEVER MARRIED
11. DATE OF DEATH (mm/dd/yyyy)	04/14/2016
12. HOUR	1200
13. EDUCATION	00
14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES?	NO
15. PRIMARY RACE	BLACK, AFRICAN AMERICAN
16. USUAL OCCUPATION	CHILD
17. KIND OF BUSINESS OR INDUSTRY	-
18. YEARS OF OCCUPATION	-
19. RESIDENCE (STREET AND NUMBER)	545 MARKHAM AVE APT. #3
20. CITY	VACAVILLE
21. COUNTY/PROVINCE	SOLANO
22. ZIP CODE	95688
23. YEARS IN COUNTY	UNK
24. STATE OR FOREIGN COUNTRY	CA
25. INFORMANT'S NAME, RELATIONSHIP	TERRY JENKINS, DECEDENT AFFAIRS COORD.
26. INFORMANT'S MAILING ADDRESS	1600 EUREKA ROAD, ROSEVILLE, CA 95661
27. NAME OF SURVIVING SPOUSE – FIRST	-
28. MIDDLE	-
29. LAST (BIRTH NAME IF APPLICABLE)	-
30. NAME OF FATHER/PARENT – FIRST	NATHANIEL
31. MIDDLE	--
32. LAST	STINSON
33. BIRTHPLACE	UNK
34. NAME OF MOTHER/PARENT – FIRST	JONEE
35. MIDDLE	--
36. LAST (BIRTH NAME)	FONSECA
37. BIRTHPLACE	UNK
38. DISPOSITION (mm/dd/yyyy)	05/21/2016
39. PLACE OF FINAL DISPOSITION	OUT OF THE COUNTRY, SOUTH AMERICA
41. TYPE OF DISPOSITION	TR
42. DISCLOSURE OF EMBALMER	NOT EMBALMED
43. LICENSE NUMBER	-
44. NAME OF FUNERAL ESTABLISHMENT	KAISER FOUNDATION HOSPITAL
45. LICENSE NUMBER	NONE
46. SIGNATURE OF LOCAL REGISTRAR	[redacted]
47. DATE (mm/dd/yyyy)	07/14/2016
48. PLACE OF DEATH	KAISER FOUNDATION HOSPITAL- ROSEVILLE
49. COUNTY	PLACER
50. FACILITY ADDRESS OR LOCATION	1600 EUREKA ROAD
51. CITY	ROSEVILLE
52. IF HOSPITAL, SPECIFY ONE	IP
53. IF OTHER THAN HOSPITAL, SPECIFY ONE	-
54. CAUSE OF DEATH – IMMEDIATE CAUSE	ANOXIC ENCEPHALOPATHY
INTERVAL	DYS: 1405220
* CARDIAC ARREST	DYS
STATUS ASTHMATICUS	DYS
55. ENTERED TO ODCMS	YES
56. WORKS PERFORMED	NO
57. AUTOPSY PERFORMED	YES
58. AUTOPSY FINDINGS CONSIDERED	NO
59. DID TOBACCO USE CONTRIBUTE TO DEATH	-
60. MAJOR SURGERY IN 4 WEEKS	NO
61. IF FEMALE, PREGNANT IN LAST YEAR	-
62. DATE SIGNED	04/18/2016
63. ATTENDING PHYSICIAN'S NAME, ADDRESS, ZIP CODE	MICHAEL STEVEN MYETTE M.D. 1600 EUREKA ROAD, ROSEVILLE, CA 95661
64. LICENSE NUMBER	A73833
65. DATE SIGNED	04/18/2016
66. DATE PRONOUNCED DEAD	04/12/2016
67. TIME PRONOUNCED DEAD	04/14/2016
68. WAS CASE REFERRED TO CORONER	NO
69. MANNER OF DEATH	NATURAL
70. DATE OF INJURY	-
71. TIME OF INJURY	-
72. PLACE OF INJURY	-
73. DESCRIBE HOW INJURY OCCURRED	-
74. LOCATION OF INJURY	-
75. CORONER / DEPUTY CORONER	-
76. DATE	-
77. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER	-
STATE REGISTRAR	A
FAX AUTH #	-
CENSUS TRACT	-

RYAN RONCO effective 5/17/2016
PLACER COUNTY CLERK-RECORDER

CERTIFIED COPY OF VITAL RECORDS
STATE OF CALIFORNIA, COUNTY OF PLACER

00020561 8

This is a true and exact reproduction of the document officially registered and placed on file in the office of the Placer County Clerk-Recorder.

DATE ISSUED 08/12/2016

JIM McCAULEY
PLACER COUNTY CLERK-RECORDER

This copy is not valid unless prepared on an engraved border displaying the date, seal and signature of the Clerk-Recorder

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EX 3

EXHIBIT 3

NEUROLOGICAL EVALUATION

I evaluated patient: Israel Stinson

1. Ischemic hypoxic encelapathy, the motive is to determine if there are signs of irreversal cerebral lesions.

- I evaluated the depth of the eye: atrophy of the bilateral optic nerve.
- Slight venous pulsation, without hemorrhage
- Negative oculovestibulary test
- Negative maneuvers of the doll of the wrist
- Pupils: two millimeters on the left, one millimeter on the right

There are primitive reflexes of defense and rejection, of position in both superior and inferior, members, there are osteotendinoses reflexes present.

He maintains cardiac frequency and arterial pressure without pharmaceutical assistance. The head has temperature, it feels warm.

CONCLUSION

1. Deep coma state
2. Persistent vegetative state, due to serious brain lesion
3. Does not belong to the encephalic criteria of brain death (warm head temperature, keeps blood pressure and cardiac frequency without medication).

The prognosis is reserved, he will be a patient dependent on mechanical ventilation.

Dr. Rubén Posadas
Neurologist
Col 3842

EVALUACION POR NEUROLOGIA

*Evalué paciente conocido por

1. Encefalopatia hipoxico isquémica, el motivo es determinar si existen signos de lesión cerebral irreversible.

*Efectué fondo de ojo: atrofia del nervio óptico bilateral

*Pulsación venosa leve, sin hemorragia

*Pruebas oculovestibulares negativas

*maniobras ojos de muñeca negativa

*pupilas: dos milimetros izquierdos, derechos un milimetro

Hay reflejos primitivos de defensa y rechazo, de posición en ambos miembros superiores e inferiores, reflejos osteotendinosos presentes.

Mantiene frecuencia cardiaca y presión arterial sin ayuda de medicamentos. La cabeza tiene temperatura, se palpa tibia

CONCLUSION:

1. Estado coma profundo
2. Estado vegetativo persistente por lesión cerebral grave
3. No cumple con criterios encefálicos de muerte cerebral (cabeza tibia, mantiene presión y frecuencia cardiaca sin fármacos)

El pronóstico es reservado, será un paciente dependiente de ventilación mecánica.

Dr. Rubén Posadas
Neurólogo
Col. 3842

I, Francisco Montiel, paediatric neurologist, have had the opportunity to evaluate Israel who was tranfered from an intensive care unit in the USA with a medicl history already known.

Upon evaluation Israel shows no spontaneous respiratiry effort, oculocepalic, oculovestibular and ciliospinal relfexes are absent, he shows no reaction to vocal stimulii, however upon physical stimulii he does show movement of his 4 limbs, more right thna left movement, this movments appearnto be spinal in nature.

He has had 2 EEG tests both of which show slowmwaves of ver low amplitude, neither of them being isoelectric.

Given the findings and history, the clinical picture appearnto be one of persistent vegetative state.

Francisco Montiel
Medical license 6932

<image001.jpg>

of 2

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Michael J. Peffer, CA SBN 192265
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Alexandra M. Snyder, SBN 252058
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P.O. Box 2015
Napa, CA 94558
Tel.: (707) 224-6675

Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GURDIAN OF ISRAEL STINSON, A MINOR, Plaintiff, v. KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; AND DOES 2-10, INCLUSIVE, Defendants.	2:16-cv-00889-KJM-EFB **OPPOSITION TO DEFENDANT'S MOTION TO DISMISS SECOND AMENDED COMPLAINT** Date: October 7, 2016 Time: 10:00 a.m. Dept.: Courtroom 3 Judge: Hon. Kimberly J. Mueller Date Filed: May 9, 2016 Trial Date: None Set

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INTRODUCTION AND SUMMARY OF THE ARGUMENT

Since Jonee Fonseca last appeared before the Court, this human tragedy has entered a new phase with the untimely passing of Baby Israel at Children's Hospital Los Angeles ("Children's Hospital"). The State believes this was the final act in the tragedy; Fonseca suggests that it may only be the climax leading toward the denouement in a story that will ultimately vindicate her struggle and spare other families needless pain.

At a minimum, the Court should consider the proposed amendments to the complaint, primarily relating to what has occurred over the past two months, before determining that Fonseca and the proposed new organizational plaintiff cannot state claims. Recent events have changed the contours of the relief sought but not the underlying controversy itself. The State's Motion should be denied as premature.

SUMMARY OF NEW FACTS

If a Third Amended Complaint is filed, the facts below would be added.

On April 14 a death certificate for Israel was signed by a physician from Kaiser Permanente (Ct. doc. 43-3) after performing two brain death examinations. No Kaiser physicians performed electroencephalogram ("EEG") tests to see if Israel had brain waives. (Ct. doc. 14-4, p. 17-36). Following this Court's decision in May denying the preliminary injunction (Ct. doc. 48), the Ninth Circuit's grant of emergency relief allowed the family to arrange transfer whereby Israel was taken out of the country to receive treatment. At the new facility, physicians performed two EEG examinations. The results showed that Israel had brain waves and was thus not dead – either biologically or under the definition of brain death. Following treatment he showed signs of improving. After several weeks, Fonseca returned to California with her son to arrange for his long-term care. At Children's Hospital, Fonseca had understood this new phase of the journey would begin. Instead, based

on the State-sanctioned pronouncement of death that had prompted the family to flee the country in the first place, Children's Hospital discontinued ventilation and permanently ended Israel's natural, biological life on August 24. Disagreement as to when Israel died, stemming from the death certificates, has and will continue to have profound implications for the family. At some point between the signing of the death certificate at Kaiser Permanente on April 14 and the end of Israel's biological life on August 24, Medi-Cal support was removed for Israel. Israel's family could be subject to liability for uncovered medical bills. Equitable relief to change the date of the death certificate *nunc pro tunc* (i.e., from April 14 to August 24) would redress the injury. In order to provide this relief the Court would need to reach the issue of the constitutionality of the California Uniform Determination of Death Act ("CUDDA").

Additionally, in light of recent developments the Third Amended Complaint proposes to name Life Legal Defense Foundation ("Life Legal"), as a co-plaintiff.[1] This organization closely assisted the family and will continue to be affected by the CUDDA protocol. The brain death definition has frustrated Life Legal's attempts to protect members of the public facing withdrawal of life-support from loved ones. The challenged law has caused a significant drain on Life Legal's time and resources to address the burdensome undertaking of maintaining life-support for members of the public whose loved ones are not biologically dead. The facts of the case at hand are representative of the consumption of time and resources. This includes counseling the families, negotiating with hospitals, litigation, and raising funds for these purposes.

[1] Attorneys from Life Legal are also acting as co-counsel on this case.

ARGUMENT

I. THE COURT CONTINUES TO POSSESS ARTICLE III JURISDICTION

a. The case is not moot.

In its Motion to Dismiss, the State presents the one-dimensional view that the death of Israel must mean the end of the litigation. Not so. While it was certainly Fonseca's primary goal to keep Israel alive, and she initially achieved that objective through the litigation in this Court and at the Ninth Circuit, the case presents enduring issues that live on. In particular, Fonseca's constitutional challenge to CUDDA has implications not only for the public at large, but to ensure financial relief from medical bills to herself and her family.

Contrary to the State's truncated treatment of it, the "capable of repetition yet evading review" doctrine is a classic fit here. The doctrine is perhaps best known for being invoked in abortion cases, where it was recognized that ordinary concepts of mootness and ordinary judicial processes would not allow for resolution of the claimed right to terminate pregnancy. *Roe v. Wade*, 410 U.S. 113, 125 (1973). The doctrine actually goes back more than a century, though, to at least *So. Pacific Terminal Co. v. Interstate Commerce Comm.*, 219 U.S. 498 (1911). There, the Court considered the authority of the Interstate Commerce Commission to issue orders on preferential wharfage arrangements in Galveston, Texas. The ICC's order had expired, so it was urged that the case was moot. The Court, however, felt the issues presented would be "capable of repetition yet evading review," so it proceeded to the merits. Id. at 515.

End-of-life cases pose an especially important need for application of the doctrine. In *Abigail Alliance for Better Access to Deve. Drugs v. Von Essenbach*, 469 F.3d 129 (D.C.Cir. 2006), the D.C. Circuit found that FDA rules posing hindrances to terminally ill cancer patients accessing potentially life-saving

treatments called for a classic application of the doctrine. Further, an entity that assisted the public in obtaining such treatments was given organizational standing. Id. at 132-33. Those facts mirror the naming of Life Legal as a plaintiff here.

Closer to home, the California appellate courts have also held that the "capable of repetition yet evading review" standard is a good fit for end-of-life cases similar to the present. In *Bartling v. Superior Court*, 163 Cal.App.3d 186 (Cal.Ct. App. 2nd Dist. 1984), the Second District considered the appeal of a man who had sought an order to discontinue his ventilator. Although he died the day before a crucial hearing, the court held that mootness should not bar resolution of the important issues he had raised. "The novel medical, legal and ethical issues presented in this case are no doubt capable of repetition and should therefore not be ignored by relying on the mootness doctrine." *Id*. at 190.

One of the primary justifications for invoking "capable of repetition yet evading review" in the abortion cases – the relatively short gestational period – is even more acute in cases such as the present where days and even hours matter. The urgency and expedited nature of the prior filings in this case are not uncommon in end-of-life cases, where every day (and often, every hour) matters. See, e.g., *Gebreyes v. Prime Healthcare Servs., LLC*, 361 P.3d 524 (Nev. 2015); *Family Independence Agency v. A.M.B.*, 248 Mich. App. 144 (Mich Ct. App. 2001).

While temporary stays can provide emergency relief, expedited briefing and hearings are not the best way to address the larger constitutional questions that lurk behind CUDDA. It is essential that the Court move forward to address the recurring life-and-death issues laid bare by this litigation. Otherwise, the injustice of critical medical decisions being taken away from the patient and his family will continue to be repeated without redress.

b. The claims will continue to be redressable.

As to redressability, a declaration that CUDDA is unconstitutional, and an injunction rescinding the death certificate from April 14 and requiring it to reflect August 24 as the date of death would remove the cloud of confusion over the true date of death for all legal, ethical and medical purposes.

In another end-of-life case, *Donaldson v. Lungren*, 2 Cal.App.4th 1614 (Cal. Ct. App. 2nd Dist. 1992), the appellate court agreed that, where a constitutional right existed, the difficulty of devising remedies for its protection was no excuse for leaving the right unprotected. "We agree with the general proposition that the difficulty in effecting a solution to a legal problem is not sufficient grounds for a court to deny relief." *Id.* at 1623.

Although no order can now resuscitate Baby Israel, some relief can and should be provided. The prayer of the Second Amended Complaint (and the proposed Third Amended Complaint) include "any and all appropriate relief available under F.R.C.P. 54(c)." Here the remedy would be for the Court to order the Defendant to change the date of the death certificate from April 14 to August 24, 2016, thereby relieving the family of potential financial liability and loss occasioned by the contradictory dates.

In *Abigail Alliance*, the appellate court found that redressability was satisfied where, despite the death of a patient who had been seeking potentially life-saving treatment, the organization's continuing interest should keep the case alive. *Abigail Alliance*, 469 F.3d at 136. To this end, Fonseca proposes adding Life Legal as a party to this litigation. This organization, whose mission focuses on preservation of the lives of the most vulnerable members of society, including the very young and those facing the end of life, would further ensure that a decision on the constitutionality of CUDDA would have direct impact and would not be advisory.

c. CUDDA is much more than merely definitional.

The State also attacks standing by asserting that causation is missing. Not true. "One of Congress's primary goals in enacting Section 1983 was to provide a remedy for killings unconstitutionally caused *or acquiesced in* by state governments." *Chaudhry v. City of Los Angeles*, 751 F.3d 1096, 1103 (9th Cir. 2014) (emphasis added). CUDDA indeed defines *death*. Health & Safety Code §7180. But it does far more than that. CUDDA prescribes the protocol for confirmation of *death*. Health & Safety Code §7181. Under CUDDA, a medical facility must record, communicate with government entities, and maintain records relative to the "irreversible cessation of all functions of the entire brain." Health & Safety Code §7183. Such includes filling out portions of the Certificate of Death provided by the Department of Public Health within 15 hours after death under (Health & Safety Code §102800) and that the medical facility register the death with county officials (Health & Safety Code §102775). County officials then jointly issue a death certificate with the State's Department of Vital Records directed by the Defendant, Karen Smith.[2]

The State relies on but two cases in support of its causation theory. In *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992), the Court stated that when the plaintiff is the object of the regulation, then there is little doubt regarding causation. Id. at 562. CUDDA reads: "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 brain stem, is dead." Health & Safety Code §7180(a). The plain language of CUDDA is that the object of the law is the

[2] The certificate bears the seals of the State of California and County of Placer. See Exhibit 3 (Death Certificate of Israel Stinson) of the Request for Judicial Notice lodged in the Los Angeles Superior Court by attorneys for Children's Hospital. Fonseca Request for Judicial Notice, Exhibit 1.

patient. Section 7181 likewise states: "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician." Israel, and by extension his mother, are the "objects of the action" under the holding in *Lujan*.

The State also relies on *Linda R.S. v. Richard D.* 410 U.S. 614, 618 (1973). That case involved a mother who sued over the fact that prosecutors would not prosecute the father of their child for failure to pay child support. The holding in *Linda R.S.* turned on prosecutorial discretion rather than third party causation. Such has no application here.

II. FONSECA HAS STATED VIABLE CLAIMS FOR BOTH PROCEDURAL AND SUBSTANTIVE DUE PROCESS.

For purposes of the claims now before the Court, the Fourteenth Amendment's due process guarantee is simple yet profound: "No State shall make or enforce any law which shall…deprive any person of life…without due process of law." U.S. Const. Fourteenth Amendment.

While the State professes not to understand the difference between Fonseca's procedural and substantive due process claims, they are straightforward. The gravamen of her procedural claim is that CUDDA lacks the safeguards necessary to ensure that the State's most vulnerable citizens are not deprived of life. The substantive claim is that innocent children like Baby Israel have a fundamental right to life that does not yield to countervailing interests such as the need for organ donors or economic efficiency.

a. The State-established procedures for brain death are inadequate to prevent deprivation of life without due process of law.

The heart of procedural due process is the requirement that "a person in jeopardy of serious loss [be given] notice of the case against him and opportunity to meet it." *Joint Anti-Fascist Comm. v. McGrath*, 341 U.S. 123, 171-172 (1951) (Frankfurter, J., concurring). Here the statutory scheme expedites the determination of *death* by ignoring whether the person remains biologically alive. This lessoned standard of *death* provides no process by which the patient's advocate can obtain a different independent medical opinion by the physician of her choosing or even challenge the findings. In the case in Placer County Superior Court, the attorney for Kaiser told the Court, that "under Health and Safety Code Section[s] 7180 and 7181, Israel has been found to be dead." Ct-doc. 14-4, p. 38 at lines 9-11. Noting the holding in *Dority v. Superior Court*, 145 Cal.App.3d 273 (Cal. Ct. App. 4th Dist. 1983) Id. 39:10-15, the Honorable Judge Michael Jones asked attorneys for Kaiser: "And, therefore, the parent should not have the opportunity to have an independent evaluation?" The response: "We are the independent [evaluation]." Id. 38:12-15.

CUDDA provided no realistic opportunity for Israel's mother to be heard. "The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard." *Goldberg v. Kelly*, 397 U.S. 254, 268-69 (1970). Surely deprivation of life must be attended with greater process and safeguards than the denial of welfare benefits at issue in *Goldberg*.

Fonseca's concern about whether here child was dead or alive was not unfounded. Indeed, it cannot be seriously disputed that the loosened standard of death is biologically inaccurate. "The concept of biological death involves the cessation of biological functioning." Michael Nair-Collins, *Death, Brain Death, and the Limits of Science: Why the Whole-Brain Concept of Death Is A Flawed*

Public Policy, 38 J.L. Med. & Ethics 667, 668 (2010). *Biology* is one of the five branches of natural science. This branch has identified certain basic characteristics of living organisms such as nutrition (the process by which organisms obtain energy and raw materials from nutrients such as proteins, carbohydrates and fats); respiration (release of energy from food substances in all living cells); movement; excretion (the cells get rid of waste products); growth; reproduction; and sensitivity.[3] Persons declared brain dead have living cells. They generate new tissue. Seema K. Shah, *Piercing the Veil: The Limits of Brain Death as a Legal Fiction*, 48 U. Mich. J. L. Reform 301 (2015). They heal if cut and fight infection. Id. at 330. They eliminate waste. Nair-Collins, at 670. Children will go into puberty. Shah at 312. Men grow beards. Id. 330. Women can continue to gestate a fetus. Id. *passim*.[4] These are consistent with life – not death.

The State has requested judicial notice of the Uniform Determination of Death Act (UDDA) drafted by the National Conference of Commissioners on Uniform State Laws. (Def. RJN, Exh. B; Ct. doc. 68-3). UDDA has its origin in the 1968 Ad Hoc Commission of the Harvard Medical School. The Commission published an article with the goal of changing how death was determined legally and medically. There were two reasons for this: (1) to prevent a waste of medical resources on keeping people alive through modern technologies; and (2) the need to have organs for transplants. Shah at 320. The redefining of death was not the result of a medical breakthrough. Id. 321. Moreover, the Commission certainly

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[3] See Cambridge University Press 978-0-521-68054-7 - NSSC Biology Module 1 Ngepathimo Kadhila.

[4] In a chilling yet predictable part of the ethical trajectory is the proposal that brain dead women be used as gestational incubators. Jennifer S. Higgins, *Not of Woman Born: A Scientific Fantasy*, 62 Case W. Res. 399, 407 (Winter 2011).

"did not believe that brain death was the equivalent of biological death." Id. at 320. Understanding this is important because there is a popular misconception that the drafters of UDDA, and by extension CUDDA, redefined death based upon medical discoveries resulting in a new understanding of when death actually occurs. Of course, that is fiction.

b. A patient and his family have significant substantive due process rights, rooted in privacy and self-determination, to resist discontinuation of life support.

"If the right of the patient to self-determination in his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors." *Bartling*, at 195. The court grounded this self-determination in the right to privacy found in both state and federal constitutions. *Id.*

The D.C. Circuit considered and acknowledged a very similar aspect of self-determination in *Abigail Alliance*, namely, the due process right of self-determination of patients to seek promising, potentially life-saving drugs. *Id.* at 137. There, similar to Life Legal, "the Alliance seeks to enforce the right of terminally ill patients to make an informed decision that may prolong life." Id.

Under this right of self-determination, emanating from the right to privacy, the choice of the patient or his legal surrogate whether to continue life-sustaining measures is not subject to veto by the medical profession or the judiciary. *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 1135 (Cal. Ct. App. 2d Dist. 1986). Stated another way, the patient's vote is not to be overridden. *Id.* at 1137.

For the first time, the State also now asserts the new End of Life Options Act, more colloquially known as the legalization of prescription suicide, has changed the State's interest in protecting life. It is far from clear that this sweeping claim is consistent with the Legislature's intent. It is well-established that, "As a general

matter, the States – indeed, all civilized nations – demonstrate their commitment to life." *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 280 (1990). Even accepting the dubious proposition that the End of Life Options Act lessened the State's commitment to the preservation of life, it most certainly does not diminish the State's commitment to self-determination. The challenged statutes purport to reverse fundamental presumptions on both the preservation of life and self-determination.

Under section 7181 determination as to whether a person has sustained an irreversible cessation of all functions of the entire brain is made by "independent confirmation of another physician." Under CUDDA, neither the patient nor the patient's representative is provided any mechanism to challenge the findings. This is true whether or not the patient's representative both understands and agrees with the State's definition of *death*.

III. FONSECA HAS STATED A STRONG CLAIM FOR VIOLATION OF FUNDAMENTAL PARENTAL RIGHTS.

Additionally, the Plaintiff challenges CUDDA because a parent naturally has a profound emotional bond with her child that is unnaturally severed by the statute. Moreover, this parent believes she has a moral and spiritual obligation to give her child every benefit of the doubt before disconnecting life support. "The choice between life and death is a deeply personal decision of obvious overwhelming finality." *Cruzan*, 497 U.S. at 281.

In the present case, the facts are that the parent has a sincerely held religious belief that life does not end until the heart ceases to beat. Stated otherwise, death occurs upon the "cessation of biological functioning." Nair-Collins, Id., at 668. Here there was a medical dispute as to whether Israel was alive. SAC ¶33. As it turned out, Fonseca's decision to err on the side of continuing life support was

justified. Physicians in Guatemala ran two EEG tests and found that Israel was not only not biologically dead, but was also not brain dead. Drs. Ruben Posadas and Francisco Montiel determined that Israel was in a "persistent vegetative state." Plaintiff's Request for Judicial Notice, Exhibit 1.[5]

But because Kaiser already acted under the CUDDA protocol, the medical providers at Children's Hospital would not accept the results of the two EEG tests, would not perform their own brain death examination, and would not allow the parents to bring in an eminent professor from UCLA's medical school to conduct an examination.[6] That Israel was alive under any definition of death was an inconvenient truth. Instead of accepting that scientific reality, attorneys for Children's Hospital filed ex parte the death certificate signed by Kaiser and the death certificate from the Defendant's Department of Vital Records with the Superior Court in Los Angeles.[7] Children's Hospital's intent was to convert the death certificate into a death warrant. As a direct and proximate result of the death certificate issued through the CUDDA protocol, the Superior Court lifted a temporary restraining order that the mother had secured – in pro per – and did not give even a 24 hour reprieve to seek emergency relief from a higher court. Before the close of business that day, Children's Hospital medical staff entered Israel's room, and disconnecting his life support, they killed him.

Typically, a fit parent has plenary authority over medical decisions for a small child. *In re Baby K*, 832 F.Supp. 1022, 1030 (E.D. Va. 1993) citing *Parham v. J.R.*, 442 U.S. 584, 603-04 (1979). As stated above and further articulated in her

[5] This exhibit was submitted to the Los Angeles Superior Court without objection.
[6] Defendant's Request for Judicial Notice, Exhibit C, p. 32-33 (Ct. doc. 68-3).
[7] Fonseca Request for Judicial Notice, Exhibit 1.

pro per filings in the Superior Court of Placer County, Fonseca felt a moral and spiritual duty to give her child every benefit of the medical doubt as to whether the child was in fact dead or could improve with additional treatment.

In *Barber v. Super. Ct.*, 147 Cal.App.3d 1006 (Cal. Ct. App. 2d 1983), the court was able to uphold the decision to withdraw life support from the decedent where his wife and all of his children agreed with the decision. *Id.* at 1021. Here, however, CUDDA excludes this parent from any due process in the decision making.

In *Family Independence Agency v. A.M.B.*, the appellate court conducted an extensive post-mortem of the circumstances surrounding the withdrawal of life support from Baby Allison. Her life and death landed in Family Court because her teenage mother was severely mentally challenged, and the child had apparently been conceived through incest and rape.

The appellate court found serious due process violations in the manner that the decision to end Baby Allison's life was taken away from her parents, all of their shortcomings notwithstanding. The Family Court had authorized the termination of life support after a doctor testified by phone that being on the ventilator was not in the child's best interests. *Id.* at 160.

On appeal, the court zeroed in on the presumption that to establish incompetency for the parent who would otherwise have a Fourteenth Amendment liberty interest in making medical decisions for their child, the evidence must be clear and convincing. *Id.* at 204-5.

Thus, the court held that, even though circumstantial and hearsay evidence pointed to the parents' inability to make life-and-death decisions for their child, much more formal adjudication of the parents' incompetence was required to take away the decision from them. *Id.* The same is much more true here, where the

parents' fitness was not in question and the State, through its statutory scheme, nevertheless took away their ability to make this monumental decision for their child.

IV. THE STATE TOO HASTILY WRITES OFF ITS OWN CONSTITUTION.

The State waves off Fonseca's claims under the California Constitution with the terse explanation that the analysis follows the federal claims. Not so.

For starters, Article I, §1 of the California Constitution has been interpreted more expansively than the federal Constitution in such well-known decisions as *Hill v. NCAA*, 7 Cal.4th 1 (1994). State interests in protecting life have also been addressed independently of federal interests. For instance, in *Donaldson v. Lungren* the Second District reiterated the State's interest in preserving life and criminalizing assisted suicide, five years before the Supreme Court spoke to the issue in *Washington v. Glucksberg*, 521 U.S. 702 (1997). In *Donaldson*, the appellate court held that California could assert an unqualified interest in the preservation of life that outweighed the plaintiff's asserted interest in quality of life. *Donaldson*, 2 Cal.App.4th at 1620. The State is now trying to flip the equation, without a passing glance to the conflict with its previously-asserted interests. *See also*, *Bouvia* and *Bardling*. In *People v. Adams*, 216 Cal.App.3d 1431, 1448 (Cal. Ct. App. 3d Dist. 1990), the court also grounded the right to self-determination and refusal of life support in the Article I, §1 right to privacy. This right outweighs a criminal defendant's right to confront his accuser. *Id.* Much more must the right of self-determination outweigh a hospital's wishes. While state interests in self-determination and preserving life have much in common with federal interests, the two are distinct and must be addressed separately.

V. THE *ROOKER-FELDMAN* DOCTRINE FARES NO BETTER NOW THAN WHEN IT WAS FIRST RAISED IN THIS LITIGATION.

Because of the prior actions taken by the Superior Court, the State claims the *Rooker-Feldman*[8] doctrine bars jurisdiction. For substantially the same reasons as Fonseca has previously briefed, such assertions are misguided.

The Supreme Court explained that the doctrine serves to prevent losers of state court actions from asking the federal courts to act as *de facto* appellate courts in reviewing the adverse state court judgment. *Exxon-Mobil v. Saudi Basic Indus. Corp.*, 544 U.S. 280 (2005). It has no bearing where, as here, Fonseca is not asking this Court to reconsider or reverse any aspect of the Superior Courts' actions. *Bianchi v. Rylaarsdam*, 334 F.3d 895, 898 (9th Cir. 2003). As this Court noted in its prior Opinion, Fonseca did not bring a constitutional challenge to CUDDA in state court or raise any of her other claims in those venues. Ct. doc. 48, p. 7

The Ninth Circuit has explained that *Rooker-Feldman* "applies only when the federal plaintiff both asserts as her injury legal error…by the state court *and* seeks as her remedy relief from state court judgment." *Kougasian v. TMSL, Inc.*, 359 F.3d 1136 (9th Cir. 2004) (emphasis in original). Neither of those two elements is in play in the present case.

[8] *Rooker v. Fid. Trust Co.*, 263 U.S. 413 (U.S. 1923); *D.C. Court of Appeals v. Feldman*, 460 U.S. 462 (U.S. 1983).

CONCLUSION

In that recent developments have changed the dynamics but not the heart of this action, Plaintiff asks the Court to consider her proposed allegations for a Third Amended Complaint rather than granting the Motion to Dismiss.

Date: September 23, 2016

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, Plaintiff, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA,** Defendant.	2:16-cv-00889-KJM-EFB **NOTICE OF MOTION AND MOTION TO DISMISS SECOND AMENDED COMPLAINT** Date: October 7, 2016 Time: 10:00 a.m. Courtroom: 3 Judge: Hon. Kimberly J. Mueller Trial Date: none set Action Filed: May 9, 2016

TO ALL PARTIES, THEIR COUNSEL OF RECORD, AND THE CLERK OF THE COURT:

PLEASE TAKE NOTICE THAT on October 7, 2016 at 10:00 a.m., or as soon thereafter as the matter may be heard before the Honorable Judge Kimberly Mueller in Courtroom 3 of the United States District Court for the Eastern District of California, located at 501 I Street, Sacramento, California 95814, defendant Karen Smith, M.D., Director of the California

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Department of Public Health, will move this Court to dismiss without leave to amend plaintiff's second amended complaint, pursuant to Federal Rules of Civil Procedure 12(b)(1) and (6).

This motion to dismiss is brought on the grounds that there is no case or controversy and plaintiff does not have standing to pursue this matter; therefore, the court lacks jurisdiction to hear plaintiff's complaint. The motion is also brought on the ground that plaintiff fails to state a claim for relief. This motion is based on this Notice, the Memorandum of Points and Authorities, the Request for Judicial Notice filed in support of this motion, the papers and pleadings on file in this action, and upon such matters as may be presented to the Court at the time of the hearing.

Pursuant to the honorable Judge Mueller's standing orders, defendant contacted plaintiff in an effort to meet and confer regarding the underlying merits of defendant's motion to dismiss. On July 8, 2016, and again on August 26, 2016, the parties met and conferred telephonically and by electronic mail. Plaintiff has not committed to address the numerous deficiencies outlined in defendant's motion to dismiss. As such, defendant is forced to bring this motion to dismiss.

Dated: August 31, 2016

Respectfully Submitted,

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SACRAMENTO DIVISION

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, Plaintiff, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; AND DOES 2 THROUGH 10, INCLUSIVE,** Defendant.	2:16-cv-00889-KJM-EFB **MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO DISMISS SECOND AMENDED COMPLAINT** **[Fed.R.Civ. Proc. 12(b)(1), (6)]** Date: October 7, 2016 Time: 10:00 a.m. Dept: 3 Judge: Hon. Kimberly J. Mueller Trial Date: none set Action Filed: 5/9/2016

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MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

Three decades ago, California enacted the Uniform Determination of Death Act (Act or CUDDA), which modified the definition of death to conform with the definition adopted by the National Commission on Uniform State Laws. The Act defines death as either "(1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem…" Cal. Health & Safety Code § 7180 *et seq.*[1] The Act requires that any determination of death be made by physicians in "accordance with accepted medical standards," and in the event of a brain death diagnosis, confirmed by an independent physician. *See* § 7180(a); *see also* § 7181. The Act is silent concerning the medical criteria for determining death and post-mortem decisions about whether or not to continue artificial life-sustaining measures. As described in more detail below, this is legally significant: plaintiff's claims fail because the alleged injuries are not caused by CUDDA or any state action, but rather by the decisions of individual physicians.

Following a series of unfortunate circumstances, in April 2016, Israel Stinson's attending physician determined that he suffered irreversible brain death and pronounced him dead. As required, the determination was made in accordance with accepted medical standards and confirmed by an independent physician. Since that time, plaintiff Fonseca has petitioned both state and federal courts attempting to reverse that determination. The gravamen of each case was the same: plaintiff did not believe that Israel was deceased and sought an order in one fashion or another to reverse the determination of death.

Following the first state court ruling affirming that Israel is deceased, plaintiff filed this action contending that the uniform definition of death is contrary to her personal beliefs and violates the state and federal Constitutions. In the operative Second Amended Complaint (SAC), plaintiff asks this Court to strike down the uniform definition adopted by the medical community as well as nearly every other state. Plaintiff contends that CUDDA deprived Israel of life without

[1] All further statutory references are to the California Health and Safety Code, unless otherwise noted.

due process and her right to make decisions on Israel's behalf in violation of the Fifth and Fourteenth Amendments of the United States Constitution, and the right to privacy as guaranteed by the United States and California Constitutions. Plaintiff's complaint for declaratory and injunctive relief should be dismissed for a number of reasons.

Foremost, there is no longer a case in controversy. On August 25, 2016, Israel was removed from life support and all circulatory and respiratory functions irreversibly ceased. Thus, there is no longer any dispute that he is deceased and plaintiff's claims are moot.

Next, even if the court determines that there remains a justiciable controversy, plaintiff does not have standing to pursue this action. Plaintiff's chief complaint is that physicians had determined that Israel is dead, when she believed he was not. She attacks the process by which death is determined and alleges that she lacked an adequate opportunity to challenge that determination. Because the decisions of which plaintiff complains are made by physicians in accordance with medical standards, plaintiff cannot establish that *CUDDA* itself caused the injury at issue (the medical determination that Israel is deceased). Additionally, because this critical determination was based upon prevailing medical standards, the declaration that CUDDA is unconstitutional would not have reversed that determination. The lack of redressability is fatal to plaintiff's claims.

Even if plaintiff has standing, her claims fail as a matter of law. Plaintiff's First, Second and Third Causes of Action contend that CUDDA deprived Israel of life and plaintiff of her right to make decisions on his behalf. Again, because CUDDA is definitional only, and the decisions at issue are made by physicians *in accordance with accepted medical standards*, plaintiff cannot demonstrate that the Director — via CUDDA— deprived Israel or plaintiff of any liberties secured by United States or California Constitutions. Additionally, plaintiff fails to allege facts showing that CUDDA is facially unconstitutional, or that she has been denied any process due under the circumstances.

Further, plaintiff's Fourth and Fifth claims for violation of privacy are also without merit. When balanced against the competing state interests, plaintiff's assertion that she, as Israel's proxy, was entitled to dictate medical decisions under the circumstances fails as a matter of law.

Finally, plaintiff's "as applied" challenges to the determination of death are barred by the *Rooker-Feldman* doctrine because they constitute a collateral attack on an underlying state court judgment upholding the physicians' determination that Israel is deceased.

Because plaintiff's claims cannot be cured by any further amendment, the complaint should be dismissed with prejudice.

LEGAL AND FACTUAL BACKGROUND

I. THE CALIFORNIA UNIFORM DETERMINATION OF DEATH ACT

The Uniform Determination of Death Act, the act upon which CUDDA is modeled, was approved by the National Conference of Commissioners on Uniform Laws in 1980. Request for Judicial Notice (RJN), Ex. B; *see also*, 14 Witkin, Summary 10th Wills § 11 (2005). The definition of death codified by the Uniform Act is the result of the agreement between the American Bar Association (ABA) and the American Medical Association (AMA). RJN, Ex. B, at 3. It was enacted with understanding that it "does not concern itself with living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support by beyond brain death in cases of pregnant women or of organ donors, and protection of the dead body." *Id.*, at 4. The drafters intended that those post-mortem determinations "are left to other law." *Id.* Further, the uniform act does not comment on "acceptable medical diagnosis or procedures;" it offers nothing more than "the general legal standard for determining death," and not the medical criteria for doing so. *Id.*

CUDDA was enacted in 1982 to conform to the uniform definition. RJN, Ex. A, at 1. CUDDA specified requirements relating to the independent confirmation of brain death and the maintenance of medical records in the event of a brain death determination. *Id.*, at 3-5.[2] The need for a uniform definition arose as a result of advances in technology that make it possible to have cardio-respiratory function aided by equipment even though the brain had ceased to function.

[2] Prior to CUDDA, the definition adopted by California referred only to brain death. RJN, Ex. A, at 1 (death is "a person who has suffered a total and irreversible cessation of brain function …."). AB 2004 added to California law, the common law definition of cessation of cardio-respiratory functions and conformed to the definition used by other jurisdictions which included both definitions. *Id.* Therefore, California recognized that brain death is death *prior* to CUDDA's enactment.

Id., at 3. CUDDA aimed to resolve the "potential disparity between current and accepted biomedical practice and existing law." *Id.*, Ex. A, at 3.

CUDDA also contains a number of patient protections. It requires "independent confirmation by another physician" when an individual is pronounced dead by determining that the individual has sustained irreversible cessation of brain function. § 7181. In the event organs are donated, the physician making the independent confirmation cannot participate in the procedures for removing or transplanting the organs. § 7182. Additionally, complete medical records shall be "kept, maintained, and preserved" with respect to the determination of brain death. § 7183. And, following determinations of death under CUDDA, families must receive a reasonable period of accommodation. § 1254.4.[3]

In the event a disagreement exists concerning the determination of death, judicial review is available by filing a petition with the superior court. *See Dority v. Superior Court*, 145 Cal. App. 3d 273, 280 (1983) ("The jurisdiction of the court can be invoked 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.") Additionally, a person may seek to correct errors stated in a registered certificate of death by complying with the process contained in § 103225 *et seq.*

II. FACTUAL BACKGROUND

On April 1, 2016, Israel suffered a severe asthma attack and was taken to Mercy General Hospital where he was placed on a breathing machine. SAC ¶ 6. He was eventually transferred to University of California, Davis Medical Center (UC Davis). *Id.* After a series of tests, physicians at UC Davis concluded on April 10, that Israel suffered brain death. SAC ¶ 19. The following day, Israel was transferred to Kaiser Permanente Roseville Medical Center (Kaiser). *Id.*

[3] Section 1254.4 provides: "A general acute care hospital shall adopt a policy for providing family or next of kin with a reasonably brief period of accommodation, … from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with Section 7180, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required."

¶ 20. Kaiser physicians, following all procedures recommended by the American Academy of Pediatrics and the Society of Critical Care Medicine, determined that Israel was brain dead. *Id.* ¶¶ 21-23. Israel's attending physician, Dr. Michael Steven Myette, completed the physician's certification portion of the death certificate attesting that as of April 14, 2016, Israel was deceased. *Id.*, ¶36.

III. OVERVIEW OF STATE AND FEDERAL COURT PROCEEDINGS

A. Placer County Superior Court

Following Dr. Myette's determination that Israel was deceased, plaintiff initiated *Israel Stinson v. UC Davis Children's Hospital; Kaiser Permanente Roseville*, Case No. S-CV-0037673. Styled as an application for a temporary restraining order directed at Kaiser, plaintiff requested time to find a physician to conduct an independent medical examination pursuant to § 7181. ECF No. 14-2. Plaintiff asserted that in accordance with *Dority*, "the court has jurisdiction over whether a person is 'brain dead' or not pursuant to [CUDDA]." *Id.*, at 5:13-15. The court issued a temporary restraining order (TRO) requiring Kaiser to maintain life support. ECF No. 14-3. The TRO was extended over two weeks to afford plaintiff time to secure an independent examination or relocate Israel. *See* ECF. No. 14-5, 14-7, 14-11.

The matter was reconvened on April 29, 2016, during which the court concluded that "a determination of death [] has been made in accordance with accepted medical standards under [Section] 7181…." ECF 14-8, 75:21-76:9. The court determined that CUDDA had been complied with and ordered the petition dismissed. ECF 19-1, 2:5-6. Plaintiff did not appeal.

B. Eastern District and the Ninth Circuit Court of Appeal

On April 28, 2016, plaintiff filed this action against Kaiser alleging claims under the federal Constitution, the federal Rehabilitation Act, and the Americans with Disabilities Act. ECF No. 1. The court granted a temporary restraining order. ECF No. 23.

On May 2, 2016, the court dismissed plaintiff's complaint. ECF No. 23. The following day, plaintiff amended the complaint to include the Director and asserted five claims: Deprivation of Life in Violation of Due Process (against all defendants); Deprivation of Parental Rights in Violation of Due Process (against all defendants); violation of the Emergency Medical Treatment

and Active Labor Act (42 U.S.C § 1395dd et seq.) (against Kaiser); and violation of the right privacy under the United States Constitution and in violation of the California Constitution (against all defendants). ECF No. 29. The complaint sought, among other things, an order preventing Kaiser from removing life-sustaining support and a declaration that CUDDA is unconstitutional on its face. *Id*., at 17-18.

On May 6, 2016, plaintiff filed a motion for preliminary injunction against Kaiser seeking an order restraining Kaiser from removing ventilation from Israel. ECF No. 33. Kaiser opposed the motion and the matter was heard on May 11, 2016. The court issued an order denying the motion on May 13, 2016. *Id.*, No. 48.

Plaintiff filed a notice of interlocutory appeal on May 14, 2016 seeking relief from the Order denying the motion for preliminary injunction. ECF No. 49. Plaintiff also requested an order requiring Kaiser to continue the life support until plaintiff could locate another facility to care for Israel. See *id*. No. 55. The Ninth Circuit stayed dissolution of this court's TRO to afford it time to review the matter. *Id.* Days later, plaintiff withdrew the motion as Israel was flown to a facility out of the country. ECF 60, SAC ¶ 42. The appeal was thereafter dismissed.

C. Los Angeles Superior Court

On August 6, 2016, Israel returned to the United States and was admitted to Children's Hospital, Los Angeles (CHLA). RJN, Ex. C, at 3:19-21. On August 16, 2016, plaintiff was informed that the hospital intended to remove Israel's ventilator. *Id.*, at 4:3-4. On August 18, 2016, plaintiff initiated *Israel Stinson v. Children's Hospital Los Angeles*, Los Angeles County Superior Court Case No. BS164387, alleging that CHLA violated CUDDA by failing to obtain or permit an independent evaluation. *Id.*, Ex. C. The court issued a TRO requiring the CHLA to refrain from removing Israel from the ventilator and to cooperate with plaintiff to facilitate an independent evaluation of Israel. *Id.*, Ex. D, p. 2.

On August 25, 2016, the court dissolved its TRO. RJN, Ex. E. CHLA subsequently removed Israel from the ventilator and there is no longer any dispute that Israel is deceased.

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IV. PLAINTIFF'S CURRENT CLAIMS BEFORE THIS COURT

Following Kaiser's dismissal, plaintiff amended her complaint for the second time. The Second Amended Complaint asserts five claims against the Director as the sole defendant: (1) Deprivation of Life in Violation of Due Process under the Fifth and Fourteenth Amendments; (2) Deprivation of Parental Rights in Violation of Due Process of Law under the Fifth and Fourteenth Amendments; (3) Deprivation of Life under the California Constitution; (4) Violation of Privacy Rights under the United States Constitution; and (5) Violation of Privacy Rights under the California Constitution. ECF No. 64.

STANDARD

The purpose of a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) "is to test the legal sufficiency of the complaint." *See North Star Int'l v. Ariz. Corp. Comm'n*, 720 F.2d 578, 581 (9th Cir. 1983). "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citations and quotations omitted). The court accepts as true all material allegations in the complaint and construes those allegations in the light most favorable to the plaintiff. *See Lazy Y Ranch Ltd. v. Behrens*, 546 F.3d 580, 588 (9th Cir. 2008).

But the court is not required to "assume the truth of legal conclusions merely because they are cast in the form of factual allegations." *Fayer v. Vaughn*, 649 F.3d 1061, 1064 (9th Cir. 2011) (per curiam) (citations and quotations omitted). Mere "conclusory allegations of law and unwarranted inferences are insufficient to defeat a motion to dismiss." *Adams v. Johnson*, 355 F.3d 1179, 1183 (9th Cir. 2004). Dismissal without leave to amend is appropriate when deficiencies in the complaint could not possibly be cured by amendment. *See Watison v. Carter*, 668 F.3d 1108, 1117 (9th Cir. 2012).

ARGUMENT

Regardless of how the complaint is styled, this challenge aims to undo the medical determination of death made by third party *physicians*, and plaintiff's complaint against the Director should be dismissed for several reasons. As a threshold matter, following Israel's recent removal from life support on August 25, 2016, all parties agree that Israel is now deceased, and

thus there is no longer a justiciable controversy before this court. Further, plaintiff lacks standing to pursue this action against the Director because plaintiff's alleged injury—the physicians' medical determination in April 2016 that Israel was deceased—was not caused by CUDDA and is not redressable in this case, as it resulted from the independent medical decisions of Israel's doctors who are not before this court.

Plaintiff's claims also fail as a matter of law on their merits. Plaintiff alleges violations of due process, the right to life, and the right to privacy based on plaintiff's contentions that death should not be defined to include brain death, SAC ¶ 49, or in the alternative that Israel was "misdiagnosed as being brain dead when he was not," SAC ¶ 50. Plaintiff's procedural due process claims fail because California law provides reasonable and constitutionally sufficient procedures to challenge a determination of death in the state superior court—procedures that plaintiff in fact utilized following the doctors' determination of Israel's death. And plaintiff's substantive due process claims fail because California has a legitimate interest in defining death, in accordance with accepted medical standards and nearly every other state, to include the "irreversible cessation of all functions of the entire brain, including the brain stem," particularly where that definition is qualified by the requirement that in all cases "[a] determination of death must be made in accordance with accepted medical standards." § 7180(a). To the extent that plaintiff alleges Israel's brain death was not irreversible, *see* SAC ¶ 50, plaintiff's complaint does not implicate CUDDA—which expressly requires that brain death be "irreversible." If plaintiff intends to allege that a mistake was made, she has sued the wrong party.

Plaintiff's right-to-life claim is analyzed under the same standards as her due process claims, and accordingly fails for the same reasons.

Plaintiff's privacy claims are premised on her assertion that she has an absolute right to make all decisions concerning Israel's medical treatment. Those claims fail for at least two reasons. First, they do not implicate the Director or CUDDA because the decision whether to continue treating a person who is brain dead is entirely left to the medical professionals, and is not addressed by CUDDA. Second, the right to make medical decisions is not absolute, and may be overridden by competing state interests. Here, to the extent that state action, rather than the

independent actions of the physicians, is responsible for overriding plaintiff's preferences concerning medical care, the State's legitimate interests in drawing boundaries between life and death, ensuring that patients at the end of their lives are treated with dignity, and ensuring that medical resources are devoted to treating living patients, and not the deceased, all significantly outweigh plaintiff's interest in making medical decisions on Israel's behalf.

Finally, plaintiff's "as applied" claims are barred by the *Rooker-Feldman* doctrine, as they amount to a collateral attack on the state superior court's judgment upholding the physicians' determination of death.

For these reasons, the Director's motion should be granted and the complaint dismissed without leave to amend.

I. THERE IS NO JUSTICIABLE CONTROVERSY; PLAINTIFF NOW SEEKS AN IMPROPER ADVISORY OPINION.

It is well-settled that an actual justiciable controversy must be present in order to satisfy the constitutional limitations on the judicial power set out in Article III, section 2, of the United States Constitution. *Aetna Life Ins. Co. of Hartford, Conn. v. Haworth*, 300 U.S. 227 (1937). "[T]he question in each case is whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between the parties … of sufficient immediacy and reality to warrant the issuance of a declaratory judgment." *Maryland Cas. Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273 (1941). The "requisite personal interest that must exist at the commencement of the litigation (standing) must continue throughout its existence (mootness)." *Cook Inlet Treaty Tribes v. Shalala*, 166 F.3d 986, 989 (9th Cir. 1999). Where a litigant has standing at the outset of the litigation, but loses her legally cognizable interest in the outcome during the pendency of the litigation and thus cannot obtain relief, the case becomes moot and should be dismissed for lack of subject-matter jurisdiction. *See McQuillion v. Schwarzenegger*, 369 F.3d 1091, 1095 (9th Cir. 2004) ("[D]eclaratory judgment without the possibility of prospective effect would be superfluous."); *Ruvalcaba v. City of L.A.*, 167 F.3d 514, 521 (9th Cir. 1999).

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The court lacks jurisdiction to hear this matter because there is no longer a justiciable controversy between the parties. Plaintiff exclusively seeks injunctive and declaratory relief related to the determination that Israel is deceased. Prayer ¶¶ 1-3. Plaintiff sues to "expunge all records archived or under the control of [the Director] that state that [Israel] is deceased." *Id*. Now that all parties agree that Israel is deceased, plaintiff no longer has a legally cognizable interest in the relief sought by this action.

Plaintiff's claims do not fit within the narrow parameters of the "capable of repetition, yet evading review" exception to the mootness doctrine, which "applies only where '(1) the duration of the challenged action is too short to allow full litigation before it ceases, and (2) there is a reasonable expectation that the plaintiffs will be subjected to it again.'" *Biodiversity Legal Found. v. Badgley*, 309 F.3d 1166, 1173 (9th Cir. 2002) (quoting *Greenpeace Action v. Franklin*, 14 F.3d 1324, 1329 (9th Cir. 1993)). Courts apply this exception "sparingly, and only in 'exceptional situations.'" *Protectmarriage.com – Yes on 8 v. Bowen*, 752 F.3d 827, 836-37 (9th Cir. 2014). Here, plaintiff's claims are not a type that "inherently precludes" judicial review, *id*, at 837. Additionally, there is no reasonable expectation that plaintiff will again be faced with these issues concerning the determination of death under CUDDA. With no relief to provide, plaintiff's complaint is academic and amounts to an impermissible advisory opinion. *Aetna*, 300 U.S. at 240-41. The complaint should be dismissed.

II. PLAINTIFF LACKS ARTICLE III STANDING BECAUSE THE DIRECTOR HAS NOT CAUSED PLAINTIFF HARM NOR WILL A FAVORABLE OUTCOME REDRESS PLAINTIFF'S ALLEGED INJURY

To satisfy Article III's standing requirements, a plaintiff must show: (1) an "injury in fact" that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision. *Cantrell v. City of Long Beach*, 241 F.3d 674, 679 (9th Cir. 2001).

Here, plaintiff lacks standing to sue the Director because the injury alleged—the determination by several physicians that Israel is deceased—was not caused by the Director or CUDDA and would not be redressed even if plaintiff prevailed in this case. The harm alleged

here was caused by, and is redressable only by challenging, the independent medical decisions of the physicians who assessed Israel. As discussed below, plaintiff has sued the wrong party.

A. Plaintiff Fails to Allege a Sufficient Nexus between Israel's Death and any State Action.

Plaintiff must show that the injury—determination of death—stems from compliance with CUDDA, and is not the result of conduct of some third party not before the court. *See Linda R.S. v. Richard D.* 410 U.S. 614, 618 (1973); *see also Lujan v. Defenders of Life*, 504 U.S. 555, 560–61 (1992). Here, Israel's death determination was a medical decision made by third party physicians. CUDDA did not cause Israel's harm.

The injury complained of is the determination that Israel is deceased. *See* SAC. That determination was initially made by three physicians, none of whom are before this court. They made that determination based upon prevailing medical standards after administering tests recommended by the American Academy of Pediatrics and the Society of Critical Care Medicine. SAC ¶ 21. While plaintiff alleges that this determination was caused by CUDDA, SAC ¶ 35, that is incorrect as a matter of law. CUDDA merely codifies the prevailing definition of death that has long been accepted by the medical community, RJN Ex. B, and CUDDA does not itself impose any requirements on physicians in making a determination of death. Instead, CUDDA ultimately defers to physicians' medical judgment in making that determination, expressly providing that "[a] determination of death must be made *in accordance with accepted medical standards*." § 7180(a) (emphasis added). Accordingly, CUDDA is not the cause of plaintiff's alleged injury, and thus plaintiff lacks standing to challenge the constitutionality of CUDDA.

B. A Favorable Decision Would not Redress Plaintiff's Alleged Injury.

Even if plaintiff could demonstrate an adequate link between the determination of death and CUDDA/the Director, she cannot show that a favorable decision will redress that injury. The redressability prong analyzes the connection between the alleged injury and requested judicial relief. It requires a likelihood that the injury will be redressed by a favorable judicial decision. *Wolfson v. Brammer*, 616 F.3d 1045, 1056 (9th Cir. 2010). Accordingly, here plaintiff must show

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that a favorable decision by this court will likely reverse the medical determination that Israel is deceased. *See Washington Envtl. Council v. Bellon*, 732 F.3d 1131, 1146 (9th Cir. 2013).

As addressed above, plaintiff seeks to reverse the medical determination that Israel is dead. Plaintiff seeks an order expunging all records that state that Israel is deceased. Prayer, ¶ 1. She also seeks a declaration that CUDDA is unconstitutional on its face and as applied. *Id.*, Prayer, ¶¶ 2-3. However, should plaintiff receive the relief she seeks, it will not undo the physicians' determination that Israel is no longer living. Even if CUDDA is found unconstitutional, physicians must still make determinations of death in accordance with accepted medical standards. Moreover, brain death was recognized as a means to determine death well before CUDDA's enactment. *See* RJN, Exs. B, at 3. Thus, plaintiff cannot allege that but for CUDDA, Israel would be alive. A judgment against the Director will not have the force and effect to compel the physicians to reverse their medical opinions. See *Native Vill. of Kivalina v. ExxonMobil Corp.*, 696 F.3d 849, 867 (9th Cir. 2012) (Standing is lacking when the injury is "th[e] result [of] the independent action of some third party not before the court."). A favorable decision by this court will not invalidate the prevailing medical standards or the medical opinions of the three physicians. Plaintiff fails to satisfy the "redressability" requirement for standing and the action should be dismissed.

III. THE FIRST AND SECOND CAUSES OF ACTION FAIL TO STATE A CLAIM AGAINST THE DIRECTOR AND SHOULD BE DISMISSED

Even if plaintiff had standing, the complaint should still be dismissed because it fails to state any claims against the Director as a matter of law. Plaintiff's First and Second Causes of Action allege generally that CUDDA deprived Israel of life and plaintiff of parental rights in violation of the due process clauses of the Fifth and Fourteenth Amendments. Though not entirely clear, plaintiff appears to allege (1) a procedural due process claim that CUDDA provides no process or procedures by which a patient or advocate can challenge the determination of death, SAC ¶ 60, and (2) a substantive due process claim that CUDDA provides an incorrect definition of death and "removes the independent judgment of medical professionals as to whether a patient is dead." SAC ¶ 54. As explained below, both contentions fail to state a claim as a matter of law.

A. California's Procedures Are Constitutionally Sufficient.

"No single model of procedural fairness, let alone a particular form of procedure, is dictated by the Due Process Clause." *Kremer v. Chemical Const. Corp.*, 456 U.S. 461, 483 (1982). Instead, the "fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner." *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976) (citations omitted). Under California law, the procedures concerning determinations of death are constitutionally adequate and plaintiff has received all the process to which she is due.

1. Plaintiff's facial challenge lacks merit.

To mount a successful facial challenge to CUDDA, plaintiff "must establish that no set of circumstances exists under which the Act would be valid." *U.S. v. Salerno*, 481 U.S. 739, 745 (1987). A statute is facially unconstitutional if "it is unconstitutional in every conceivable application, or it seeks to prohibit such a broad range of protected conduct that it is unconstitutionally overbroad." *Foti v. City of Menlo Park*, 146 F.3d 629, 635 (9th Cir. 1998) (internal quotation marks omitted). Where, however, a statute has "a plainly legitimate sweep," the challenge must fail. *Hoye v. City of Oakland*, 653 F.3d 835, 857 (9th Cir. 2011) (quoting *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008)). Plaintiff cannot meet her burden and her facial challenge to CUDDA fails.

While CUDDA itself does not expressly set forth procedures to challenge a determination of death, such procedures are provided under California law. *See Dority v. Superior Court*, 145 Cal. App. 3d 273, 280 (1983) ("The jurisdiction of the court can be invoked 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."); *see also* ECF No. 48, at 26-28 (in ruling on plaintiffs' preliminary injunction motion, this court noted that the "state court has jurisdiction to hear evidence and review physician's determination that brain death has occurred"). Indeed, plaintiff has invoked these procedures to challenge the doctors' determinations that Israel is deceased on two separate occasions, filing suits in Placer County Superior Court to challenge Drs. Myette's and Maselink's determination, in case no.

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S-CV-0037673, and more recently filing suit in Los Angeles County Superior Court to challenge CHLA's physicians' determination in case no. BS164387.

Further, CUDDA itself provides certain preliminary procedures that must be followed at the time of the initial determination of death. First, all determinations of death must be made by physicians in accordance with prevailing medical standards. § 7180(a). Second, in cases of brain death a single physician's opinion is insufficient; CUDDA requires *independent* confirmation by another physician. *Id.*, § 7181.[4] These procedures and the right to contest a determination of death in the superior court, *see Dority*, *supra*, are more than sufficient to satisfy all constitutional procedural due process requirements.

2. Plaintiff's "as applied" challenge fails.

Plaintiff's "as applied" challenge meets the same fate. Plaintiff cannot demonstrate that CUDDA, as applied to the facts of this case, is unconstitutional. *See Hoye*, *supra*, at 857. Here, three physicians performed the requisite tests and independently concluded that Israel suffered irreversible brain death. SAC ¶¶ 17-23. Following the third pronouncement, plaintiff contested the determination by initiating the Placer County Superior Court action. *Id.*, 40-41; *see also* ECF 14-2. Plaintiff was given a full evidentiary hearing. She was given time to secure her own independent examination by a qualifying physician, as well as the opportunity to cross-examine Dr. Myette, Israel's attending physician. After considering the evidence before it, the court concluded that there was no basis to question the medical determination that Israel was deceased. *See* ECF No. 19-1. Given these facts, plaintiff has not, nor can she, demonstrate that these procedures are constitutionally inadequate.

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[4] CUDDA provides a number of additional procedural protections. For example, § 7182 forbids physicians involved in the determination of death from participating in any procedures to remove or transplant the deceased person's organ; § 7183 requires the hospital to keep, maintain and preserve patient medical records in the case of brain death; § 1254.4(a) requires hospitals to "adopt a policy for providing family or next of kin with a reasonably brief period of accommodation . . ."; § 1254.4 (b) requires the hospital to provide the patient's family with a written statement of the policy regarding a reasonably brief accommodation period; and § 1254.4(c)(2) requires the hospital to make reasonable efforts to accommodate a family's religious and cultural practices and concerns

B. Plaintiff's Substantive Due Process Allegations Fail to State a Claim.

Plaintiff's substantive due process allegations also fail to state a claim as a matter of law. As this Court has previously noted, the Due Process Clause of the Fourteenth Amendment prohibits states from making or enforcing laws that deprive a person of life, liberty, or property without due process. ECF 48, 21:22-24; U.S. Const. amend, XIV, section 1. The substantive due process right "protects individual liberty against 'certain government actions regardless of the fairness of the procedures used to implement them.'" *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992) (quoting *Daniels v. Williams*, 474 U.S. 327, 331 (1986)). It "provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). Inherent in this protection is the notion that a state by law or enforcement actually *deprives* a person of life, liberty, or property.

Plaintiff contends that under CUDDA an advocate for a patient is not allowed to bring in her own physician to contest the findings, SAC ¶¶ 49, 50, and that CUDDA prevents a physician from exercising his or her independent judgment as to whether a patient is dead, SAC ¶ 54. Both allegations are incorrect as a matter of law.

Nothing in CUDDA prevents physicians from exercising their independent medical judgment as to whether a patient is deceased or precludes an advocate from seeking an independent opinion. As discussed above, CUDDA expressly provides that "[a] determination of death must be made *in accordance with accepted medical standards*. § 7180(a) (emphasis added). In cases of brain death, CUDDA also requires that before a patient is declared deceased "there shall be *independent* confirmation by another physician." *Id.*, § 7181 (emphasis added). Accordingly, the statute, by its plain terms, defers to the medical judgment of doctors. Nothing in CUDDA dictates or directs any physician concerning when an inquiry of death should ensue, which tests to perform, or whether an actual declaration of death should be made. It provides a general definition of brain death, but leaves the ultimate determination to the discretion of doctors "in accordance with accepted medical standards." *Id.*, § 7180(a). Moreover, the statute does not state which physicians are permitted to examine the patient. Thus, *CUDDA*, does not prevent advocates from securing their own medical opinions.

Even if plaintiff could allege sufficient governmental encroachment (which she cannot), plaintiff's substantive due process claim still fails. Whether the constitutional rights at stake have been violated is determined by balancing them against the "relevant state interests." *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 279 (1990) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)). As this court previously noted, California "has a broad range of legitimate interests in drawing boundaries between life and death." ECF No. 48, at 24:4-16 (recognizing the state's interest in the context of criminal law, probate and estates law, and general healthcare and bioethics). The State also has a compelling interest in the quality of health and medical care received by its citizens. ECF No. 48, at 24:14-15 (citing *Varandani v. Bowen*, 824 F.2d. 307, 311 (4th Cir. 1987)). Similarly, the State seeks to ensure that patients are treated with dignity, particularly during their end of life. *See* Cal. Prob. Code § 4650 (b) (The "prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person."); *id.*, § 4735 (health care provider "may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution"). And it is also well settled that the State has a legitimate interest in securing the public safety, peace, order, and welfare. *See Wisconsin v. Yoder*, 406 U.S. 205, 230; *Carnohan v. United States*, 616 F.2d 1120, 1122 (1980) (no fundamental right to access drugs the FDA has not deemed safe and effective).

As this court observed, plaintiff provides no facts that "suggest [] CUDDA is arbitrary, unreasoned, or unsupported by medical science." ECF No. 48, at 24:17-18. This definition is the result of the agreement between the AMA and ABA and has been "uniformly accepted throughout the country." ECF No. 48, at 24:22-28 (quoting *In re Guardianship of Hailu*, 361 P.3d 524, 528 (Nev. 2015)). Plaintiff has not alleged any additional facts to sustain her claim. It remains that plaintiff's disagreement with the prevailing definition of death cannot override the

/ / /

State's interests in enacting CUDDA. Plaintiff's substantive due process claim fails as a matter of law.

IV. THE COMPLAINT'S THIRD CAUSE OF ACTION FOR DEPRIVATION OF RIGHT TO LIFE IN VIOLATION OF THE CALIFORNIA CONSTITUTION ALSO FAILS TO STATE A CLAIM.

Identical to her first claim, plaintiff, in support of the third claim, asserts that CUDDA deprived Israel of his right to life. SAC ¶ 66. The California Constitution also protects persons from deprivation of life, liberty, or property without due process of law and is "identical in scope with the federal due process clause." *Sanchez v. City of Fresno*, 914 F. Supp. 2d 1079, 1116 (E.D. Cal. 2012) citing *Owens v. City of Signal Hill*, 154 Cal.App.3d 123, 127 n. 2, (1984). Accordingly, for the reasons articulated above as to First and Second Causes of Action, plaintiff's Third Cause of Action should also be dismissed.

V. CUDDA DOES NOT VIOLATE PLAINTIFF'S RIGHT TO PRIVACY AND THEREFORE THE FOURTH AND FIFTH CAUSES OF ACTION SHOULD BE DISMISSED

Plaintiff alleges that health care decisions are part of the right to personal autonomy and privacy, and that CUDDA violated these rights by allegedly denying plaintiff the right to make medical decisions on Israel's behalf. SAC ¶¶ 69, 73-74. This claim fails because the medical decisions in question were not dictated by CUDDA but rather made by doctors, using their medical judgment, and plaintiff had the right to challenge those medical decisions through appropriate avenues.

Article I, section 1 of the California Constitution provides: "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, *and privacy*." (Emphasis added.) The federal Constitution does not expressly mention the right to privacy but recognizes a realm of personal liberties upon which the government may not intrude. *Roe v. Wade*, 410 U.S. 113, 152 (1973). However, this right is not absolute; one's right to dictate medical treatment may be outweighed by supervening public concerns. *Roe*, *supra*, at 155. Thus, as with the due process claims, the court is charged with balancing the liberty at stake against the State's interests in limiting that right.

/ / /

In her complaint, plaintiff contends that one's right to dictate medical decisions and treatment is boundless. SAC ¶¶ 69, 71, 74, 76. Plaintiff is mistaken. As articulated above, the State's interests in defining death and limiting a parent's right to make medical decisions are vast. *See infra.*, Part, III.B. In the case at bar, the right to dictate medical decisions gave way once three physicians determined that Israel suffered irreversible cessation of brain activity and is, therefore, deceased. Additionally, though plaintiff, was provided ample opportunity to refute that determination, plaintiff did not do so. In light of these facts, and the competing state interests, plaintiff cannot demonstrate that CUDDA violated Israel's right to continued privacy as afforded by the California or United States Constitutions. Plaintiff's Fourth and Fifth Causes of Action should be dismissed.

VI. "AS APPLIED" CLAIMS IN THE FIRST AND SECOND CAUSES OF ACTION ARE BARRED BY THE *ROOKER-FELDMAN* DOCTRINE

The *Rooker-Feldman* doctrine precludes this court from considering plaintiff's "as applied" challenges to the constitutionality of CUDDA in the First and Second Causes of Action. In April 2016, plaintiff expressly challenged the determination of death in state court alleging that the brain death declaration was wrong. After affording plaintiff time to secure her own medical opinion, the court upheld the determination of death. Plaintiff did not appeal the trial court's decision. Instead, plaintiff filed series of complaints, the latest of which directly challenged the physician's determination of death. Plaintiff's newly asserted "as applied" claims are nothing more than an impermissible challenge to the state trial court's decision.

"Stated plainly, *Rooker–Feldman* bars any suit that seeks to disrupt or 'undo' a prior state-court judgment, regardless of whether the state-court proceeding afforded the federal-court plaintiff a full and fair opportunity to litigate her claims." *Bianchi v. Rylaarsdam*, 334 F.3d 895, 900 (9th Cir. 2003) (citation omitted). Unlike res judicata, the *Rooker–Feldman* doctrine is not limited to claims that were actually decided by the state courts, but rather it precludes review of all state court decisions. *Id.* The doctrine "applies even though the direct challenge is anchored to alleged deprivations of federally protected due process and equal protection rights." *Allah v. Superior Court*, 871 F.2d 887, 891 (9th Cir.1989), superseded by statute on other grounds as

stated in *Schroeder v. McDonald*, 55 F.3d 454, 458 (9th Cir.1995); *Worldwide Church of God v. McNair*, 805 F.2d 888, 891 (9th Cir.1986) ("This doctrine applies even when the challenge to the state court decision involves federal constitutional issues.").

The *Rooker–Feldman* doctrine precludes the exercise of jurisdiction not only over claims that are de facto appeals of a state court decision but also over suits that raise issues that are "inextricably intertwined" with an issue resolved by the state court. *See Feldman*, 460 U.S. at 483 n. 16; *Noel v. Hall*, 341 F.3d 1148, 1158 (9th Cir. 2003). As the Ninth Circuit has explained: "If claims raised in the federal court action are 'inextricably intertwined' with the state court's decision such that the adjudication of the federal claims would undercut the state ruling or require the district court to interpret the application of state laws or procedural rules, then the federal complaint must be dismissed for lack of subject matter jurisdiction." *Bianchi, supra*, at 898. In determining whether a plaintiff's federal claims are "inextricably intertwined" with a state court decision, "a court must do more than simply 'compare the issues involved in the state-court proceeding to those raised in the federal-court plaintiff.' " *Id.* at 900 (quoting *Kenmen Engineering v. City of Union*, 314 F.3d 468, 476 (10th Cir.2002)). Rather, it must "'pay close attention to the relief sought by the federal-court plaintiff.'" *Id.*

In this newly amended action, plaintiff expressly asserts an "as applied" challenge to CUDDA. SAC ¶¶ 49-50, 55, 60.[5] Identical to plaintiff's state court petition, plaintiff First and Second Causes of Action allege there is a medical dispute of fact as to whether Israel is dead or alive. *See* SAC ¶¶ 55, 65. Additionally, the remedy she seeks reveals that this action is a direct challenge to the determination of death and the superior court's order upholding the determination. Prayer, ¶ 1 (Plaintiff seeks "[a]n order expunging all records … which state or imply that Israel is deceased."). This most recent complaint is simply an improper appeal from the state court decision that CUDDA was appropriately complied with and Israel is deceased. Thus, plaintiff is

/ / /

[5] This court previously rejected application of *Rooker-Feldman* noting plaintiff challenged CUDDA's constitutionality generally, not CUDDA's particular application to this case. ECF 48, at 7:14-17.

barred from seeking what in substance would be appellate review of a state judgment in federal district court, even if she contends the state judgment violated her federal rights.

CONCLUSION

This court should dismiss the Second Amended Complaint without leave to amend.

Dated: August 31, 2016

Respectfully Submitted,

KAMALA D. HARRIS
Attorney General of California
ISMAEL A. CASTRO
Supervising Deputy Attorney General

/s/ Ashante L. Norton

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Deputy Attorney General
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Attorneys for Defendant

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, Plaintiff, **v.** **KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA,** Defendant.	2:16-cv-00889-KJM-EFB **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS SECOND AMENDED COMPLAINT** Date: October 7, 2016 Time: 10:00 a.m. Courtroom: 3 Judge: Hon. Kimberly J. Mueller Trial Date: none set Action Filed: May 9, 2016

Defendant Karen Smith, M.D., in her official capacity as Director of the California Department of Public Health respectfully requests that the court take judicial notice, pursuant to Rule 201 of the Federal Rules of Evidence, of the documents listed below.

Judicial notice is appropriate where the fact is not subject to reasonable dispute because it is "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b)(2). Federal courts routinely take judicial notice of state court records. *Harris v. County of Orange*, 682 F.3d 1126, 1132 (9th Cir. 2012); *Cachil Dehe Band of Wintun Indians v. California*, 547 F.3d 962, 968 n. 4 (9th Cir. 2008) (taking judicial notice of state records); *United States v. Black*, 482 F.3d 1035, 1041 (9th Cir. 2007) (noting that a

court "may take notice of proceedings in other courts, both within and without the federal judicial system, if those proceedings have a direct relation to matters at issue"); *Reyn's Pasta Bella, LLC v. Visa USA, Inc.*, 442 F.3d 741, 746 n. 6 (9th Cir. 2006) (taking judicial notice of pleadings, memoranda, and other court filings); *Asdar Group v. Pillsbury, Madison & Sutro*, 99 F.3d 289, 290 n. 1 (9th Cir. 1996) (court may take judicial notice of pleadings and court orders in related proceedings).

Judicial notice of documents constituting legislative history is appropriate. These materials are not subject to reasonable dispute and "can be accurately and readily determined from sources whose accuracy cannot be questioned." Fed. R. Evid. 201(b)(2); *See Chaker v. Crogan*, 428 F.3d 1215, 1223 n. 8 (9th Cir. 2005) (taking judicial notice of the legislative history of a state statute); *see also Joseph v. J.J. Mac Intyre Companies, L.L.C.*, 238 F. Supp. 2d 1158, 1165 n. 5 (N.D. Cal. 2002). Additionally, the court may take judicial notice of "matters of public record." *Lee v. City of L.A.*, 250 F.3d 668, 689 (9th Cir.2001). This includes public records of a governmental entity that is available from reliable sources. *See Daniels-Hall v. Nat'l Educ. Ass'n*, 629 F.3d 992, 999, 1004-05 (9th Cir. 2010)

On a Rule 12(b)(6) motion to dismiss, a court may take judicial notice of another court's opinion. *Lee v. City of Los Angeles*, 250 F.3d 668, 690 (9th Cir. 2001). "It may do so 'not for the truth of the facts recited therein, but for the existence of the opinion, which is not subject to reasonable dispute over its authenticity.'" *Id.* citing *Southern Cross Overseas Agencies, Inc. v. Wah Kwong Shipping Group Ltd.*, 181 F.3d 410, 426–27 (3rd Cir.1999).

Judicial notice by a court is mandatory "if requested by a party and supplied with the necessary information." Fed. R. Evid. 201(c)(2). Therefore, the Director requests that the court take judicial notice of the following 5 items:

1. Attached as Exhibit A are true and correct copies of documents from the Assembly Health Committee Analysis of Senate Bill 2004 (May 1982).

2. Attached as Exhibit B is a true and correct copy of the Uniform Determination of Death Act drafted by the National Conference of Commissioners on Uniform State Laws. The Uniform Act is also contained as part of the Assembly Health Committee Analysis of Senate Bill

2004 (May 1982). Exhibit B is separately noticed for ease of reference by the parties and the court. A copy can also be found at:

http://www.uniformlaws.org/shared/docs/determination%20of%20death/udda80.pdf

3. Attached as Exhibit C is a true and correct copy of the Verified Ex Parte Petition for Temporary Restraining Order/Injunction: Request for Order of Independent Neurological Exam filed August 18, 21016, in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case no. BS164387.[1]

4. Attached as Exhibit D is a true and correct copy of the Temporary Restraining Order and Order to Show Cause Re Preliminary Injunction filed August 18, 2016, in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case no. BS164387.

5. Attached as Exhibit E is a true and correct copy of the Order on Ex Parte Application to Dissolve Temporary Restraining Order filed August 25, 2016, in *Fonseca v. Children's Hospital Los Angeles*, Los Angeles County Superior Court, Case no. BS164387.

CONCLUSION

For the foregoing reasons, the Director respectfully requests that the Court take judicial notice of the above referenced documents and further, that the Court consider the above referenced documents in connection with Defendant's Motion to Dismiss Plaintiff's Second Amended Complaint.

Dated: August 31, 2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ISMAEL A. CASTRO
Supervising Deputy Attorney General

/s/ Ashante L. Norton

ASHANTE L. NORTON
Deputy Attorney General
Attorneys for Defendant

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[1] Exhibits to the Petition have been omitted.

Exhibit A

ASSEMBLY HEALTH COMMITTEE
ART TORRES, CHAIRMAN

SB 2004

ANALYSIS: SB 2004 (BEVERLY) AS AMENDED MAY 12, 1982

SUBJECT: Determination of Death - Conformance with National Commission on Uniform State Laws Definition

DIGEST: Existing law authorizes physicians to pronounce death of a person who has suffered a total and irreversible cessation of brain function and requires the independent confirmation by another physician. In addition, the physicians making such determination when the deceased is a donor of anatomical gift may not participate in the procedures for removing or transplanting the part.

This bill would repeal existing law and substitute language that would define death as either:
(1) An irreversible cessation of circulatory and respiratory functions, or
(2) ~~An irreversible cessation of all functions of the entire brain, including the brain stem.~~

Existing law regarding confirmation of death of a transplant donor and the maintenance of medical records is retained.

STAFF COMMENTARY: This bill was introduced at the request of the California Commission on Uniform State Laws. In many states, the definition of death is limited to an irreversible cessation of vital functions (cardio-respiratory) in accordance with common law. In California, death is determined when there is an irreversible cessation of brain function.

Although there can be no brain function without cardio-respiratory support, it is possible to have cardio-respiratory function aided by equipment without brain function.

This bill, therefore, adds to California law the common law definition of cessation of cardio-respiratory functions and would thus conform this state to other jurisdictions using the national uniform definition.

POSITIONS: Support: California Commission on Uniform State Laws

Oppose: None received

CONSULTANT: Paul Press SB 2004

AUTHOR'S STATEMENT FOR

SENATE BILL 2004

Senate Bill 2004 enacts the Uniform Death Act, which modifies the definition of death in state law to conform with the definition as adopted by the National Conference of Commissioners on Uniform State Laws. The measure also specifies that when an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all brain functions, independent confirmation by another physician will be required.

The Uniform Death Act provides a comprehensive basis for determining death in all situations. It is based on a ten year evolution of statutory language on the subject. The Act has been necessitated as a result of recent advances in life saving technology which have led to a potential disparity between current and accepted biomedical practice and existing law.

This Act contains language that is the result of agreement between the American Bar Association, the American Medical Association and the National Conference of Commissioners on Uniform State Laws.

SUPPORT: California Commission on Uniform State Laws (sponsor
Osteopathic Physicians and Surgeons of California

OPPOSE: No known.

PASSED: Senate Health and Welfare 5-0, Senate Floor 37-0

BRM:cy

SENATE COMMITTEE ON
HEALTH AND WELFARE

JU

STAFF ANALYSIS OF SENATE BILL NO. 2004 (BEVERLY)
AS INTRODUCED MARCH 22, 1982

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SUBJECT

Confirmation of death

PURPOSE

Technical: to conform language of the state's Uniform Determination of Death Act with language used by other states.

DESCRIPTION

The bill makes technical changes to the state's Uniform Determination of Death Act, to conform with the current definition of death that has been approved by the National Commission on Uniform State Laws.

The technical language changes add, in the definition of the determination of death, the "irreversible cessation of circulatory and respiratory functions." This has been added to the existing definition of the "irreversible cessation of all functions of the entire brain, including the brain stem."

BACKGROUND

The common law standard for determining death is the cessation of all vital functions, traditionally demonstrated by an absence of spontaneous respiratory and cardiac functions. This definition is not in the current state law, which only refers to brain death. However, respiratory and cardiac functions can nowadays be perpetuated through artificial support.

The new wording therefore codifies the existing common law basis for determining death; total failure of the cardio-respiratory system. Thus, if the person's brain or brain stem is totally dead, the person is legally considered dead, even if the person is also receiving artificial support to keep the respiratory and cardiac functions operating.

- MORE -

COMMENTS

Under the current law, a person's death must be confirmed by another physician. The new rewriting of Section 7180 under 2004, however, does not require the confirmation of another physician. A second physician's confirmation would only be required if the deceased were to undergo organ removal for purposes of transplantation.

If the Legislature feels that confirmation of death in cases other than those where the deceased will undergo organ removal should also require the confirmation of a second physician, this should be clarified in Section 7181 of the bill, by adding the requirement for a second physicians' confirmation for "non-doner" deaths.

POSITIONS

SUPPORT: None reported.

OPPOSE: None reported.

* * * * * * * * *

Hearing Date: May 05, 1982

PLEASE RETURN AS SOON AS POSSIBLE TO:

Assemblyman Art Torres, Chairman
Assembly Health Committee
Room 2160, State Capitol

BILL ANALYSIS WORK SHEET

MEASURE: SB 2004 AUTHOR: Burt

1. Origin of the bill:

   (a) What is the source of the bill? (What person, organization or governmental entity, if any, requested introduction?)
   California Commission on Uniform State Laws (Bion Gregory)

   (b) Has a similar measure been before the Legislature either this session or a previous session? If so, please identify the session, bill number and disposition of the bill.
   No.

   (c) Has there been an interim committee report on the bill? If so, please identify the report.
   No.

   ~~(d) Please attach copies of letters from any group or governmental agency who has contacted you, indicating a position on the bill.~~

2. Problem or deficiency in present law which the bill seeks to remedy: SB 2004 enacts the Uniform Determination of Death Act, which modifies the definition of death in state law to conform with the definition as adopted by the National Conference of Commissioners on Uniform State Laws.

3. Please attach a copy of any background material in explanation of the bill or state where such material may be available.

4. Hearing:

   (a) Approximate amount of time necessary for hearing bill:
   10 minutes.
   (b) Names of witnesses to testify at hearing:

IF BILL IS TO BE AMENDED BEFORE THE HEARING, PLEASE CONTACT THE COMMITTEE AS SOON AS POSSIBLE SO THE ANALYSIS WILL REFLECT THE PROPOSED AMENDMENTS. AMENDMENTS, IN LEGISLATIVE COUNSEL FORM, MUST BE RECEIVED BY THE COMMITTEE NO LATER THAN WEDNESDAY BEFORE THE HEARING.

OPSC Osteopathic Physicians and Surgeons of California

A DIVISIONAL AFFILIATE OF THE AMERICAN OSTEOPATHIC ASSOCIATION

Matt Weyuker
Executive Director

April 21, 1982

RECEIVED
APR 23 1982
CAPITOL OFFICE

Honorable Robert G. Beverly
Member of the Senate
State Capitol, Room 2054
Sacramento, CA 95814

Dear Senator Beverly:

Legislation which you introduced on March 22, 1982 (SB 2004) will soon be coming before the Senate Health & Welfare Committee, chaired by Senator Diane Watson.

The Osteopathic Physicians and Surgeons of California is in support of this measure as it is one which is of benefit to the people and the osteopathic profession here in California.

Please feel free to contact me if there is anything I can do to aid in the passage of this bill or if you need any further comments.

Sincerely,

Matt Weyuker
Executive Director

MW:cpr
cc: Senator Diane Watson,
Chairman of Senate Health
& Welfare Committee

921 Eleventh Street • Suite 1200 • Sacramento, California 95814 • Telephone (916) 447-2004

UNIFORM DETERMINATION OF DEATH ACT

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS EIGHTY-NINTH YEAR
ON KAUAI, HAWAII
JULY 26 - AUGUST 1, 1980

Uniform Laws Commissioners

WITH PREFATORY NOTE

Approved by the American Medical Association
October 19, 1980
Approved by the American Bar Association
February 10, 1981

COUNSEL

The Committee which acted for the National Conference of Commissioners on Uniform State Laws in preparing the Uniform Determination of Death Act was as follows:

GEORGE C. KEELY, 1600 Colorado National Building, 950 Seventeenth Street, Denver, CO 80202, *Chairman*

ANNE MCGILL GORSUCH, 243 South Fairfax, Denver, CO 80222

JOHN M. MCCABE, Room 510, 645 North Michigan Avenue, Chicago, IL 60611, *Legal Counsel*

WILLIAM H. WOOD, 208 Walnut Street, Harrisburg, PA 17108

JOHN C. DEACON, P.O. Box 1245, Jonesboro, AR 72401, *President, Ex Officio*

M. KING HILL, JR., 6th Floor, 100 Light Street, Baltimore, MD 21202, *Chairman, Executive Committee, Ex Officio*

WILLIAM J. PIERCE, University of Michigan, School of Law, Ann Arbor, MI 48109, *Executive Director, Ex Officio*

PETER F. LANGROCK, P.O. Drawer 351, Middlebury, VT 05753, *Chairman, Division E, Ex Officio*

Copies of all Uniform and Model Acts and other printed matter issued by the Conference may be obtained from:

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS
645 North Michigan Avenue, Suite 510
Chicago, Illinois 60611

PREFATORY NOTE

This Act provides comprehensive bases for determining death in all situations. It is based on a ten-year evolution of statutory language on this subject. The first statute passed in Kansas in 1970. In 1972, Professor Alexander Capron and Dr. Leon Kass refined the concept further in "A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal," 121 Pa. L. Rev. 87. In 1975, the Law and Medicine Committee of the American Bar Association (ABA) drafted a Model Definition of Death Act. In 1978, the National Conference of Commissioners on Uniform State Laws (NCCUSL) completed the Uniform Brain Death Act. It was based on the prior work of the ABA. In 1979, the American Medical Association (AMA) created its own Model Determination of Death statute. In the meantime, some twenty-five state legislatures adopted statutes based on one or another of the existing models.

The interest in these statutes arises from modern advances in life-saving technology. A person may be artificially supported for respiration and circulation after all brain functions cease irreversibly. The medical profession, also, has developed techniques for determining loss of brain functions while cardiorespiratory support is administered. At the same time, the common law definition of death cannot assume recognition of these techniques. The common law standard for determining death is the cessation of all vital functions, traditionally demonstrated by "an absence of spontaneous respiratory and cardiac functions." There is, then, a potential disparity between current and accepted biomedical practice and the common law.

The proliferation of model acts and uniform acts, while indicating a legislative need, also may be confusing. All existing acts have the same principal goal—extension of the common law to include the new techniques for determination of death. With no essential disagreement on policy, the associations which have drafted statutes met to find common language. This Act contains that common language, and is the result of agreement between the ABA, AMA, and NCCUSL.

Part (1) codifies the existing common law basis for determining death—total failure of the cardiorespiratory system. Part (2) extends the common law to include the new procedures for determination of death based upon irreversible loss of all brain functions. The overwhelming majority of cases will continue to be determined according to part (1). When artificial means of support preclude a determination under part (1), the Act recognizes that death can be determined by the alternative procedures.

Under part (2), the entire brain must cease to function, irreversibly. The "entire brain" includes the brain stem, as well as the neocortex. The concept of "entire brain" distinguishes determination of death under this Act from "neocortical death" or "persistent vegetative state." These are not deemed valid medical or legal bases for determining death.

This Act also does not concern itself with living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support beyond brain death in cases of pregnant women or of organ donors, and protection for the dead body. These subjects are left to other law.

This Act is silent on acceptable diagnostic tests and medical procedures. It sets the general legal standard for determining death, but not the medical criteria for doing so. The medical profession remains free to formulate acceptable medical practices and to utilize new biomedical knowledge, diagnostic tests, and equipment.

It is unnecessary for the Act to address specifically the liability of persons who make determinations. No person authorized by law to determine death, who makes such a determination in accordance with the Act, should, or will be, liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts or the acts of others based on that determination. No person who acts in good faith, in reliance on a determination of death, should, or will be, liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts. There is no need to deal with these issues in the text of this Act.

Time of death, also, is not specifically addressed. In those instances in which time of death affects legal rights, this Act states the bases for determining death. Time of death is a fact to be determined with all others in each individual case, and may be resolved, when in doubt, upon expert testimony before the appropriate court.

Finally, since this Act should apply to all situations, it should not be joined with the Uniform Anatomical Gift Act so that its application is limited to cases of organ donation.

UNIFORM DETERMINATION OF DEATH ACT

§1. [*Determination of Death.*] 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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

§2. [*Uniformity of Construction and Application.*] This Act shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this Act among states enacting it.

§3. [*Short Title.*] This Act may be cited as the Uniform Determination of Death Act

Uniform Law Memo

Published by the National Conference of Commissioners on Uniform State Laws · Winter 1980

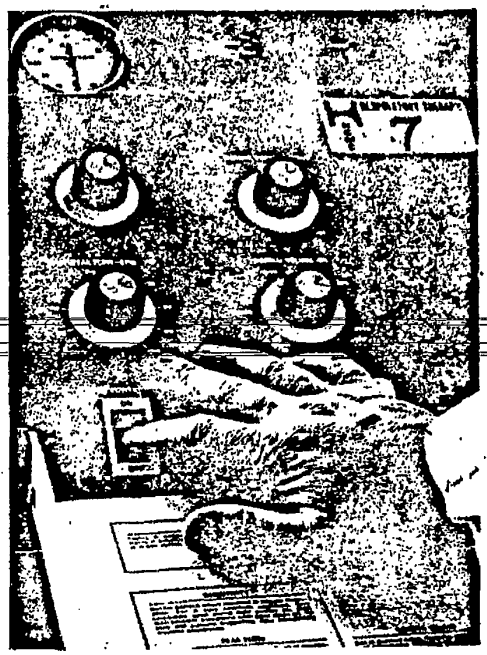
Law recognizes Brain Death

By Ronald E. Cranford and John M. McCabe

Only 20 years ago, a victim of a cardiac arrest suffered outside a hospital had virtually no chance. Today, up to one in five cardiac arrest victims go back to their homes and jobs.

But there are tragic byproducts of the technology that's responsible for these "medical miracles." They include "brain death" and the "persistent vegetative state." For example, some urban medical centers blessed with the latest life-saving equipment now classify about one in 20 deaths as brain death — a term that didn't even exist until a few years ago. And the concept couldn't have been imagined when the common law description of death as cessation of heart-lung activity was developed. Ancient law's ignorance of 20th Century advances in medical hardware and skill still is reflected in *Black's Law Dictionary* which relies exclusively on

(See BRAIN DEATH, page 2)



Should respirators be used on the "brain dead," or should they be reserved for those with some chance for life?

Three adoptions

Nevada's Legislature and the supreme courts of Colorado and Arizona have brought the Uniform Brain Death Act to their states.

Nevada's legislators acted early in 1979, and the high courts of Colorado and Arizona handed down decisions in October that recognized the Uniform Brain Death Act's definition of brain death as having equal standing with the traditional definition of death – cessation of respiration and circulation.

Twenty-four other states use other language to define "brain death." The Conference believes its simple act that points up the significance of the brain stem – and avoids confusion over the legal standing of the common law definition of death – is superior to earlier efforts of states to deal with the problem. Therefore, uniform law commissioners are urging every state to adopt the Uniform Brain Death Act.

Brain Death

the cardiorespiratory standard in describing death as:

"The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, . . . respiration, pulsation, etc."

The centuries-old cardiorespiratory factors still are valid for most determinations of death. But physicians now have tools capable of bringing some patients back from the common law concept of death. These modern miracles usually have a happy ending with victims rehabilitated and playing productive roles in society.

Critical minutes

But not always. Sometimes the medical arsenal of respirators, intubation and cardiopulmonary resuscitation manages to maintain heartbeat and breathing in patients who have suffered massive, irreversible brain damage. That can mean brain death.

How does it happen? In acute emergencies, such as cardiac arrest or severe head injuries, medical teams concentrate on stabilizing vital cardiorespiratory functions while diagnosing and treating potentially reversible causes of brain dysfunction. During those critical early minutes which often stretch into hours, there's little time to ascertain the extent of irreversible brain damage. Only after other factors have stabilized can the medical team assess the extent of permanent damage. That assessment might take a few hours, several days, weeks, and, in some cases, months.

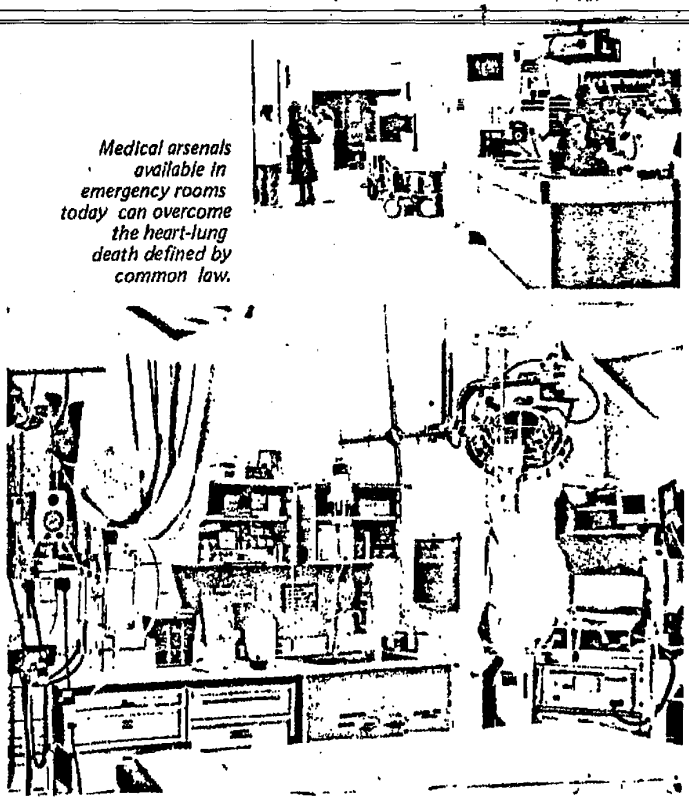
The three most common causes of brain death are (1) head injuries such as those sustained in auto accidents and shootings; (2) massive spontaneous brain hemorrhage which usually is secondary to complications of hypertension or rupture of a congenital berry aneurysm; and (3) lack of blood pumped into the brain because of cardiac arrest or systemic hypotension.

Whatever the cause, a severe insult to the brain often produces swelling (cerebral edema). When swelling is so severe that the pressure within the cranial cavity exceeds the systolic blood pressure, blood flow to the brain — including the brain stem — ceases. When cerebral circulation stops, all brain functions cease within a matter of minutes to a few hours. This characteristic sequence of events occurs in the majority of cases of brain death and is fundamental to an understanding of the certainty of prognosis in these cases.

No response

Clinical examination of the patients in this condition reveals no evidence of brain functions. They are in the deepest possible coma; totally unaware of themselves or their environment. Intense stimulation brings no response or voluntary motor movements.

However, some movements or reflexes originating in the spinal cord may be present, because the brain and spinal cord have separate circulatory systems. That means the spinal cord is unaffected by the massive increase



Medical arsenals available in emergency rooms today can overcome the heart-lung death defined by common law.

in intracranial pressure, and blood flow to the spinal cord may be normal. In that case, the cord would not suffer the widespread destruction sustained by the brain. Nevertheless, even in the presence of these persisting spinal cord responses, the patient's brain is definitely and irremediably destroyed. This condition can be described as "physiological decapitation."

All brain stem functions are absent. Pupils do not respond to light. There are no eye movements at the brain stem level. Spontaneous respiration ceases because the vital respiratory centers of the lower brain are destroyed. Therefore, the patient depends entirely on mechanical respiratory support to maintain the appearance, if not the substance, of life.

Heart may continue

Although spontaneous respiratory function depends totally on the brain and cannot exist without a functioning brain stem, that's not true of the heart. Normal cardiac functioning can occur in the presence of total brain destruction. For example, when a patient is pronounced dead using accepted medical criteria for brain death and the respirator is discontinued, the heart may continue to function for up to an hour.

Because of the sequence of events — primary injury, brain swelling, increased intracranial pressure, loss of cerebral blood flow and, finally, irreversible cessation of all brain functions — the prognosis for recovery of brain functions usually can be determined within the first few days after primary injury. The time period varies depending on rapidity and magnitude of brain swelling and other pathologic changes. Normally, brain swelling begins soon after the primary insult and reaches its greatest intensity within 12 to 24 hours. That means stoppage of cerebral blood flow typically occurs during the second or third day after a patient is hospitalized. But it can happen more quickly.

Confirmation needed

The bedside clinical examination necessary to confirm the absence of all brain functions can be performed within a matter of minutes. But establishment of an irreversible process as the basis for cessation of brain functions may require several days. Reversible loss of brain functions usually involves ingestion of suppressant drugs, such as barbituates, though it also is theoretically possible to experience temporary suspension of all brain functions because of hypothermia — low body temperature.

Therefore, when a patient's history can't be determined, it's necessary to exclude such possibilities before a patient may be pronounced "brain dead." Even laboratory screening of drugs can't be trusted completely. Physicians must wait several days to ensure that any drugs have been cleared from the body or, in some cases, document a total cessation of cerebral blood flow.

But in the great majority of cases, the cause of brain injuries can be ascertained within the first few hours. For example, when a head is split open as a side effect of a collision between a motorcycle and a utility pole, there's no reasonable doubt about the cause of the loss of brain function.

New diagnostic tools

New medical tools have increased diagnostic accuracy early in the treatment process. For example, CAT (computerized

Kansas led 26 other states in recognizing brain death

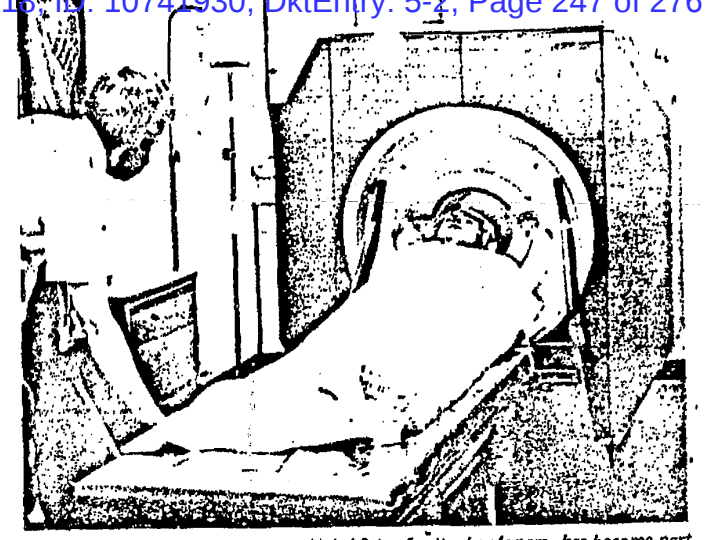
Kansas was the first state to adopt brain death legislation. That state's 1971 act set up a two-tier definition of death. Some experts feel the Kansas statute could be construed as creating a "special category" of death — one designed to encourage transplants of viable vital organs.

In 1972, law professor Alexander Morgan Capron of the University of Pennsylvania and physician Leon R. Kass developed a model statute aimed at eliminating the duality problem. The Capron-Kass proposal was adopted by at least eight states.

In 1975, the American Bar Association sought to simplify earlier brain death legislation. It approved a model used by at least two states, but also asked the Uniform Law Commissioners to refine the proposal. The American Medical Association's board of trustees recently approved another model which no state has reported adopting.

The key difference between the ABA and AMA models and the Uniform Act is the phrase "including the brain stem" — which draws a clear legal line between brain death and the persistent vegetative state.

Brain Death



The CAT Scanner—which won a Nobel Prize for its developers—has become part of the diagnostic arsenal available to physicians in major medical centers.

axial tomography) scanning enables physicians to visualize the size, location and effect of a massive intracranial hemorrhage. And without moving a patient, bedside radioisotope tests can determine if there has been a total interruption of blood flow to the brain.

Survival time limit

Sophisticated medical therapy is necessary to maintain cardiac function in brain death victims for even short periods of time. Prolonged maintenance of heartbeat and circulation is possible in theory. But when the brain stem is destroyed, cardiac function usually can be maintained for only hours or days. As many as one-fourth of all brain death victims may suffer a cardiac arrest while physicians are determining that brain death has occurred.

This limit on "survival time" points up an important distinction between brain death and the persistent vegetative state.

Unlike the multiple causes of brain death, the persistent vegetative state ordinarily results from a cardiac arrest that produces "ischemic encephalopathy" — brain damage secondary to lack of blood. In such cases, brain damage occurs primarily in the cerebral cortex which suffers more from lack of blood than the brain stem.

Fifteen to 20 minutes of total cessation of blood flow will destroy the entire brain, including the brain stem, to produce brain death. But if there is a total interruption of no more than four to six minutes, the result can be severe and irreversible structural damage to the cerebral cortex, resulting in the persistent vegetative state. Most neurologists use that term to describe a medical condition in which the patient demonstrates no behavioral responses even during periods of apparent "wakefulness."

Patient seems "normal"

The appearance of a patient existing in a persistent vegetative state contrasts with the profound coma of brain death. There may be spontaneous movements of eyes, changes in facial expression, movement of the extremities and even sleep-wake cycles. In other words, the patient at first glance might appear to be "normal." But detailed neurologic examinations over a prolonged period will demonstrate a total lack of

John M. McCabe...

. . . serves as legal counsel and legislative director for the NCCUSL. He joined the Conference in 1972 to head up legislative activities. His duties now include working with Uniform Law Commissioners; committees and advisors to state legislatures; state officials; and national, state and local interest groups to develop and urge enactment of NCCUSL-drafted legislation. He came to the Conference from the University of Montana where he served as assistant dean and taught local government law, torts, and professional responsibility. He also served as consultant to Montana state advisory committees on legislative planning and mined land reclamation.

awareness of self and environment even though the patient is not in a coma.

The cortex may be destroyed, but the brain stem functions even though it may have been depressed enough to produce a coma requiring respirator support shortly after the inital injury. Recovery of brain stem function is signaled by a return to "normal" wakefulness. This phenomenon can play a cruel trick on the patient's family when they interpret it as "improvement." But in reality the change only amounts to evolution into the persistent vegetative state. At this point, most patients no longer depend on a respirator. This has been demonstrated graphically in the case of Karen Ann Quinlan.

Prognosis takes longer

And in contrast to brain death when a prognosis usually requires only a few days, it's much later in the course of the illness before a prognosis for recovery of cognitive or other intellectual functions can be made. Considerations involved in dealing with this condition are entirely different from those involved in brain death.

Differences hinge on the fact that accepted medical standards for determination of death, using either cardiorespiratory or brain standards, draw a careful line between severe dysfunction and no function at all. That's why a patient suffering from severe, intractable heart failure with an extraordinarily poor prognosis continues to receive treatment while an individual whose heart no longer functions at all must be pronounced dead.

Both medical and legal authorities have applied that general principle to brain death. A patient with overwhelmingly severe, irreversible brain damage, no matter how poor the prognosis, no matter how poorly the brain is functioning, still is considered a living person. But once the entire brain – including the brain stem – ceases to function, an individual is medically and legally dead.

Uniform Act's 38 words

That distinction is the basis for the Uniform Brain Death Act which the Conference adopted in 1978. Its one operative section states simply:

"For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards."

This gives brain death equal legal standing with the common law's heart-lung death. By including the reference to the brain stem, the Conference eliminated any possible confusion of brain death with the persistent vegetative state.

The act is short, simple and narrow. Commissioners chose not to clutter it and possibly confuse issues by trying to deal with related problems such as living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support beyond brain death in pregnant women or organ donors, and protection of the decedent. These important subjects were left to other law.

And the Conference did not try to establish medical criteria for brain death. That was left to the medical profession which is constantly working to expand its horizons through development of new knowledge and diagnostic equipment.

Five per cent question

Drafters also emphasized that the tried and true common law standard of heart-lung cessation still is valid in at least 95 per cent of determinations of death.

Why should every state adopt legislation making it clear that brain death is as certain and final as cardiorespiratory death? The Conference first asked that question of itself when it was drafting the Uniform Anatomical Gift Act. In the final 1968 draft of that act, drafters commented they had made "no attempt. . . to

Ronald E. Cranford...

. . . served as advisor to the NCCUSL committee that prepared preliminary drafts of the Uniform Brain Death Act. He is associate physician in neurology and a director of the Neurological Intensive Care Unit at Hennepin County (Minn.) Medical Center and has taught neurology at the University of Minnesota since 1971. He is chairman of the Minnesota Medical Association Ad Hoc Committee on Death and the American Academy of Neurology Ethics Committee. He serves as faculty advisor to the University of Minnesota Medical School's program in biomedical ethics and is a member of the Minnesota Interreligious Committee on Biomedical Ethics.

Brain Death

define the uncertain point in time when life terminates...No reasonable statutory definition is possible. The answer depends upon many variables, differing from case to case."

Clear delineation

In 1968, the Conference felt pronouncement of death should be strictly a medical decision. It still does. But it now recognizes that a large portion of the lay public and too many lawyers don't understand the medical fact of brair death. The Uniform Brain Death Act provides legal support for the medical reality by carefully delineating the line between brain death and the persistent vegetative state through a specific reference to a non-functional brain stem.

This distinction should eliminate problems encountered now in trying to explain the medical fact of brain death in some state courts. Such problems have arisen in frivolous malpractice suits equating the removal of a respirator or "beating heart" with unreasonable medical practice. Ignorance of the fact of brain death also has impeded prosecution of criminal cases when the defense is based on the irrational claim that the physician performing a transplant and not the accused murderer was responsible for the crime.

Professional decision

Most important of all, the uniform act makes it clear that determination of brain death should be a medical decision as is determination of cardio-respiratory death. In too many states, physicians are forced to involve grieving "next of kin" in determinations of brain death. Laymen should not face the agony of such a decision which amounts only to postponment of the time when death's reality must be faced and accepted. The act promotes societal acceptance of the concept of brain death assisting families in coming to grips with the death of a loved one.

Legal delays can postpone medical decisions affecting the viability of life-giving transplantations — a kidney, or a skin graft for a burn victim — that may tip the scales toward life for another critically ill patient.

No matter how elaborate the life-support paraphernalia may seem, it always remains secondary to the relationship between physician, patient and family. The Uniform Brain Death Act helps rather than hinders this relationship.

A gift of life

Legal as well as medical acknowledgement of brain death should hasten permission for anatomical donations before degeneration makes them useless. Such gifts often help overcome the despair of the decedent's family and friends, who can find consolation in knowing that their loved one was able to pass on the torch of life. ●

Exhibit B

UNIFORM DETERMINATION OF DEATH ACT

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS EIGHTY-NINTH YEAR
ON KAUAI, HAWAII
JULY 26 - AUGUST 1, 1980

Uniform Law Commissioners

WITH PREFATORY NOTE

Approved by the American Medical Association
October 19, 1980
Approved by the American Bar Association
February 10, 1981

COUNSEL

The Committee which acted for the National Conference of Commissioners on Uniform State Laws in preparing the Uniform Determination of Death Act was as follows:

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Copies of all Uniform and Model Acts and other printed matter issued by the Conference may be obtained from:

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS
645 North Michigan Avenue, Suite 510
Chicago, Illinois 60611

PREFATORY NOTE

This Act provides comprehensive bases for determining death in all situations. It is based on a ten-year evolution of statutory language on this subject. The first statute passed in Kansas in 1970. In 1972, Professor Alexander Capron and Dr. Leon Kass refined the concept further in "A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal," 121 Pa. L. Rev. 87. In 1975, the Law and Medicine Committee of the American Bar Association (ABA) drafted a Model Definition of Death Act. In 1978, the National Conference of Commissioners on Uniform State Laws (NCCUSL) completed the Uniform Brain Death Act. It was based on the prior work of the ABA. In 1979, the American Medical Association (AMA) created its own Model Determination of Death statute. In the meantime, some twenty-five state legislatures adopted statutes based on one or another of the existing models.

The interest in these statutes arises from modern advances in life-saving technology. A person may be artificially supported for respiration and circulation after all brain functions cease irreversibly. The medical profession, also, has developed techniques for determining loss of brain functions while cardiorespiratory support is administered. At the same time, the common law definition of death cannot assume recognition of these techniques. The common law standard for determining death is the cessation of all vital functions, traditionally demonstrated by "an absence of spontaneous respiratory and cardiac functions." There is, then, a potential disparity between current and accepted biomedical practice and the common law.

The proliferation of model acts and uniform acts, while indicating a legislative need, also may be confusing. All existing acts have the same principal goal—extension of the common law to include the new techniques for determination of death. With no essential disagreement on policy, the associations which have drafted statutes met to find common language. This Act contains that common language, and is the result of agreement between the ABA, AMA, and NCCUSL.

Part (1) codifies the existing common law basis for determining death—total failure of the cardiorespiratory system. Part (2) extends the common law to include the new procedures for determination of death based upon irreversible loss of all brain functions. The overwhelming majority of cases will continue to be determined according to part (1). When artificial means of support preclude a determination under part (1), the Act recognizes that death can be determined by the alternative procedures.

Under part (2), the entire brain must cease to function, irreversibly. The "entire brain" includes the brain stem, as well as the neocortex. The concept of "entire brain" distinguishes determination of death under this Act from "neocortical death" or "persistent vegetative state." These are not deemed valid medical or legal bases for determining death.

This Act also does not concern itself with living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support beyond brain death in cases of pregnant women or of organ donors, and protection for the dead body. These subjects are left to other law.

This Act is silent on acceptable diagnostic tests and medical procedures. It sets the general legal standard for determining death, but not the medical criteria for doing so. The medical profession remains free to formulate acceptable medical practices and to utilize new biomedical knowledge, diagnostic tests, and equipment.

It is unnecessary for the Act to address specifically the liability of persons who make determinations. No person authorized by law to determine death, who makes such a determination in accordance with the Act, should, or will be, liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts or the acts of others based on that determination. No person who acts in good faith, in reliance on a determination of death, should, or will be, liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts. There is no need to deal with these issues in the text of this Act.

Time of death, also, is not specifically addressed. In those instances in which time of death affects legal rights, this Act states the bases for determining death. Time of death is a fact to be determined with all others in each individual case, and may be resolved, when in doubt, upon expert testimony before the appropriate court.

Finally, since this Act should apply to all situations, it should not be joined with the Uniform Anatomical Gift Act so that its application is limited to cases of organ donation.

UNIFORM DETERMINATION OF DEATH ACT

§1. [*Determination of Death.*] 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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

§2. [*Uniformity of Construction and Application.*] This Act shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this Act among states enacting it.

§3. [*Short Title.*] This Act may be cited as the Uniform Determination of Death Act

Exhibit C

FEE WAIVER

Filed in Forma Pauperis (GRC 3.60, et seq.) per order dated: AUG 18 2016
Amount recoverable pursuant to GC §68637 Pub a one time administrative fee upon judgment if the party becomes a judgment creditor. (GC §6103.5, 68638)

Jonee Fonseca
Mother of Israel Stinson
P.O. Box 2105
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707.450.6900
joneefonseca@yahoo.com

FILED
Superior Court of California
County of Los Angeles
AUG 18 2016
Sherri R. Carter, Executive Officer/Clerk
By Nancy Di Giambattista Deputy
N. DiGiambattista

IN THE SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES

UNLIMITED CIVIL JURISDICTION

Israel Stinson, a minor, by Jonee Fonseca his mother.

Petitioner,

v.

Children's Hospital Los Angeles.

Respondent.

Case No. BS164887

VERIFIED EX PARTE PETITION FOR TEMPORARY RESTRAINING ORDER/INJUNCTION: REQUEST FOR ORDER OF INDEPENDENT NEUROLOGICAL EXAM; REQUEST FOR ORDER TO MAINTAIN LEVEL OF MEDICAL CARE;

D 8/16

I, Jonee Fonseca, am the mother of Israel Stinson, who on August 7 was admitted to Children's Hospital of Los Angeles ("Children's) for treatment and care pending transfer to home care. Israel suffered an asthma attack while at UC Davis Children's Hospital in Sacramento that resulted in a temporary lack of oxygen to Israel's brain. Israel was placed on a ventilator and has needed ventilator support since the injury.

Because Israel is a Medi-Cal patient with Kaiser Permanente, Israel was transferred to Kaiser Permanente Medical Center in Roseville ("Kaiser") for treatment on April 12, 2016. Dr. Michael Myette, a pediatric intensivist at Kaiser, did not treat Israel, but instead performed a brain death exam. On April 13, I was told Israel would be removed from his ventilator. I obtained a court order keeping Israel alive while I sought a physician who could perform an independent examination. I found several physicians willing to examine Israel, but Kaiser refused to allow the independent exam.

After doing much research on caring for patients with serious brain injuries, I decided that I wished for Israel to be cared for at home. However, in order for Israel to be transferred to home care, he required a breathing tube and feeding tube ("g-tube"). Kaiser refused to perform these procedures. Dr. Myette said that Israel's digestive system was "dead" and that trying to feed him would be "catastrophic." Dr. Myette also said the only reason Israel was alive is because he was continually adjusting Israel's blood pressure through medication. These statements were later proved to be inaccurate.

I began looking for another hospital that would accept Israel as a patient in order to provide the procedures needed for Israel to be cared for at home.

Dr. Juan Zaldana, a pediatric specialist at Sanatorio Nuestra Señora del Pilar ("del Pilar") in Guatemala City, Guatemala, agreed to admit Israel and provide the breathing tube and g-tube. On May 21, 2016, Israel was transported to Guatemala City and was admitted to del Pilar.

Because Kaiser refused to feed my son, Israel had not received any nutrition in almost six weeks. He was on dextrose (sugar water) for hydration.

Shortly after Israel was transferred to del Pilar, Dr. Zaldana performed a tracheotomy and gastrostomy to provide Israel with a breathing tube and feeding tube. Israel responded very well

to the procedures and to receiving nutrition. Within one week, he was off of the blood pressure medication and was able to regulate his blood pressure on his own. He was also able to regulate his body temperature on his own. Israel also increased his movements in response to my voice and touch. He is able to move his upper body and his arms and legs. He recently started to squeeze his hands and make a fist.

Dr. Zaldana, and Dr. Francisco Montiel, a pediatric neurologist at del Pilar, performed numerous exams on Israel, including two EEGs. Both doctors concluded that Israel's condition was inconsistent with the criteria for brain death (see attached). They determined that Israel is in a "persistent vegetative state." This was confirmed by Dr. Rubén Posadas, a neurologist at del Pilar (see attached).

We remained in Guatemala with Israel for approximately 2 1/2 months. During that time we made arrangements for Israel's return to the U.S.

In July, I was told that Children's Hospital of Los Angeles (Children's) consulted with Dr. Zaldana regarding Israel's condition. After speaking with Dr. Zaldana, Children's agreed to accept Israel as a transfer patient for treatment.

On Saturday, August 6, Israel was transported by air ambulance from Guatemala City to Children's. He was admitted to Children's the morning of August 7. That same day, Dr. Ashraf Abou-Zamzam, Israel's attending physician at Children's, told me that Israel's sodium levels were high.

Over the next few days, Israel's face and torso became increasingly red and swollen. I was shocked by his appearance, as Israel had never had this reaction before. Israel was able to maintain proper sodium levels, blood pressure, and temperature without medication while at del

Pilar (see attached). On August 9, I was told that Children's stopped feeding Israel because of his sodium levels. On August 15, limited feeding was reinstated.

On August 16, Children's informed me that it intended to remove Israel's ventilator, which will almost certainly result in my son's death.

MEMORANDUM OF POINTS AND AUTHORITIES

California Health and Safety Code Section 7180 (a) (The Uniform Determination of Death Act) provides for a legal determination of brain death as follows; "(a) 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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."

Health and Safety Code Section 7181 provides for an "independent" verification of any such determination stating; "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be ***independent confirmation*** by another physician."

As established by the Court in *Dority v Superior Court* (1983) 145 Cal.App.3d 273, 278, this Court has jurisdiction over the issue of whether a person is "brain dead" or not pursuant to Health and Safety Code Sections 7180 & 7181. Acknowledging the moral and religious implications of such a diagnosis and conclusion, the *Dority* court determined that it would be "unwise" to deny courts the authority to make such a determination when circumstances warranted.

Here, Kaiser performed a brain death exam and declared that Israel was brain dead, but refused to allow for an independent examination. Kaiser also said that as a result of Israel's brain

injury, his condition would deteriorate. Dr. Myette said that Israel's digestive system was "dead." Not only did Israel's condition not deteriorate, but he began improving. After Israel began receiving nutrition at del Pilar, he no longer required medication to stabilize his blood pressure, heart rate, or sodium levels. He was also able to regulate his own body temperature without artificial devices (i.e., "Bare Hugger"). Only Kaiser physicians have examined Israel is regards to possible brain death.

Israel received an independent examination by three physicians—Dr. Juan Zaldana, a pediatric specialist; Dr. Francisco Montriel, a pediatric neurologist; and Dr. Ruben Posadas, a neurologist. All three have determined that while Israel has a serious brain injury, he is not brain dead. Israel's EEGs show brain activity. This is not consistent with brain death.

Children's accepted Israel for treatment based on reports by these physicians. The admitting physician personally talked with Dr. Zaldana about Israel's condition and prognosis. Israel's condition has significantly worsened since being under the care of Dr. Abou-Zamzam at Children's. Now Children's wants to remove Israel's ventilator, which will most likely cause Israel's death by suffocation.

I had Israel transferred to Children's, as I believed the medical staff would provide him with care and treatment, while I made arrangements for Israel to be cared for at home. Instead, Children's is planning to put Israel to death.

My son responds to treatment. He is able to move his upper body, turn his head, and move his arms and legs in response to my voice and touch. The fact that he responds to my voice indicates, at the very minimum, brain stem activity. Section 7180, requires the cessation of *all* functions of the brain, including the brain stem.

At this time, I do not trust Children's to provide an independent evaluation of Israel. Because Israel's condition has worsened since being admitted to Children's, the hospital has a conflict of interest in determining his condition. If Children's can make a finding of brain death, they no longer have to pay for any of his care, while if he is severely brain damaged, but not brain dead, they may be legally liable to provide his ongoing care and treatment at Children's or elsewhere.

Only one other case of this type is on record in California, namely the case of Jahi McMath which was heard in Alameda County in December of 2013. That case, one of first impression, where Nailah Winkfield challenged Children's Hospital Oakland's determination of brain death after they negligently treated her daughter, Jahi, led to an Order, issued by Hon E. Grillo, holding that an independent determination is one which is performed by a physician with no affiliation with the hospital facility (in that case Children's Hospital Oakland) which was believed to have committed the malpractice which led to the debilitating brain injuries Jahi suffered. A true and correct copy of Judge Grillo's Order is attached to this Petition. In the *McMath* case, the Trial Court rejected the Hospital's position that the Court had no jurisdiction over the determination of whether not Jahi McMath was "brain dead" or not.

In *McMath*, Judge Grillo stated that the Section 7180's language regarding "accepted medical standards" permitted an inquiry into whether the second physician (also affiliated with Children's Hospital Oakland) was "independent" as that term was defined under Section 7181. Judge Grillo determined that the petitioner's due process rights would be protected by a focused proceeding providing limited discovery and the right to the presentation of evidence.

The Court determined that, under circumstances which are strikingly similar to those which present themselves here, the conflict presented was such that the court found that the

Petitioner was entitled to have an independent physician, unaffiliated with Children's Hospital Oakland, preform neurological testing, an EEG and a cerebral blood flow study. Indeed, the Court Ordered Children's Hospital Oakland to permit the Court's own court appointed expert to be given temporary privileges and access to the Hospital's facilities, diagnostic equipment, and technicians necessary to perform an "independent" exam.

In a Nevada Supreme Court case with similar facts, the court unanimously questioned whether the American Association of Neurology guidelines that are used to determine brain death in both Nevada and California, "adequately measure all functions of the entire brain, including the brain stem." *In re Guardianship of Hailu*, 131 Nev. Adv. Op. 89. (Nov. 16, 2015). In that case, Aden Hailu, a young college student, went into cardiac arrest during emergency surgery for severe stomach pain and subsequently suffered a brain injury. The hospital performed three EEGs, which showed some brain activity, yet doctors still proceeded to declare her brain dead pursuant to Nevada's brain death statute, which is identical to California's. Both states use the same guidelines to determine brain death, namely those developed by the American Association of Neurology.

In this case, Children's wants to remove my son from his ventilator, even though three separate independent examinations have concluded that he is not brain dead and two EEGs show brain activity.

As in *Dority* and *McMath*, the unique circumstances of this case invoke the Court's jurisdiction and due process considerations require that this Court grant my Petition for a Temporary Restraining Order and order that Children's Hospital of Los Angeles recognize the independent examinations performed by Drs. Zaldana, Montriel, and Posadas, or permit Dr. Alan

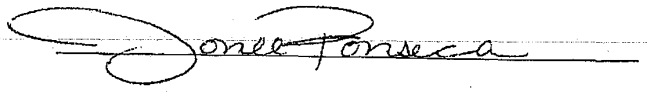
Shewmon to conduct another independent examination with the assistance of Children's diagnostic equipment and technicians necessary to carry out a repeat EEG.

In order to provide the requisite physical conditions for a reliable set of tests to be performed, Israel Stinson should continue to be treated so as to provide his optimum physical health and in such a manner so as to not interfere with the neurological testing (such as the use of sedatives or paralytics).

WHEREFORE, petitioner prays:

1) That a Temporary Restraining Order be issued precluding Respondents from performing any apnea tests on Israel Stinson be issued;
2) That an Order be issued precluding Respondents from removing Israel Stinson from respiratory support, or removing or withholding medical treatment;
3) That an Order be issued that Respondents are to provide Israel Stinson treatment to maintain his optimum physical health, including nutrition and thyroid hormone as needed, in such a manner so as to not interfere with the neurological testing (such as the use of sedatives or paralytics in such a manner and/or at such time that they may interfere with the accuracy of the results).
4) That an Order be issued that Petitioner is entitled to an independent neurological examination, by Dr. Alan Shewmon with the assistance of Childrens diagnostic equipment and technicians necessary to carry out a repeat EEG.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on August 17, 2016, at Los Angeles, California.



Jonee Fonseca

Jonee Fonseca
Mother of Israel Stinson
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joneefonseca@yahoo.com

IN THE SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES

UNLIMITED CIVIL JURISDICTION

Israel Stinson, a minor, by Jonee Fonseca his mother. Petitioner, v. Children's Hospital Los Angeles Dr. Ashraf Abou-Zamzam Respondent.	Case No. DECLARATION OF JONEE FONSECA IN SUPPORT OF EX-PARTE PETITION FOR TEMPORARY RESTRAINING ORDER/ INJUNCTION: REQUEST FOR ORDER OF INDEPENDENT NEUROLOGICAL EXAM; REQUEST FOR ORDER TO MAINTAIN LEVEL OF MEDICAL CARE ; REQUEST FOR ORDER TO FACILITATE TRANSFER TO ANOTHER FACILITY OR TO HOME CARE

I; Jonee Fonseca, declare that I am the mother of petitioner Israel Stinson.

1. On April 2, 2016, my son Israel Stinson suffered an asthma attack while being treated at UC Davis Children's Hospital in Sacramento, CA. It took several minutes for a doctor to

respond to my calls for help and by that time, Israel had stopped breathing. Doctors were able to resuscitate him, but he suffered a brain injury due to lack of oxygen.

2. Israel is insured through Medi-Cal with Kaiser Permanente so he was transferred to Kaiser Permanente Medical Center ("Kaiser") in Roseville, CA for treatment.

3. Within 24 hours of his arrival at Kaiser, the admitting physician, Dr. Michael Myette, performed a brain death exam. I was told my son would be removed from life support on April 14.

4. I then sought an independent evaluation of Israel's condition and obtained a court order to keep my son on the ventilator until another doctor could be found.

5. Although I found several doctors who were willing to provide an independent examination, Kaiser refused to allow them to examine Israel.

6. My intention was—and is—to have Israel cared for at home. In order for Israel to be cared for at home, Israel needed a breathing tube and feeding tube ("g-tube").

7. I asked Kaiser to perform the procedures, but Doctor Myette said that Israel's digestive system was not functional and that trying to feed him would be "catastrophic." He also said that Israel would not survive the tracheotomy procedure to provide him with a breathing tube.

8. During the nearly six weeks that Israel was at Kaiser, the hospital refused to provide him with any nutrition. He was only on a dextrose solution for hydration.

9. Kaiser also refused to do the two procedures necessary for Israel to be transferred to home care.

10. Dr. Myette told me the only reason Israel was alive was because he was making continual adjustments to his blood pressure medication, primarily vasopressin.

11. Dr. Juan Zaldana, a pediatric specialist at Sanatorio Nuestra Señora del Pilar ("del Pilar") in Guatemala City, Guatemala, agreed to admit Israel and provide the breathing tube and g-tube.

12. On May 21, Israel was transported by air ambulance (AirCARE One) to Guatemala City and admitted to del Pilar.

13. It took about five days for Israel to become stable enough to have the procedures. Both the tracheotomy and the gastrostomy were performed on the same day.

14. Israel responded very well to finally receiving nutrition. Within one week, he was off of all of the vasopressors and was able to regulate his blood pressure on his own. He was also able to regulate his body temperature on his own. Israel also increased his movements in response to my voice and touch. He is able to move his upper body and his arms and legs. He recently started to squeeze his hands and make a fist.

15. Dr. Zaldana, and Dr. Francisco Montiel, a pediatric neurologist at del Pilar, performed numerous exams on Israel, including two EEGs. Both doctors concluded that Israel's condition was inconsistent with the criteria for brain death (see emails, attached). They determined that Israel is in a "persistent vegetative state." This was confirmed by Dr. Rubén Posadas, a neurologist at del Pilar (see email, attached).

16. We remained in Guatemala with Israel for approximately 2 1/2 months. During that time we made arrangements for Israel's return to the U.S.

17. In July, I was told that Children's Hospital of Los Angeles (Children's) consulted with Dr. Zaldana regarding Israel's condition. After speaking with Dr. Zaldana, Children's agreed to accept Israel as a transfer patient.

18. On Saturday, August 6, Israel was transported by air ambulance from Guatemala City to Children's.

19. On Sunday, August 7, Dr. Ashraf Abou-Zamzam, Israel's attending physician at Children's told me that Israel's sodium levels were high. Israel's face and torso were red and swollen. This had never occurred at del Pilar.

20. On August 9, I was told that Children's stopped feeding Israel because of his sodium levels. On August 15, limited feeding was reinstated.

21. I have requested that Israel be examined by an independent physician. Dr. Alan Shewmon, a neurologist with UCLA Medical Center, is willing to examine Israel (see attached). Dr. Shewmon is a highly qualified and respected neurologist who serves as Professor Emeritus of Neurology and Pediatrics at UCLA's David Geffen School of Medicine. Children's refused to allow Dr. Shewmon temporary admitting privileges for the purpose of examining Israel.

22. I have also been informed that Totally Kids, a long-term care facility for children with severe brain injuries, is expecting to have a bed open for Israel early next month. If Israel cannot be transferred to home care, I would like him to go to a facility that specializes in children with special needs.

23. On August 16, I was told that Children's is planning to remove Israel from ventilator support tomorrow, August 18.

24. I am hereby asking that Children's Hospital of Los Angeles be prevented from removing my son, Israel Stinson, from the ventilator.

25. If Children's removes Israel from the ventilator and he stops breathing, they will have ended his life as well as their responsibility to provide care for the harm their negligence caused. For this reason I hereby request that an independent examination be performed, including the use of an EEG.

26. I also request that Children's be prevented from performing an "apnea test" on Israel during which he would be removed from the ventilator.

27. I also request that Children's be ordered to continue to provide such care and treatment to Israel that is necessary to maintain his physical health and promote any opportunity for healing and recovery of his brain and body, including nutrition and thyroid hormone as needed.

28. I also request that Children's Hospital of Los Angeles be ordered to facilitate Israel's transfer to either a long-term care facility or home care as soon as possible.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on August 17, 2016, in Los Angeles, California.

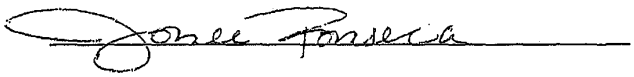
_____

Jonee Fonseca

26. I also request that Children's be ordered to continue to provide such care and treatment to Israel that is necessary to maintain his physical health and promote any opportunity for healing and recovery of his brain and body, including nutrition and thyroid hormone as needed.

27. I also request that Children's Hospital of Los Angeles be ordered to facilitate Israel's transfer to either a long-term, subacute care facility or home care as soon as possible.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on August 17, 2016, in Los Angeles, California.



Jonee Fonseca

Exhibit D

Israel Stinson, a minor, by Jonee Fonseca his mother, Petitioner, v. Children's Hospital Los Angeles, Respondent.	Case No.: BS164387 Judge Amy D. Hogue Hearing Date: August 18, 2016 Time: 11:15 a.m. Dept.: 86 TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE RE PRELIMINARY INJUNCTION

FILED
Superior Court of California
County of Los Angeles
AUG 18 2016
Sherri R. Carter, Executive Officer/Clerk
By _____ Deputy
N. DiGiambattista

Jonee Fonseca, appearing on behalf of her son, Petitioner, seeks a temporary restraining order and an order permitting independent neurological examination of Petitioner Israel Stinson. Fonseca states in her Verified Ex Parte Application and Declaration that Respondent Children's Hospital Los Angeles (Hospital") advised her on August 16 that it intends "to remove Israel's ventilator which will almost certainly result in [her] son's death." Fonseca states that Israel suffered severe brain damage as a result of an asthma attack and has been comatose ever since. Although his condition was stable while hospitalized in Guatemala, it has deteriorated since his transfer to the Hospital in July.

As the court noted in *Dority v. Superior Court* (1983) 145 Cal.App.3d 273, 280, "The jurisdiction of the court can be invoked 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." Under Health & Safety Code §§ 7181, a pronouncement of death based on "irreversible cessation of all functions of the entire brain including the brain stem" requires "independent confirmation by another physician."

Fonseca avers that Respondent has violated section 7181 by failing to obtain or permit an independent evaluation. She asserts that the Hospital has an inherent conflict of interest because it may be responsible to provide ongoing care if he is not declared dead. She also advises that

Dr. Alan Shewman, a neurologist with UCLA Medical Center, is willing to examine Israel for purposes of an independent evaluation.

This Court finds that Fonseca has made a sufficient showing of emergency and the possibility of irreparable harm to justify the issuance of a temporary restraining order requiring the Hospital to (1) refrain from removing Israel from the ventilator, (2) take reasonable measures necessary to maintain Israel in a stable condition pending a hearing before this court, and (3) cooperate with Fonseca to facilitate an independent evaluation of Israel by Dr. Shewman.

The Court further orders the Hospital to show cause, at 9:30 a.m. on September 9, 2016, why a preliminary injunction to the same effect shall not issue. The Hospital is ordered to file any written opposition on or before September 1, 2016. Any reply memorandum must be filed on or before September 6, 2016.

Petitioner is order to personally serve the Hospital with the Petition and all supporting papers in accordance with California Code of Civil Procedure 413.10 et seq.

Petitioner is hereby appointed guardian ad litem for her minor child, Israel, based on her sworn statement to the court that she is his natural mother. In all further proceedings, the guardian ad litem must be represented by counsel and cannot represent the minor child as a self-represented litigant.

Dates: August 18, 2016

SUPERIOR COURT LOS ANGELES COUNTY CALIFORNIA

Amy D. Hogue
Judge of the Superior Court

Exhibit E

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ISRAEL STINSON, a minor, by Jonee Fonseca his mother,

Petitioner,

vs.

CHILDREN'S HOSPITAL LOS ANGELES

Respondent.

CASE NO.: BS164387

ORDER ON EX PARTE APPLICATION TO DISSOLVE TEMPORARY RESTRAINING ORDER [PROPOSED]

DATE: AUGUST 25, 2016
TIME: 8:30 A.M.
DEPT: 86

ASSIGNED FOR ALL PURPOSES TO:
JUDGE AMY D. HOGUE
DEPARTMENT 86

For the reasons stated in the ex parte application of Children's Hospital Los Angeles, the temporary restraining order of August 18, 2016 is dissolved and the action is dismissed.

AMY D. HOGUE, JUDGE

DATED: August 25, 2016

AMY D. HOGUE
JUDGE OF THE SUPERIOR COURT

Docket No. 17-17153

In the

United States Court of Appeals

For the

Ninth Circuit

JONEE FONSECA, an individual parent and guardian of I.S., a minor and LIFE LEGAL DEFENSE FOUNDATION,

Plaintiffs-Appellants,

v.

KAREN SMITH, M.D. in her official capacity as Director of the California Department of Public Health,

Defendant-Appellee.

Appeal from a Decision of the United States District Court for the Eastern District of California, No. 2:16-cv-00889-KJM-EFB · Honorable Kimberly J. Mueller

EXCERPTS OF RECORD
VOLUME III OF V – Pages 284 to 542

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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, v. Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendant.	Case No.: 2:16-cv-00889-KJM-EFB **Second Amended Complaint for Equitable Relief** **REQUEST FOR JURY TRIAL**

INTRODUCTION

A toddler, Israel Stinson, has been declared brain dead pursuant to the California Uniform Determination of Death Act ("CUDDA" or "Act"). The child lives. This action is brought through his mother to expunge all records archived or under the control of the Director of the California Department of Public Health that state that the child is deceased. To this end, the Plaintiff challenges the constitutionality of the Act.

JURISDICTION

1. This Court has federal question jurisdiction over Plaintiff's claims arising under the Fifth and Fourteenth Amendments of the United States Constitution and 42 U.S.C. §1983. Jurisdiction is therefore proper under 28 U.S.C. §1331. This Court has supplemental jurisdiction over Plaintiff's claims arising under the Constitution of the State of California pursuant to 28 U.S.C. §1337.

VENUE

2. Venue is proper in the United States District Court for the Eastern District of California, pursuant to 28 U.S.C. sections 84 and 1391. The events that gave rise to this complaint did and are occurring in Sacramento and Placer Counties, in the State of California, and the Defendant has her principal place of business in Sacramento, California.

PARTIES

3. Plaintiff, JONEE FONSECA, is an adult and a resident of the State of California. She is the mother of Israel Stinson and the healthcare decision maker for Israel Stinson, a minor. Ms. Fonseca is a devout Christian and believes in the healing power of God. She also believes that life does not end until the cessation of biological functioning. In all interactions with medical providers as described more fully below, she has consistently requested that her son not be removed from life

support. She believes that removing him from such would be tantamount to ending his life.

4. Defendant, KAREN SMITH, M.D., serves as the Director of the California Department of Public Health. The Department which she heads has supervisorial, regulatory and enforcement roles over California hospitals. Further, the Department issues death certificates, requires compliance by hospitals and physicians in the manner in which death certificates are filled out and recorded. Dr. Smith's Department enforces the requirement that hospitals, physicians, and coroners use California's definition of death and that the determination of death be performed in a manner consistent with the State's statutory protocol. The definitions and protocol are part of CUDDA. The Department that she heads has created and dispatched to physicians and hospitals, a mandatory form known as a Certificate of Death – State of California. Acting pursuant to the Act, she requires that medical doctors and hospitals use the operational definition of death found in Health & Safety Code §7180 and that procedures are followed under Health & Safety Code §7181 and that recordation be provided on the Certificate of Death. Pursuant to Health & Safety Code §7183 she requires that medical providers maintain records, in accordance to regulations that her Department adopts, regarding individuals who have been pronounced dead under the definition of death found in CUDDA. Further, her Department also requires that medical providers fill out the Certificate of Death within 15 hours after death under (Health & Safety Code §102800) and that medical providers register the death with local officials (Health & Safety Code §102775). All of the conduct is done under color of law. Dr. Smith is sued in her official capacity.

5. Plaintiff is ignorant of the true names and capacities of defendants sued herein as Does 2 through 10, inclusive, and therefore sue these defendants by such fictitious names and capacities. Plaintiff is informed and believes and thereon

alleges that each fictitiously named defendant is responsible in some manner for the occurrences herein alleged, and that Plaintiff's injuries as herein alleged were proximately caused by the actions and/or in-actions of said Doe defendants. Plaintiff will amend this complaint to include the true identities of said doe defendants when they are ascertained.

FACTS

6. On April 1, 2016, Ms. Fonseca took her son, Israel Stinson, to Mercy General Hospital ("Mercy") with symptoms of an asthma attack. The medical personnel in the emergency room examined him and placed him on a breathing machine. He underwent x-rays. Shortly thereafter he began shivering, his lips turned purple, his eyes rolled back and he lost consciousness. He had an intubation performed on him. Doctors then told Ms. Fonseca they had to transfer her son to the University of California Davis Medical Center in Sacramento ("UC Davis") because Mercy did not have a pediatric unit. He was then taken to UC Davis via ambulance and admitted to the pediatric intensive care unit.

7. The next day, the tube was removed from the child at UC Davis. The respiratory therapist said that the patient was stable and that they could possibly discharge him the following day, Sunday April 3. The doctors at UC Davis put him on albuterol for one hour, and then wanted to take him off albuterol for an hour. About 30 minutes later while off the albuterol, Ms. Fonseca noticed that he began to wheeze and have trouble breathing. The nurse came back in and put him on the albuterol machine. Within a few minutes the monitor started beeping. The nurse came in and repositioned the mask, then left the room. Minutes after the nurse left the room, the child started to shiver and went limp in his mother's arms. He suffered a bronchospasm (squeezing of the airway, preventing air from passing). Ms. Fonseca pressed the nurses' button, and screamed for help, but no one came to the room. A different nurse entered, and Ms. Fonseca asked to see a doctor.

8. The doctor, Stephanie Meteev, came to the room and said she did not want to intubate the child to see if he could breathe on his own without the tube. The child was not breathing on his own.

9. Ms. Fonseca had to leave the room to compose herself. When Ms. Fonseca came back into the room five minutes later, the doctors were performing CPR on him. The doctors dismissed Ms. Fonseca from the room again while they continued to perform CPR. The doctors were able to resuscitate him. Dr. Meteev told Ms. Fonseca that the child was "going to make it" and that he would be put on Extracorporeal Membrane Oxygenation ("ECMO") machine to support his heart and lungs. Initially, doctors thought the patient might have a lung blockage, but no such blockage was found by the pulmonologist who examined him.

10. Dr. Meteev then indicated that there was a possibility that the child will have brain damage. He was sedated twice due to his blood pressure being high, and was placed on an ECMO machine and ventilator machine.

11. Two brain tests were performed on April 3 and 4 respectively. The tests included touching his eye with a Q-tip, striking his knee, shining a light in his eye, flushing cold water down his ear, and inserting a stick down his throat to check his gag reflexes.

12. On Sunday April 3, 2016, a brain test was conducted to determine the possibility of brain damage while he was hooked up to the ECMO machine.

13. On April 4, 2016, the same tests were performed when he was taken off the ECMO machine.

14. Prior to the first brain death examination, a UC Davis nurse contacted an organ donor company.

15. California Health and Safety Code §7180, which was in force and effect, at all times material to this action, provides that "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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." Section 7180 is part of CUDDA and UC Davis medical staff conducted the tests for death pursuant to that section.

16. California Health and Safety Code §7181 provides that an individual can be pronounced dead by a determination of "irreversible cessation of all functions of the entire brain, including brain stem." CUDDA requires "independent" confirmation by another physician. Section 7181 is also part of the Act.

17. On April 6, 2016, the child was taken off the ECMO machine because his heart and lungs were functioning on their own. The next day, a radioactive test was performed to determine blood flow to the brain.

18. On April 7 a radionuclide test was performed to determine the blood flow to the brain; doctors claimed the test showed no uptake of oxygen or nutrients in the child's brain.

19. On April 10 a magnetic resonance imaging ("MRI") and computed tomography ("CT") scan were performed on the patient; doctors asserted the MRI and CT scan confirmed "diffused brain swelling," "severe global injury," and transforaminal herniation across the foramen of the brain stem. As a result of these tests, physicians at UC Davis found that the patient's condition was consistent with brain death.

20. On April 11, 2016, child was transferred via ambulance from UC Davis to Defendant Kaiser Permanente Roseville Medical Center – Women and Children's Center ("Kaiser") for additional treatment. Upon his arrival at Kaiser, another reflex test was done, in addition to an apnea test. On April 14, 2016, a further reflex test was performed for determination of brain death in conjunction with protocol directed by the State of California and enforced by Defendant Smith's Department.

21. Dr. Myette testified in Superior Court that the hospital followed all procedures recommended by the American Academy of Pediatrics, the Society of Child Neurology, and the Society of Critical Care Medicine. This included regulating the patient's body temperature and sodium levels prior to testing.

22. The apnea test lasted for seven and a half minutes, and the patient was on 100 percent oxygen; the carbon dioxide level in his blood at the beginning of the test ranged between 35 and 45, and at the end of the test his carbon dioxide level was 85. In court, Dr. Myette testified that such a level would cause "anybody with any function of their brain stem" to breath. Dr. Myette testified that no brain activity was found, and had he "discovered that there was some activity in [the patient's] brain" doctors would not have declared him dead.

23. Dr. Myette testified that a second confirmatory exam was performed by his colleague Brian Masselink. (The Physician in Chief, Shelly Garone, was present along with the child's great aunt and one of his grandmothers). Dr. Masselink is a board certified pediatric neurologist. Medical records state that Dr. Masselink found no evidence of any brain function.

24. That same day a Certificate of Death was issued.

25. That notwithstanding, at the time of the issuance of the Certificate of Death, with pulmonary support provided by the ventilator, the child's heart and other organs functioned well, and continue to function to this day. He has also begun moving his upper body in response to his mother's voice and touch.

26. Ms. Fonseca has knowledge of other patients who had been diagnosed as brain dead, using the same criteria as in her son's case. In some of those cases, where the decision makers were encouraged to consent to the withdrawal of life support, the patients emerged from legal brain death to where they had cognitive ability and some even fully recovering. Such cases are fully medically documented.

27. Plaintiff is a Christian with firm religious beliefs that as long as the

heart is beating, her child is alive. These religious beliefs involve providing all treatment, care, and nutrition to a body that is living, treating it with respect and seeking to encourage healing.

28. Kaiser informed Ms. Fonseca that it intended to disconnect the ventilator that her son was relying upon to breath claiming that he is brain dead pursuant to California Health and Safety Code §7180.

29. Kaiser claims that, since its medical doctors have declared the child as brain dead, his mother has no right to exercise any decision making authority vis-a-vis maintaining her son on a ventilator.

30. Ms. Fonseca contacted Paul Byrne, a board certified neonatologist, pediatrician, and Clinical Professor of Pediatrics at University of Toledo, College of Medicine. However, Kaiser would not allow Dr. Byrne to examine Israel or even be present during an examination, as he is not a California licensed physician.

31. Ms. Fonseca repeatedly asked Kaiser's medical staff that her child be given nutrition, including protein and fats. She also asked that he be provided nutritional feeding through a nasal-gastric tube or gastric tube to provide him with nutrients as soon as possible. She further requested that care be administered to her son to maintain his heart, tissues and organs. Kaiser refused to provide such treatment stating that they do not treat or feed brain dead patients. Because of this Kaiser denied her ability to make decisions over the health care of her son. Ms. Fonseca therefore sought alternate placement of her son, outside a Kaiser facility.

32. Ms. Fonseca vehemently opposed the efforts to exclude her from the decision making regarding her son and Kaiser's insistence that she has no right vis-a-vis the decision to disconnect the ventilator that provides oxygen necessary for her son's heart to beat and the organs to be kept profused with blood. She expressly forbad the hospital from removing life support. Kaiser refused her requests for nutritional support and the placement of a tracheostomy tube and a gastric tube

stating that she has no rights to request medical care for her son as he is brain dead. Kaiser's position is that under California law, the removal of mechanical life support does not require consent by the patient's advocate – the parent in this case – if there has been a declaration of brain death under CUDDA.

33. Despite Kaiser's insistence that Israel Stinson is dead, at that time he moved his upper body in response to his mother's voice and touch. Dr. Byrne communicated to the parents that the child is alive. In view of her child's movements and a physician's opinion that the boy is alive, Ms. Fonseca believes that she has a moral and spiritual obligation to give her child the benefit of the medical doubt.

34. The State definition of death is in stark and material difference to the religious beliefs of Ms. Fonseca. She believes that the disconnection of life support would be tantamount to killing her son.

35. The State of California, acting by and through the Department of Public Health, has not authorized physicians to exercise independent professional judgment regarding determination of death. The State specifically defines death and requires physicians to practice medicine in accordance to that definition, regardless of medical opinion or evidence to the contrary.

36. In accordance to the definition of death under CUDDA, On April 14, 2016, Dr. Myette filled out and signed a Certificate of Death which declared that Israel Stinson is deceased. The Certificate of Death is provided by the California Department of Public Health. Additionally, the Certificate of Death was subsequently submitted to the Department of Vital Statistics which is a subdivision of the Department of Public Health and under the supervision of Defendant, Dr. Smith.

37. Per the requirements of the laws of California, Kaiser communicated to the Placer County Coroner's office that Israel Stinson is dead.

38. Despite an official determination that Israel Stinson is dead, the child has shown movement in direct response to the voice and touch of his mother.

39. Since the issuance of the Certificate of Death, three physicians, independent of Kaiser and UC Davis, have given their medical judgment that this child is in fact alive.

40. Because Kaiser insists that Israel Stinson is dead according to the Act, Kaiser sought to remove life support from him. On April 14, in an act of desperation, Ms. Fonseca filed – in pro per – papers in the Superior Court in which she pleaded with the Court to spare the life of her child.

41. The Superior Court granted temporary relief. However, based upon the testimony of Dr. Myette, the Superior Court determined that all medical protocols were met and the child was dead pursuant to the definition under CUDDA.

42. Ms. Fonseca retained new counsel and filed this action in this Court. She received temporary relief in this Court against Kaiser, but her request for a preliminary injunction was denied. This Court granted her a stay while emergency relief was sought in the Ninth Circuit Court of Appeals. While the emergency motion was still under review, Ms. Fonseca was able to find another medical facility outside of the United States which admitted her son as a patient.

43. A tracheotomy was performed and a feeding tube inserted at the facility. He has stabilized and has gained weight. Kaiser physicians refused to provide this treatment because they claim that it is unethical to treat a dead person.

44. An electroencephalogram ("EEG") was performed on the child. The EEG revealed that he has brain waves. Physicians have informed the parents that he is not dead, but is in a persistent vegetative state.

45. As of the filing of this Second Amended Complaint the child is increasingly having more purposeful movements. In addition to the prior movements that he had at Kaiser in April, he now moves his arms, hands, legs and

toes. Further, these movements are not random. They occur primarily in response to voices and music. A song that the child knows was played. He begins to move at the sound of the music.

46. He is now on a portable ventilator and is increasingly taking breaths off of the ventilator.

47. There is an actual dispute between the parties. California has officially certified that Israel Stinson is deceased. Plaintiff asserts that he is alive, now in fact having brain waves. This is a dispute of fact.

48. The continued existence of government documents that certify that Israel Stinson is dead causes actual injury. This results in the loss of medical insurance coverage and government benefits to the child and his family. In the future, he will be unable to enroll in school, meet the identity requirements for employment, marry, obtain a driver license, register to vote, qualify for a credit card, or secure a home loan if he remains officially deceased.

49. Plaintiff is informed and believes and thereon alleges that the definition of death is fallacious. In essence, the presupposition is that the cessation of all functions of the entire brain – including the brain stem – is per se irreversible. However, Plaintiff is informed and believes and thereon alleges that brain waves return in rare cases after having disappeared. Nonetheless, California law directs that such a person be deemed dead. CUDDA requires independent confirmation by another physician. But that confirmation is exclusively confined to the definition of death in the statute. Hence it is a tautology. On its face and as applied, under CUDDA an advocate for a patient is not allowed to bring in their own physician to contest the findings. In this case, Kaiser used two of its own doctors for the tests. As such, it asserted in Superior Court that it is the independent evaluation under CUDDA.

50. In the alternative, Plaintiff alleges that the definition of death under

CUDDA is correct but that Ms. Fonseca's child was misdiagnosed as being brain dead when he was not. The Act, either on its face or under its application, does not provide for an advocate of the patient to retain a doctor, at the advocate's own expense, to examine the patient and contest the findings.

51. There is verifiable evidence that persons who have been declared brain dead have in fact not died. Some have recovered.

52. The aforementioned conduct was done under color of state law and by state actors. Such includes the implementation and enforcement of CUDDA.

FIRST COUNT

Deprivation of Life and Liberty in Violation of Due Process of Law under the Fifth and Fourteenth Amendments (42 U.S.C. §1983)

53. The Plaintiff incorporates by reference as if fully set forth herein the foregoing paragraphs.

54. Under the Fifth and Fourteenth Amendments, a citizen cannot be deprived of life or liberty without due process of law. Historically, death has been defined as the cessation of breath and the beating of the heart. Such understanding was true at the ratification of said Amendments. The State of California has defined death in a matter that is broader than the historical definition. The State's statutory scheme related to the definition of death and how it is determined have provided no procedures or process by which a patient or their advocate can independently challenge the findings of death. Further, the statutory scheme removes the independent judgment of medical professionals as to whether a patient is dead.

55. Under the facts described herein, there is a medical dispute of fact as to whether Israel Stinson is dead or alive. On this Earth, there can be few rights more precious than the liberty interest in life. Life is a fundamental right that finds explicit protection in the U.S. Constitution.

56. The enactment and enforcement of CUDDA deprives Israel Stinson of his right to life without due process of law. The Act defines death and requires that physicians declare a person as dead when the conditions found in the definition are met. But because a patient is declared dead by California does not make the patient become biologically dead. Death is the cessation of biological functioning. By State action, the Act requires a declaration that a person is deceased at a point in time earlier than the cessation of biological functioning. This is what happened to Israel Stinson. Such a premature official certification of death deprives an individual of the liberty interest in life in a manner that is inconsistent with the Fifth and Fourteenth Amendments.

SECOND COUNT

Deprivation of Parental Rights in Violation of Due Process of Law under the Fifth and Fourteenth Amendments (42 U.S.C. §1983)

57. Plaintiffs incorporate by reference as if fully set forth herein the foregoing paragraphs.

58. As the fit parent of Israel Stinson, Ms. Fonseca has plenary authority over medical decision relative to her 2-year-old child.

59. In addition to the natural profound bounds of affection between parent and child, Ms. Fonseca believes that she has a moral and spiritual obligation to give her child every benefit of the medical doubt before disconnecting life support.

60. On its face and as applied the Act provides no due process for a parent to contest the medical findings by bringing in her own physician for a second opinion. Because as a fit parent she is completely cut off under the State's protocol, she is being deprived of her parental rights.

61. In addition and in the alternative, there is a close nexus between the

conduct of Kaiser, Dr. Myette and the State of California. The child was deprived of medical treatment because medical professionals at Kaiser assert that treating a dead person violates medical ethics.

THIRD COUNT

Deprivation of Life

CA Const. Art. I §1

62. Plaintiff incorporates, herein by reference, the foregoing paragraphs.

63. This count arises under the right to life enumerated in the California Constitution which provides as follows: "[a]ll people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life… ." CA Const. Art. I §1.

64. The State of California has defined death in a matter that is broader than the historical definition. The State's statutory scheme related to the definition of death and how it is determined have provided no procedures or process by which a patient or their advocate can independently challenge the findings of death. Further, the statutory scheme removes the independent judgment of medical professionals as to whether a patient is dead.

65. Under the facts described herein, there is a medical dispute of fact as to whether Israel Stinson is dead or alive. On this Earth, there can be few rights more precious than the liberty interest in life. Life is a fundamental right that finds explicit protection in the California Constitution.

66. The enactment and enforcement of the CUDDA deprives Israel Stinson of his right to life. The Act defines death and requires that physicians declare a person as dead when the conditions found in the definition are met. But because a patient is declared dead does not make the patient become biologically dead when in fact the person was and is alive. By State action, the Act requires a declaration that a person is deceased at a point in time earlier than the cessation of biological

functioning.

FOURTH COUNT

Violation of Privacy Rights

(42 U.S.C. §1983)

67. Plaintiff incorporates, herein by reference, the foregoing paragraphs.

68. This count arises under the right to privacy protected by the United States Constitution.

69. Under the penumbra of rights guaranteed under the United States Constitution, health care decisions are part of the right to personal autonomy and privacy. As a fit parent, Ms. Fonseca has plenary authority over the health care decisions of her child.

70. As a direct and proximate cause of the compliance with the Act, health care treatment was denied to Israel Stinson because he was declared dead.

71. His mother was deprived of the rights of privacy that she enjoys and seeks to exercise over on behalf of her child, relative to medical decisions.

FIFTH COUNT

Violation of Privacy Rights

CA Const. Art. I §1

72. Plaintiff incorporates, herein by reference, the foregoing paragraphs.

73. This count arises under the right to life enumerated in the California Constitution which provides as follows: "[a]ll people are by nature free and independent and have inalienable rights. Among these are… privacy." CA Const. Art. I §1.

74. Under the California Constitution, health care decisions are part of the right to personal autonomy and privacy. As a fit parent, Ms. Fonseca has plenary authority over the health care decisions of her child. She possesses a reasonable expectation of exercising personal autonomy and privacy on behalf of her son.

75. As a direct and proximate cause of the compliance with the Act, health care treatment was denied to Israel Stinson because he was declared dead.

76. A fallacious declaration of death constitutes a serious invasion of the liberty interest in privacy. As such, Ms. Fonseca was deprived of the rights of privacy that she enjoys and seeks to exercise on behalf of her child relative to medical decisions.

PRAYER

Wherefore, Plaintiffs pray for judgment against the Defendants as follows:

1. An order expunging all records archived by Defendant, or persons and entities under her control or authority, which state or imply that Israel Stinson is deceased;
2. A declaration that the California Uniform Determination of Death Act is unconstitutional on its face;
3. A declaration that the California Uniform Determination of Death Act is unconstitutional as applied;
4. Any and all other appropriate relief to which the Plaintiff may be entitled including all "appropriate relief" within the scope of F.R.C.P. 54(c); and,
5. Costs and attorney fees.

Dated: July 1, 2016

/S/ Kevin Snider_____
Kevin T. Snider
Attorney for Plaintiffs

REQUEST FOR A JURY TRIAL

Plaintiff hereby respectfully requests a jury trial.

DATED: July 1, 2016

S/_Kevin Snider_____
Kevin T. Snider
Attorney for Plaintiffs

06/08/2016	61	USCA CASE NUMBER 16-15883 for 49 Notice of Interlocutory Appeal filed by Jonee Fonseca. (Zignago, K.) (Entered: 06/08/2016)

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
SACRAMENTO DIVISION

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, PLAINTIFF,

Plaintiff,

v.

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE; DR. MICHAEL MYETTE M.D.; KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; AND DOES 2 THROUGH 10, INCLUSIVE,

Defendants.

Case No.: 2:16-CV-00889-KJM-EFB

STIPULATED REQUEST FOR DISMISSAL OF DEFENDANTS, KAISER PERMANENTE MEDICAL CENTER ROSEVILLE AND DR. MICHAEL MYETTE M.D., WITHOUT PREJUDICE

IT IS HEREBY STIPULATED that THE KAISER PERMANENTE ROSEVILLE MEDICAL CENTER and DR. MICHAEL MYETTE are dismissed as defendants in the above-captioned case without prejudice. *See* Fed. R. Civ. P.

41(a)(1)(A)(ii) (allowing for voluntary dismissal after responsive pleadings have been filed.)

The parties have agreed that each side shall bear its own costs.

For Plaintiff, JONEE FONSECA,
an individual parent and guardian
of ISRAEL STINSON, a minor, Plaintiff

DATED: June 7, 2016

PACIFIC JUSTICE INSTITUTE

By: _____
KEVIN T. SNIDER
Attorney for Plaintiff
JONEE FONSECA, an individual parent and guardian of ISRAEL STINSON, a minor, Plaintiff

For Defendants, KAISER PERMANENTE MEDICAL CENTER ROSEVILLE and DR. MICHAEL MYETTE M.D.

DATED: June 7, 2016

BUTY & CURLIANO LLP

By: _____
JASON J. CURLIANO
Attorney for Defendants
KAISER PERMANENTE MEDICAL CENTER ROSEVILLE
DR. MICHAEL MYETTE M.D.

Kevin T. Snider, State Bar No. 170988
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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
SACRAMENTO DIVISION

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR, PLAINTIFF, Plaintiff, v. KAISER PERMANENTE MEDICAL CENTER ROSEVILLE; DR. MICHAEL MYETTE M.D.; KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; AND DOES 2 THROUGH 10, INCLUSIVE, Defendants.	Case No.: 2:16-CV-00889-KJM-EFB **ORDER DISMISSING DEFENDANTS KAISER PERMANENTE MEDICAL CENTER ROSEVILLE AND DR. MICHAEL MYETTE M.D. WITHOUT PREJUDICE**

IT IS HEREBY ORDERED that the parties' stipulated request to dismiss defendants KAISER PERMANENTE ROSEVILLE MEDICAL CENTER and DR. MICHAEL MYETTE in the above-captioned case, without prejudice, is granted.

Each party shall bear its own costs.

DATED:

So Ordered: _____
Kimberly J. Mueller
UNITED STATES DISTRICT COURT JUDGE

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONEE FONSECA, an individual parent and guardian of I.S., a minor, Plaintiff - Appellant, v. KAISER PERMANENTE MEDICAL CENTER ROSEVILLE; et al., Defendants - Appellees.	No. 16-15883 D.C. No. 2:16-cv-00889-KJM-EFB Eastern District of California, Sacramento ORDER

Appellant's motion for voluntary dismissal of this appeal is granted. Fed. R. App. P. 42(b). Costs shall be allocated pursuant to the terms of the motion.

This order shall act as and for the mandate of the Court.

FOR THE COURT:

MOLLY C. DWYER
CLERK OF COURT

Cole Benson
Supervising Deputy Clerk
Ninth Circuit Rules 27-7 and 27-10

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Attorneys for Defendants:
KAISER PERMANENTE MEDICAL CENTER
ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, Plaintiff, v. KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, DR. MICHAEL MYETTE M.D., KAREN SMITH, M.D. in her official capacity as Director of the CALIFORNIA DEPARTMENT OF PUBLIC HEALTH and DOES 1 THROUGH 10, INCLUSIVE, Defendants.	Case No: 2:16-CV-00889-KJM-EFB **ORDER GRANTING EXTENDED TIME FOR FILING RESPONSIVE PLEADING** **Pursuant to Fed. R. Civ. P. 6(b)(1) and Eastern District Local Rule 144** Hon. Kimberly J. Mueller Complaint Filed: April 28, 2016

Having read the stipulation between plaintiff and defendants stipulating that Plaintiff is willing to provide additional time for Defendants KAISER PERMANENTE MEDICAL CENTER ROSEVILLE and DR. MICHAEL MYETTE M.D., to prepare and file their responsive pleadings.

IT IS HEREBY ORDERED that Defendants' last day to file their responses to the Amended Complaint on file in this matter is extended two weeks from May 19, 2016 to June 2, 2016.

DATED: May 19, 2016

UNITED STATES DISTRICT COURT
FOR THE
EASTERN DISTRICT OF CALIFORNIA

OFFICE OF THE CLERK
501 "I" Street
Sacramento, CA 95814

JONEE FONSECA,
Plaintiff

v.

CASE NO. 2:16−CV−00889−KJM−EFB

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, ET AL.,
Defendant

You are hereby notified that a Notice of Appeal was filed on **May 14, 2016** in the above entitled case. Enclosed is a copy of the Notice of Appeal, pursuant to FRAP 3(d).

May 17, 2016

MARIANNE MATHERLY
CLERK OF COURT

by: /s/ L. Reader
Deputy Clerk

UNITED STATES DISTRICT COURT
FOR THE
EASTERN DISTRICT OF CALIFORNIA

OFFICE OF THE CLERK
501 "I" Street
Sacramento, CA 95814

TO: **CLERK, U.S. COURT OF APPEALS**

FROM: **CLERK, U.S. DISTRICT COURT**

SUBJECT: **NEW APPEALS DOCKETING INFORMATION**

CASE INFORMATION

USDC Number:	**2:16−CV−00889−KJM−EFB**
USDC Judge:	**DISTRICT JUDGE KIMBERLY J. MUELLER**
USCA Number:	**NEW APPEAL**
Complete Case Title:	**JONEE FONSECA vs. KAISER PERMANENTE MEDICAL CENTER ROSEVILLE**
Type:	**CIVIL**
Complaint Filed:	**4/28/2016**
Appealed Order/Judgment Filed:	**5/13/2016**
Court Reporter Information:	**Kathy Swinhart**

FEE INFORMATION

Fee Status: Paid on 5/14/2016 in the amount of $505.00

Information prepared by: /s/ **L. Reader , Deputy Clerk**

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Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **NOTICE OF INTERLOCUTORY APPEAL; REPRESENTATION STATEMENT**

NOTICE OF INTERLOCUTORY APPEAL

Plaintiff, Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, appeal to the United States Court of Appeals for the Ninth Circuit from the Order denying Plaintiff's motion for a preliminary injunction dated May 13, 2016.

Dated: May 14, 2016

_s/ Kevin Snider_____
Kevin T. Snider
Attorney for Plaintiff/Appellant

REPRESENTATION STATEMENT

The undersigned represents Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor who is the Plaintiff and Appellant in this matter. Below is a service list that shows all of the parties to the above-encaptioned action and identifies their counsel by name, firm address, e-mail, and telephone number, where appropriate. (F.R.A.P. 12(b); Circuit Rule 3-2(b)).

Dated: May 14, 2016

_s/ Kevin Snider_____
Kevin T. Snider
Attorney for Plaintiff/Appellant

Plaintiff/Appellant:

JONEE FONSECA, AN INDIVIDUAL PARENT AND GUARDIAN OF ISRAEL STINSON, A MINOR

Attorneys for Plaintiff/Appellant:

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KAREN SMITH, M.D. IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Attorneys for Defendants/Appellees:

NOTICE OF INTERLOCUTORY APPEAL

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Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health; and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **APPELLANT'S NOTICE AND STATEMENT OF ISSUES**

1. Whether the District Court erred in denying Plaintiff/Appellant's Motion for Preliminary Injunction by ruling that Plaintiff/Appellant did not meet the serious questions test.

2. Whether the District Court erred in denying Plaintiff/Appellant's Motion for Preliminary Injunction by ruling that Defendants Kaiser Permanente Medical Center Roseville and Michael Myette M.D. did not act under color of law for purposes of a claim under 42 U.S.C. §1983.

3. Whether the District Court erred in denying Plaintiff/Appellant's Motion for Preliminary Injunction by ruling that Plaintiff/Appellant did not meet the serious questions test on her 42 U.S.C. § 1395dd claim.

4. Whether the District Court erred in denying Plaintiff/Appellant's Motion for Preliminary Injunction by ruling that Plaintiff/Appellant did not meet the serious questions test on her 42 U.S.C. § 1983 claim regarding violation of substantive due process as against Defendant Karen Smith, M.D.

5. Whether the District Court erred in denying Plaintiff/Appellant's Motion for Preliminary Injunction by ruling that Plaintiff/Appellant did not meet the serious questions test on her 42 U.S.C. § 1983 claim regarding violation of procedural due process as against Defendant Karen Smith, M.D.

Dated: May 14, 2016

_s/ Kevin Snider_____
Kevin T. Snider
Attorney for Plaintiff/Appellant

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA,

Plaintiff,

v.

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, et al.,

Defendants.

No. 2:16-cv-00889-KJM-EFB

ORDER

Approximately one month ago, doctors at a Kaiser Permanente hospital in Roseville, California determined that two-year-old Israel Stinson had suffered the irreversible cessation of all functions of his entire brain, including the brain stem. Under California law, this determination means Israel has suffered brain death and is no longer alive. But because Israel's heart is still beating and he is still breathing, with the support of a ventilator and careful, ongoing medical intervention, Israel's mother, Jonee Fonseca, asks this court to prohibit Kaiser from ending its life-support efforts. She argues California's definition of "death" violates the United States Constitution and deprives both her and Israel of due process. She also claims the defendants' actions have violated the California Constitution and the federal Emergency Treatment and Active Labor Act. She names Kaiser, one of its physicians, and the Director of the California Department of Health as defendants, and she requests a preliminary injunction to

maintain and improve Israel's condition during this lawsuit. Although Kaiser and Ms. Fonseca have been attempting to reach a mediated resolution to accomplish Ms. Fonseca's goal of transporting Israel to a different location, there currently is no concrete proposal identifying either a location that will receive Israel or a method of transport. The court therefore is called to resolve the parties' legal disputes.

To this end, the court held a hearing on the preliminary injunction request on May 11, 2016. Kevin Snider, Matthew McReynolds, and Alexandra Snyder appeared for Ms. Fonseca, and Jason Curliano appeared for Kaiser and Michael Myette, M.D. Ashante Norton and Ismael Castro appeared and observed on behalf of Karen Smith, M.D., the Director of California's Department of Public Health.

I. DETAILED BACKGROUND

On April 1, 2016, Ms. Fonseca took Israel to a local emergency room. Fonseca Decl. ¶ 1, ECF No. 3-2. He had displayed symptoms of an asthma attack. *Id.* He was transferred to the pediatric unit at the hospital for the University of California, Davis, and his condition stabilized at least somewhat. *Id.* ¶¶ 1–2. Later the same day, however, after arriving at U.C. Davis, his condition worsened, he went into cardiac arrest, and he fell unconscious. *See id.* ¶¶ 3-5. Doctors attempted to revive him, and then used an extracorporeal membrane oxygenation (ECMO) machine to provide cardiac and respiratory support. *Id.* ¶¶ 5–7. Within a few days, his heart and lungs were functioning again on their own, but he requires a ventilator to breathe. *See id.* ¶¶ 9–14. A doctor determined Israel had suffered brain death; he was therefore no longer alive within the meaning of the California Uniform Determination of Death Act (CUDDA), Cal. Health & Safety Code § 7180 *et seq.*[1] *See id.* ¶ 14; First Am. Compl. ¶¶ 14, 19, ECF No. 1. Israel was then transported to the Kaiser hospital in Roseville, where he has been attended to since April 11,

[1] *See* Cal. Health & Safety Code § 7180(a) ("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 brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."); *see also id.* § 7181 ("When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician.").

2016. Doctors at Kaiser have twice independently confirmed he is brain dead. Fonseca Decl. ¶ 13; *see also* Myette Decl., ECF No. 43-1. The hospital completed its portion of a death certificate, which identifies the date of Israel's death as April 14, 2016, but other portions of the certificate remain incomplete. *See* Myette Decl. Ex. B, ECF No. 43-3 (incomplete portions include parents' names and information about the disposition). In light of its doctors' determinations, Kaiser intends to end life support efforts.

Ms. Fonseca believes Israel is not dead because his heart is beating and he is breathing, but if he no longer receives life support, he will then die. First Am. Compl. ¶ 3. She perceives that he responds to her voice and touch, and at times he appears to have taken breaths on his own. *See* Fonseca Decl., ECF No. 35. She therefore feels an imperative moral and spiritual obligation to ensure life support efforts for her son do not end. *Id.* ¶ 62.

Dr. Michael Myette, M.D. is the Medical Director for the Pediatric Intensive Care Unit at Kaiser in Roseville, the doctor ultimately responsible for Israel's care, and a defendant in this action. He explains his understanding of Israel's condition in basic terms: "Israel's brain is not telling his organs how to function." Myette Decl. ¶ 5. This means doctors must meticulously monitor and support his condition by adjusting his blood pressure and hormone levels pharmaceutically, providing support with a ventilator, and keeping his body warm with blankets. *Id.* ¶¶ 5–7. He is receiving only dextrose—sugar—for nutrition, but has not lost weight over the three to four weeks since he was admitted. *Id.* ¶ 9. Dr. Myette worries that if he fed Israel internally, complications would likely arise, including infection, which would be difficult to detect and combat. *Id.* ¶ 8. Israel does not respond to any stimulus. *Id.* ¶¶ 10, 12. Dr. Myette opines that although Ms. Fonseca believes Israel has taken breaths on his own, this is a misreading of the ventilator, which can be artificially triggered. *Id.* ¶ 14. The movements Israel makes in response to his mother's touch or voice are reflexes that originate in his spine; they also are triggered by more innocuous and lighter contact, for example, a bump on the side of his bed. *Id.* ¶¶ 10–12.

On April 14, 2016, after Kaiser completed its portion of the death certificate, Ms. Fonseca sought relief from the Placer County Superior Court on Israel's behalf. *See Fonseca*

ex rel. *Stinson v. U.C. Davis Children's Hosp.*, No. S-CV-0037673 (Placer Cty. Super. Ct. filed Apr. 14, 2016).[2] The superior court entered a temporary restraining order (TRO) requiring Kaiser to continue life support, and over a period of about two weeks during which the order was extended twice, Ms. Fonseca and Israel's biological father, Nathaniel Stinson, attempted unsuccessfully to arrange for Israel's transfer to another medical facility. *See generally* Curliano Decl. Exs. A–G, J–K, ECF No. 14-2 to -8 & -11 to -12. On April 29, the state court dismissed Ms. Fonseca's petition for relief and dissolved the TRO. ECF No. 19-1. The state court found California Health and Safety Code sections 7180 and 7181 had "been complied with." *Id.* at 2.

On April 28, 2016, the day before the Superior Court's restraining order was set to finally expire, Ms. Fonseca filed this lawsuit. *See* Compl., ECF No. 1. Her original complaint alleged claims directly under the U.S. Constitution, the federal Rehabilitation Act, and the Americans with Disabilities Act. The court granted a temporary restraining order until a hearing could be held on Monday, May 2, 2016. ECF No. 9. At the May 2 hearing, the court dismissed the original complaint by bench order, as the complaint's allegations did not show the court had jurisdiction. Minutes, ECF No. 22; Minute Order, ECF No. 23. The court ordered Ms. Fonseca to file a first amended complaint the next day. Kaiser did not object to an extension of the TRO through May 11, and a hearing was set for that day on a motion for a fully briefed preliminary injunction. The matter was also referred to emergency mediation before a magistrate judge of this court, but as noted the parties have been unable to reach an agreement so as to moot the current motion. Minutes, ECF No. 28.

Ms. Fonseca timely filed a first amended complaint, which includes five claims. First, she claims under 42 U.S.C. § 1983 that CUDDA is unconstitutional on its face under the Fifth and Fourteenth Amendments. First Am. Compl. ¶¶ 51–59. CUDDA provides that "death" is not just the cessation of breath and a heartbeat—the prior, historical conception—but also the absence of all functions of the brain and brain stem. *Id.* ¶ 56. Because the CUDDA provision is

[2] The court may take judicial notice of the filings in the state case. *See* Fed. R. Evid. 201(b) (governing judicial notice); *Asdar Grp. v. Pillsbury, Madison & Sutro*, 99 F.3d 289, 290 n.1 (9th Cir. 1996) (court filings and orders in related litigation may be subject to judicial notice).

broader than the historical conception and because it allows for no specific appeal of a death determination, Ms. Fonseca alleges it deprives Israel of due process. *Id.* ¶¶ 56–57. She asserts this claim against all the defendants: Kaiser, Dr. Myette, and Dr. Smith. *See id.* ¶¶ 5–6. Ms. Fonseca asks the court to declare CUDDA unconstitutional on its face, *id.* ¶ 59, and requests Kaiser be ordered to take certain steps to maintain and improve Israel's condition, *id.* ¶¶ 47–50.

Second, Ms. Fonseca alleges under 42 U.S.C. § 1983 that CUDDA deprives her of due process as Israel's parent. *Id.* ¶¶ 60–67. For this independent reason, she claims CUDDA is unconstitutional on its face. *Id.* ¶ 67. She alleges this claim against all the defendants.

Third, Ms. Fonseca alleges Kaiser violated the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd *et seq.* First Am. Compl. ¶¶ 68–79. Under EMTALA, hospitals with emergency departments must perform appropriate medical screening to determine whether those who come to the hospital asking for treatment have an emergency medical condition. 42 U.S.C. § 1395dd(a). If the hospital discovers a medical emergency, it must examine, treat, and "stabilize" the patient's condition or, alternatively, transfer the person to another medical facility. *See id.* § 1395dd(b), (e). Ms. Fonseca alleges Kaiser has not and will not appropriately stabilize Israel's condition if it removes life support, and she alleges Kaiser has not otherwise made an appropriate effort to transfer Israel to another facility. First Am. Compl. ¶¶ 71–75. She asks for declaratory relief, money damages, and an injunction ordering Kaiser to comply with EMTALA and stabilize Israel's condition. *Id.* ¶¶ 77–79.

Fourth, Ms. Fonseca alleges under 42 U.S.C. § 1983 that Kaiser and Dr. Myette have deprived her and Israel of their rights to privacy under the Fourth Amendment. *Id.* ¶¶ 80-84. She refers specifically to her right and Israel's right to have control over Israel's healthcare.

Fifth, Ms. Fonseca alleges Kaiser and Dr. Myette have violated her right and Israel's right to privacy and autonomy under Article I of the California Constitution. *Id.* ¶¶ 85-88.

Ms. Fonseca's motion for a preliminary injunction was filed on May 6, 2016. *See* Mot. Prelim. Inj., ECF No. 33. She requests relief at this stage on the basis of her claims under the EMTALA and federal Constitution, but not under her California constitutional claim. Kaiser

and Dr. Myette filed an opposition on May 10, 2016, ECF No. 43, and the court allowed reply argument at the hearing on May 11, 2016.

II. JURISDICTION

Federal courts are courts of limited jurisdiction. Therefore, as in every case, the court first asks whether it has jurisdiction to hear and decide the dispute before it. As explained below, the court is satisfied it has jurisdiction over the claims and defendants, although federal question jurisdiction does not adhere to Kaiser and Dr. Myette based on the civil rights claims.

A. Rooker-Feldman

As a preliminary matter, in the May 2 hearing, the court voiced its concern that it lacks jurisdiction over this action under *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923), and *District of Columbia Court of Appeals v. Feldman*, 460 U.S. 462 (1983), two cases that form the basis of what courts call the *Rooker-Feldman* doctrine. On further review and in light of the allegations in the First Amended Complaint, the court is satisfied this doctrine does not deprive it of all jurisdiction over this case.

Under the *Rooker-Feldman* doctrine, federal district courts are without jurisdiction to hear direct and de facto appeals from the judgments of state courts. *Cooper v. Ramos*, 704 F.3d 772, 777 (9th Cir. 2012); *Noel v. Hall*, 341 F.3d 1148, 1155 (9th Cir. 2003). To determine whether an action functions as a de facto appeal, the court "pay[s] close attention to the relief sought by the federal-court plaintiff." *Id.* at 777–78 (quoting *Bianchi v. Rylaarsdam*, 334 F.3d 895, 900 (9th Cir. 2003)) (emphasis omitted). "It is a forbidden de facto appeal under *Rooker–Feldman* when the plaintiff in federal district court complains of a legal wrong allegedly committed by the state court, and seeks relief from the judgment of that court." *Id.* (quoting *Noel*, 341 F.3d at 1163). However, the *Rooker-Feldman* doctrine does not preclude a plaintiff from bringing an "independent claim" that, though raising similar or even identical to issues, was not the subject of a previous judgment by the state court. *Id.* at 778.

A review of *Feldman* itself is instructive here. In *Feldman*, two graduates of unaccredited law schools petitioned a local court for a waiver to permit them to sit for the bar. 460 U.S. at 466. After the local court rejected their claims, the graduates filed suit in federal

court. *Id.* at 468. The Supreme Court deemed the action a de facto appeal to the extent it sought review of the local court's denial. *Id.* at 482. On the other hand, as recounted by the Ninth Circuit in *Noel*, the Supreme Court allowed the "challenge to the local court's legislative act of promulgating its rule" prohibiting the graduates from sitting for the bar. *Noel*, 341 F.3d at 1157. This aspect of the lawsuit "was a challenge to the validity of the rule rather than a challenge to an application of the rule." *Id.*; *see also Feldman*, 460 U.S. at 487.

In some instances, the independent constitutional claims a plaintiff asserts in federal court may not be possible to disentangle from a state court's earlier decision. *See Feldman*, 460 U.S. at 482 n.16. If that is the case, then the federal district court may not review the state court decision. *Id.* This was true of only some of the claims before the *Feldman* Court; other claims could be separated from the de facto appeal, for example the graduates' claims that the District of Columbia's law-school requirement discriminated against them and impermissibly delegated authority to the American Bar Association to regulate the bar. *Id.* at 487–88.

Here, Ms. Fonseca challenges CUDDA's constitutionality generally. For the most part, she does not challenge CUDDA's particular application. *See* Mot. Prelim. Inj. at 12 ("At this stage of the proceedings, Plaintiff is not asserting that [Kaiser] has misread or misapplied CUDDA."); *but see, e.g.*, First Am. Compl. ¶ 32; Byrne Decl. ¶¶ 5, 12–15, ECF No. 36. Her constitutional claims here were not presented to the state superior court and except for the mandatory aspects of the injunction she proposes, discussed toward the end of this order, the relief she now seeks does not undermine the factual or legal conclusions the state court reached. The same is true of her non-constitutional claims; none was before the superior court.

Ms. Fonseca neither asserts legal error by the state court nor seeks relief from a state court judgment. If Ms. Fonseca can otherwise establish this court's subject matter jurisdiction over her claims, the *Rooker–Feldman* doctrine does not prevent her case from going forward.

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B. Standing

Next is the question of standing. Given Ms. Fonseca's status as Israel's mother and general guardian, she may litigate here on his behalf. *See* Fed. R. Civ. P. 17(c) (a general guardian may sue on behalf of a minor or incompetent person); *Doe* ex rel. *Sisco v. Weed Union Elementary Sch. Dist.*, No. 13-01145, 2013 WL 2666024, at *1 (E.D. Cal. June 12, 2013) ("Rule 17(c)(1)(A) permits a 'general guardian' to sue in federal court on behalf of a minor, and a parent is a guardian who may so sue." (citation and quotation marks omitted)). This presupposes that the rules of parental guardianship govern equally the relationship between a parent and a child whose death is disputed. Whatever the correct procedural method of representation, for purposes of this motion Ms. Fonseca may represent Israel's interests in this case. *See, e.g.*, *Lopez v. Cty. of L.A.*, No. 15-01745, 2015 WL 3913263, at *9 (C.D. Cal. June 25, 2015) (survival claims under Constitution by parent); *see also Williams v. Bradshaw*, 459 F.3d 846, 848 (8th Cir. 2006) ("Federal courts are to apply state law in deciding who may bring a § 1983 action on a decedent's behalf."); Cal. Civ. Proc. Code § 377.10, .20, .30 (governing survival claims); Cal. Prob. Code §§ 6401–02 (who may bring a survival action). She has standing. Her request to be appointed as Israel's guardian *ad litem* is therefore denied as moot. *See* Pet., ECF No. 31.

C. Federal Question Jurisdiction and Action Under Color of Law

Turning now to the complaint's substantive claims, Ms. Fonseca proposes three jurisdictional pillars to support her action in federal court.

1. EMTALA and § 1331

First, she cites her EMTALA claims and 28 U.S.C. § 1331, the latter of which establishes this court's jurisdiction over all claims arising under the Constitution, laws, and treaties of the United States. This court's jurisdiction to evaluate her EMTALA claim, which arises under a federal statute, is beyond dispute, as is this court's supplemental jurisdiction to consider any state-law claims that are a part of the same case or controversy. *See* 28 U.S.C. § 1367(a).

2. 42 U.S.C. § 1983

This leaves Ms. Fonseca's claims under § 1983, a broad federal civil rights statute. Any claim under that section must concern the defendants' actions under color of law. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 946 (1982). State action is a "jurisdictional requisite" in any claim under § 1983. *Polk Cty. v. Dodson*, 454 U.S. 312, 315 (1981). In this regard, Ms. Fonseca notes her addition of Dr. Smith as a defendant. Dr. Smith is alleged to be the Director of the California Department of Public Health and is sued in her official capacity under 42 U.S.C. § 1983. First Am. Compl. ¶ 6.

a. Dr. Smith

"Claims under § 1983 are limited by the scope of the Eleventh Amendment."[3] *Doe v. Lawrence Livermore Nat. Lab.*, 131 F.3d 836, 839 (9th Cir. 1997). Specifically, states and state governmental entities are not "persons" within the meaning of § 1983. *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 70 (1989). The Supreme Court has, however, interpreted the Eleventh Amendment as allowing federal courts to grant prospective injunctive relief against state officials acting "under color of law." *Va. Office for Prot. & Advocacy v. Stewart*, 563 U.S. 247, 255 (2011); *Ex parte Young*, 209 U.S. 123, 159–60 (1908). In short, "the Eleventh Amendment does not generally bar declaratory judgment actions against state officers." *Nat'l Audubon Soc'y, Inc. v. Davis*, 307 F.3d 835, 847 (9th Cir. 2002), *opinion amended on denial of reh'g*, 312 F.3d 416 (2002). This court therefore has jurisdiction to consider Ms. Fonseca's request for prospective declaratory relief against Dr. Smith, which targets an allegedly ongoing violation of federal constitutional law in the form of her application of CUDDA in the provision of procedures related to issuance of death certificates.

b. Kaiser and Dr. Myette

Kaiser and Dr. Myette, by contrast, have not in any way supported by the record acted "under color of law." Kaiser is a private hospital, and Dr. Myette is a private person.

[3] "The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state, or by citizens or subjects of any foreign state." U.S. Const. amend. XI.

"[P]rivate parties are not generally acting under color of state law," *Price v. State of Haw.*, 939 F.2d 702, 707–08 (9th Cir. 1991), "no matter how discriminatory or wrongful" their actions may be, *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 50 (1999) (citation and quotation marks omitted). But "[u]nder familiar principals, even a private entity can, in certain circumstances, be subject to liability under section 1983." *Villegas v. Gilroy Garlic Festival Ass'n*, 541 F.3d 950, 954 (9th Cir. 2008) (en banc). The basic question a court must answer is whether the private person's conduct "may be fairly characterized as 'state action'" or "fairly attributable to the State." *Lugar*, 457 U.S. at 924, 937. The phrase "under color of law" for purposes of a § 1983 claim has the same meaning as the phrase "state action" for purposes of the Fourteenth Amendment. *Id.* at 928.

At the outset, the Supreme Court has taken care to distinguish two related elements of "fair attribution" in a § 1983 claim: the plaintiff must show both that a "state action" has occurred and that the defendants acted "under color of law." *Id.* at 937; *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 156 (1978). Here, a state has acted: California passed CUDDA, and the California Department of Public Health imposes procedural requirements related to the issuance of a death certificate, including for people who have suffered brain death under CUDDA. *See* First Am. Compl. ¶¶ 6, 21; *see also Am. Mfrs.*, 526 U.S. at 50 (a private person's actions "with the knowledge of and pursuant to" a statute shows "state action" occurred (citation and quotation marks omitted)). But these facts do not establish Kaiser's and Dr. Myette's action under color of law.

Federal courts have often been called on to decide whether doctors and hospitals have acted under color of law. In general, private doctors and hospitals are more commonly found not to be state actors. *See, e.g.*, *Babchuk v. Indiana Univ. Health, Inc.*, 809 F.3d 966, 970-71 (7th Cir. 2016); *McGugan v. Aldana-Bernier*, 752 F.3d 224, 229–31 (2d Cir. 2014), *cert. denied*, 135 S. Ct. 1703 (2015); *Wittner v. Banner Health*, 720 F.3d 770, 775–81 (10th Cir. 2013); *Briley v. State of Cal.*, 564 F.2d 849, 855–56 (9th Cir. 1977) (noting that "private hospitals and physicians have consistently been dismissed from § 1983 actions for failing to come within the

color of state law requirement of this section" and collecting authority).[4] This is likely the result of two rules of thumb. First, the Supreme Court has "consistently held that '[t]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment." *Am. Mfrs.*, 526 U.S. at 52 (quoting *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 350 (1974), and citing *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982)) (alteration in original). On a related note, even though doctors' services are "affected with a public interest," the same may be said of many professions, and this does not automatically convert their every action into an action of the state. *See Jackson*, 419 U.S. at 354. Second, although doctors and hospitals are often the beneficiaries of state and federal funding, receipt of government funding alone does not make for action under color of law. *See Chudacoff v. Univ. Med. Ctr. of S. Nev.*, 649 F.3d 1143, 1149–50 (9th Cir. 2011) (collecting authority).

In addition, the choices a doctor or a hospital must make are often matters of discretion, informed by expertise, training, and the specifics of the patient presented to them, and for this reason, courts often hesitate to find a doctor's actions fairly attributable to the state. *See, e.g.*, *Blum*, 457 U.S. at 1008 (decisions that "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State" undercut claims of action under color of law); *Collyer v. Darling*, 98 F.3d 211, 232–33 (6th Cir. 1996) (noting the absence of any contractual relationship between the doctors and the state and the "independence with which the doctors completed their tasks"); *Pinhas v. Summit Health, Ltd.*, 894 F.2d 1024, 1034 (9th Cir. 1989) (a decision that "ultimately turned on the judgments made by private parties according to professional standards that are not established by the State," but flowed from a peer-review process created by statute, was not an action under color of law), *aff'd on unrelated question*, 500 U.S. 322 (1991).

At the same time, no categorical rule prevents the mixture of professional judgment and action under the color of law. *See, e.g.*, *West v. Atkins*, 487 U.S. 42, 51 (1988)

[4] Kaiser previously has been found by another district court not to be a state actor, in a case challenging California's statutory scheme governing medical peer review proceedings. *See generally Safari v. Kaiser Found. Health Plan*, No. 11-05371, 2012 WL 1669351 (N.D. Cal. May 11, 2012).

(explaining the court below misread Supreme Court precedent "as establishing the general principle that professionals do not act under color of state law when they act in their professional capacities"). Nevertheless, private doctors and hospitals do not even act under color of state law when they participate in the civil commitment of mentally ill patients. *See, e.g.*, *Bass v. Parkwood Hosp.*, 180 F.3d 234, 243 (5th Cir. 1999) (collecting authority).

By contrast, a doctor or hospital is much more likely to have acted under color of law when the hospital is a public hospital, or if it assumed that role for all practical purposes, for example when a doctor contracts with a state to provide medical services to the inmates of a state prison. *See generally West*, 487 U.S. 42; *see also Chudacoff*, 649 F.3d at 1150 (citing, *inter alia*, *Woodbury v. McKinnon*, 447 F.2d 839, 842 (5th Cir. 1971)). In these situations, the doctor or hospital has "exercised power possessed by virtue of state law and made possible only because the wrongdoer is clothed with the authority of state law." *West*, 487 U.S. at 49 (citation and quotation marks omitted).

The Ninth Circuit case of *Sutton v. Providence St. Joseph Medical Center*, 192 F.3d 826 (9th Cir. 1999), provides a helpful framework. In *Sutton*, the Circuit considered in detail the potential liability of a private defendant under § 1983. It concluded "the mere fact that the government compelled a result does not suggest that the government's action is "fairly attributable" to the private defendant. *Id.* at 838. To find otherwise "would be to convert every employer—whether it has one employee or 1,000 employees—into a governmental actor every time it complies with a presumptively valid, generally applicable law, such as an environmental standard or a tax-withholding scheme." *Id.* The court emphasized the importance of "something more" between the state and private person: Did the defendant perform a public function? Did the government and defendants act together? Did the government compel or coerce the defendants? Or is there some other "nexus" between the government and the defendants? *See id.* at 835. The Circuit cited three cases as examples of this nexus: (1) *Adickes v. S.H. Kress & Co.*, 398 U.S. 144 (1970), where the Supreme Court relied on an alleged conspiracy between private and public actors; (2) *Lugar*, 457 U.S. 922, where the Court relied on official cooperation between the private and public actors; and (3) *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163

(1972), where the Court relied on the state's enforcement and ratification of the private person's actions. *See Sutton*, 192 F.3d at 839–41.

Here, Ms. Fonseca cites four facts to argue Kaiser's and Dr. Myette's determination of death is fairly attributable to the state: (1) "declarations of death are essentially a state-prescribed function"; (2) the defendants acted as "willful participants" in the State's determination of death; (3) the defendants had "no discretion to entertain independent medical judgment inconsistent with CUDDA's definition" and participated in a specific, state-defined protocol; and (4) Kaiser received Israel from one public institution, U.C. Davis, and is attempting to transfer him to another public official, the coroner. *See* Mot. Prelim. Inj. at 6–9.

These facts do not show Kaiser and Dr. Myette are state actors. Several relate to the question of whether a "state action" occurred, but not whether the defendants here acted "under color of law." In other words, it may be that a state normally prescribes the exact criteria for a doctor to check when deciding whether a patient is living, and it may be that Kaiser and Dr. Myette willfully complied with state laws and regulations, but these facts suggest only that a "state action" has occurred, not that Kaiser and Dr. Myette acted under color of law.

At most it can be said that California passed a law and that the defendants willfully complied with the law. *See, e.g.*, Cal. Health & Safety Code §§ 102800, 102825 (physicians' obligations related to a death certificate). As *Sutter* teaches, state compulsion does not establish a private defendant's actions under color of law; "something more" is necessary. *Sutton*, 192 F.3d at 835. If the facts here were enough to show Kaiser and Dr. Myette had acted under color of law, then a private person would act under color of law every time he or she obeyed laws or regulations of his or her own accord, which cannot be. *See Am. Mfrs.*, 526 U.S. at 52. Consider a lawyer who studies the California Code of Civil Procedure, or a driver who fills out the paperwork to apply for a driver's license. California defines its rules of procedure and a state agency creates the forms the driver fills out, but the lawyer is not a state actor when he follows the rules, and a driver is not a state actor when he fills out and turns in the form. Something more is required. The defendants suggest an analogy to a priest who completes a marriage license,

Opp'n at 1, which, though unsupported by citation to a specific authority, illustrates the same point.

The fact that Kaiser received and would transfer Israel to and from a state institution does not show the private defendants acted under color of law. It is a coincidence that Israel was transferred from a university hospital, and the presence of state entities in this respect cannot make for action under color of law.

Professional expertise, training, and discretion also show California played at most a minor role in Kaiser's and Dr. Myette's actions. CUDDA describes brain death in general terms—the "irreversible cessation of all functions of the entire brain, including the brain stem"—and it specifically refers to "accepted medical standards." *See* Cal. Health & Safety Code § 7180. California has not dictated which tests must be performed, how, when, or by whom. These specifics are all matters of private medical expertise and discretion. They are the subject of guidelines published by professional medical organizations. *See, e.g.*, Am. Acad. Pediatrics, *Clinical Report—Guidelines for the Determination of Brain Death in Infants and Children* (2011), ECF No. 36-1. The determination of Israel's brain death "ultimately turn[ed] on medical judgments made by private parties according to professional standards" that California did not establish. *Blum*, 457 U.S. at 1008.

Upon close review, this case contrasts with the others in which doctors and hospitals have been found to act under color of law. For example, drawing from those cited above, in *West v. Atkins*, the Supreme Court held that a doctor employed part-time by the state acted under color of law when he treated inmates in a state prison. *See generally* 487 U.S. 42. In *Chudacoff v. University Medical Center of South Nevada*, the Ninth Circuit described the defendant hospital as public "through and through," because it was "controlled and managed" by the state and the defendants' authority "flow[ed] directly from the state." 649 F.3d at 1150.

This case also contrasts with the general body of decisions based on action under color of law that occurred outside the hospital context. In the *Lugar* case on which plaintiff has relied, for example, the Supreme Court considered whether a private defendant who used an *ex parte* state procedure to obtain an order sequestering the plaintiff's property could be liable as a

state actor. 457 U.S. at 924–25. The Court reaffirmed that a private person could be held liable as a state actor in that situation, noting that the state's involvement was "overt" and "official" and that the private person participated jointly with the state in a seizure of property. *Id.* at 927–28, 941; *see also Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 290–91 (2001) ("[T]he association in question here includes most public schools located within the State, acts through their representatives, draws its officers from them, is largely funded by their dues and income received in their stead, and has historically been seen to regulate in lieu of the State Board of Education's exercise of its own authority.").

Ms. Fonseca has not cited any case where a private doctor working at a private hospital providing treatment to a private person was found to have acted under color of law. The court's independent research has likewise produced no example. This is a case of private action, not public action. The § 1983 claims against Kaiser and Dr. Myette cannot support Ms. Fonseca's request for a preliminary injunction.

In determining whether an injunction should issue, therefore, the court considers only the EMTALA claim against Kaiser, which appears to be the claim on which plaintiff primarily relies, as well as the § 1983 claims against Dr. Smith.

III. LEGAL STANDARD

A preliminary injunction preserves the relative position of the parties until a trial is completed on the merits or the case is otherwise concluded. *See Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). It is an extraordinary remedy awarded only upon a clear showing that the plaintiff is entitled to relief. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008). The plaintiff must show she is "likely to succeed on the merits," "likely to suffer irreparable harm in the absence of the preliminary relief," "the balance of equities tips in [her] favor," and "an injunction is in the public interest." *Id.* at 20. Alternatively, if a plaintiff cannot demonstrate she is likely to succeed on the merits of her claims, but can show at least (1) that "serious questions" go to the merits of her claims, (2) that the "balance of hardships tips *sharply*" in her favor, and (3) that the other two parts of the *Winter* test are satisfied, then a preliminary injunction may be proper nonetheless. *Shell Offshore, Inc. v. Greenpeace, Inc.*, 709 F.3d 1281, 1291 (9th Cir. 2013)

(quoting *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1134–35 (9th Cir. 2011)) (emphasis in *Shell*).

But if the plaintiff cannot show she has even a "fair chance of success on the merits," then it does not matter how the other parts of the *Winter* test may be resolved; "at an irreducible minimum the moving party must demonstrate a fair chance of success on the merits, or questions serious enough to require litigation." *Pimentel v. Dreyfus*, 670 F.3d 1096, 1111 (9th Cir. 2012) (quoting *Guzman v. Shewry*, 552 F.3d 941, 948 (9th Cir. 2009)) (internal quotation marks omitted).

When deciding whether to issue a preliminary injunction, the court may rely on declarations, affidavits, and exhibits, among other things, and this evidence need not conform to the standards that apply at summary judgment or trial. *Johnson v. Couturier*, 572 F.3d 1067, 1083 (9th Cir. 2009); *see also Flynt Distrib. Co. v. Harvey*, 734 F.2d 1389, 1394 (9th Cir. 1984) ("The trial court may give even inadmissible evidence some weight, when to do so serves the purpose of preventing irreparable harm before trial"); *Rubin* ex rel. *N.L.R.B. v. Vista Del Sol Health Servs., Inc.*, 80 F. Supp. 3d 1058, 1072 (C.D. Cal. 2015) ("It is well established that trial courts can consider otherwise inadmissible evidence in deciding whether or not to issue a preliminary injunction."). "A credibility determination is well within the court's province when ruling on a preliminary injunction motion . . . ." *N.E. England Braiding Co. v. A.W. Chesterton Co.*, 970 F.2d 878, 884 (Fed. Cir. 1992); *accord Oakland Tribune, Inc. v. Chronicle Pub. Co., Inc.*, 762 F.2d 1374, 1377 (9th Cir. 1985); 11A Charles A. Wright, et al., Federal Practice & Procedure § 2949 (3d ed. 2013). A district court may also hear oral testimony at a hearing. *Stanley v. Univ. of S. Cal.*, 13 F.3d 1313, 1326 (9th Cir. 1994). Oral testimony is unnecessary, however, if the parties had an adequate opportunity to submit written testimony and argue the matter. *Id.*

IV. DISCUSSION

A. EMTALA Claim Against Kaiser

Ms. Fonseca argues that under EMTALA, Kaiser is required to provide "stabilizing treatment" to Israel until he can be transferred. Mot. Prelim. Inj. at 10–11. She relies

heavily on the Fourth Circuit's decision in *In re Baby K*, 16 F.3d 590 (4th Cir. 1994), discussed below.

Congress enacted EMTALA over concerns that "hospitals were dumping patients who were unable to pay for care, either by refusing to provide emergency treatment to these patients, or by transferring the patients to other hospitals before the patients' conditions stabilized." *Jackson v. East Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001); *see* H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), reprinted in 1986 U.S. Code Cong. & Admin. News 579, 605. EMTALA provides,

> In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

42 U.S.C. § 1395dd(a).

If the hospital determines that the individual has an emergency medical condition, then the hospital must provide either

> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for transfer of the individual to another medical facility . . . .

Id. § 1395dd(b). An "emergency medical condition" is defined as

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . . .

Id. § 1395dd(e)(1)(A). "To stabilize" and "stabilized" are also specifically defined:

> (A) The term "to stabilize" means, with respect to an emergency medical condition . . . , to provide such medical treatment of the

> condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . . .
>
> (B) The term "stabilized" means, with respect to an emergency medical condition . . . , that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility . . . .

Id. § 1395dd(e)(3).

It appears there is no binding or persuasive authority on all fours with this case. As noted, Ms. Fonseca analogizes her case to that of the child in *Baby K*. Mot. Prelim. Inj. at 11. The patient in *Baby K* was an anencephalic[5] infant suffering from respiratory distress. 16 F.3d at 592–93. The hospital physicians informed Baby K's mother that most anencephalic infants die within a few days of birth due to breathing difficulties and other complications, and recommended that Baby K be provided only with supportive care in the form of nutrition, hydration and warmth. *Id.* at 592. Baby K's mother and physicians were not able to reach an agreement as to the appropriate care for Baby K; thus, Baby K's mother transferred her to a nursing home. *Id.* at 593. After the transfer, Baby K was readmitted to the hospital three times due to breathing difficulties. *Id.* Each time, after breathing assistance was provided and Baby K was stabilized, she was discharged to the nursing home. *Id.* Following Baby K's second admission, the hospital sought a declaratory judgment that it was not required to provide respiratory support to anencephalic infants. *Id.* The district court denied that relief, and the Fourth Circuit affirmed, observing:

> Congress rejected a case-by-case approach to determining what emergency medical treatment hospitals and physicians must provide and to whom they must provide it; instead, it required hospitals and physicians to provide stabilizing care to any individual presenting an emergency medical condition. EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more

[5] Anencephaly is a congenital malformation where a major portion of the patient's brain, skull and scalp are missing. *Baby K*, 16 F.3d at 592. The presence of a brain stem supported Baby K's autonomic functions and reflex actions, but, without a cerebrum, the patient was permanently unconscious and had no cognitive abilities or awareness. *Id.* She could not see, hear, or interact with her surroundings. *Id.*

> than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy—all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death.

Id. at 598. EMTALA was therefore applicable and required the hospital to provide stabilizing care to Baby K when her mother sought emergency care. *Id.*

Two years later, the Fourth Circuit clarified its holding in *Baby K* and provided a narrowed reading of EMTALA. *See Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996). In *Bryan*, the plaintiff argued that the hospital defendant violated EMTALA when, after treating the adult patient for an emergency condition for twelve days, it decided that no further efforts to prevent the patient's death should be made. *Id.* at 350, 352. The hospital refused to follow instructions from the patient's husband and family, and entered a "do not resuscitate" order against the family's wishes. *Id.* at 350. As a result, the patient's condition worsened, and she died a few days later. The Fourth Circuit found EMTALA did not apply and distinguished *Baby K*:

> Under the circumstances [in *Baby K*], the requirement was to provide stabilizing treatment of . . . respiratory distress, without regard to the fact that the patient was anencephalic or to the appropriate standards of care for that general condition.
>
> The holding in *Baby K* thus turned entirely on the substantive nature of the stabilizing treatment that EMTALA required for a particular emergency medical condition. The case did not present the issue of the temporal duration of that obligation, and certainly did not hold that it was of indefinite duration.

Id. at 352. The *Bryan* court went on to affirm the district court's order dismissing the case because the plaintiff had conceded that the patient received stabilizing treatment in accordance with EMTALA for twelve days. *Id.* at 353. The plaintiff's claim rested only on the "ultimate cessation of that or any further medical treatment upon entry of the anti-resuscitation order," which did not violate EMTALA. *Id.*

The Fourth Circuit further noted that EMTALA is "a limited 'anti-dumping' statute, not a federal malpractice statute." *Id.* at 351. It echoed the decisions of other circuit

courts, noting that EMTALA was enacted to prevent patients from being turned away from emergency rooms for lack of insurance or other non-medical reasons. *Id.*; *see also, e.g.*, *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 796 (10th Cir. 2001) (Congress enacted EMTALA to regulate emergency room care to prevent the dumping" of the uninsured); *Cherukuri v. Shalala*, 175 F.3d 446, 448 (6th Cir. 1999) (same). The Ninth Circuit, in finding EMTALA provides no private right of action against physicians, has characterized the law's purpose in the same way: "Congress enacted [EMTALA] in response to a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." *Eberhardt v. City of L.A.*, 62 F.3d 1253, 1255 (9th Cir. 1995) (citation and quotation marks omitted). "Congress was concerned that hospitals were 'dumping' patients who were unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their conditions were stabilized." *Id.*

Ultimately, the Fourth Circuit held in *Bryan* that once stabilizing treatment has been provided for a patient who arrives with an emergency condition, "the patient's care becomes the legal responsibility of the hospital and the treating physicians," and the legal adequacy of the subsequent care is no longer governed by EMTALA. 95 F.3d at 351. A hospital is not obligated to provide "stabilizing treatment" for a particular "emergency medical condition" for an indefinite duration, at least in terms of its liability under EMTALA. *See id.* at 352.

Here, after Israel's first admission to a local hospital for an asthma attack, then his loss of consciousness, intubation and transfer to U.C. Davis, followed by a brain death examination and apnea tests[6] at U.C. Davis, Israel was transferred to Kaiser on the eleventh day after his asthma attack. At Kaiser, stabilizing treatment was provided, another apnea test was performed, and after another three days, two doctors performed tests independently to determine whether Israel's brain was still functioning. Each doctor determined Israel had suffered brain

[6] In performing an apnea test, a doctor removes the ventilator and allows the carbon dioxide levels within a patient to rise in order to provoke a respiratory response. The First Amended Complaint appears to allege that Israel was not comatose at the time of this testing, but does not provide further clarification as to his actual state. FAC ¶ 19.

death as provided by CUDDA on April 14, 2016.[7] Kaiser completed a portion of a Certificate of Death for Israel soon afterward. ECF No. 43-3. Nonetheless, Kaiser has continued to provide support for Israel pending the parties' efforts at mediation and court decisions.

As a practical matter, after stabilizing Israel, Kaiser determined Israel's condition was no longer an emergency medical condition because it found Israel had suffered brain death. This determination distinguishes this case from *Baby K*, where the patient, despite breathing difficulties, was stabilized and discharged. Also, unlike *Baby K*, this is not a case where the patient still "seek[s] emergency stabilizing treatment for [medical] distress." *Baby K*, 16 F.3d at 598. Rather, Ms. Fonseca requests that Israel remain on a ventilator with additional treatment so he can be in his current condition once she has a plan for transfer. The dispute here, as in *Bryan*, raises at best a question of long-term care. *See id.* EMTALA does not obligate Kaiser to maintain Israel on life support indefinitely. Plaintiff identifies no date by which she would agree Kaiser's obligations cease. This case raises no serious questions under EMTALA.

B. Substantive Due Process Claim Against Dr. Smith

The complaint alleges generally that CUDDA deprives Ms. Fonseca of liberty and privacy and Israel of life without due process. *See* First Am. Compl. at 11–15. In her moving papers, Ms. Fonseca clarifies that she challenges CUDDA both as a matter of substance and with respect to the procedures CUDDA establishes. *See* Mot. Prelim. Inj. at 11–12. The court considers first, here, her substantive challenge. As explained below, the court does not enjoin CUDDA, and therefore does not provide Dr. Smith time to brief her position on plaintiff's claims against her.

The Due Process Clause of the Fourteenth Amendment prohibits states from making or enforcing laws that deprive a person of life, liberty, or property without due process. U.S. Const. amend. XIV, § 1. The Clause has been construed to "protect[] individual liberty against certain government actions regardless of the fairness of the procedures used to implement them." *Collins v. City of Harker Heights, Tex.*, 503 U.S. 115, 125 (1992) (citation and quotation

[7] As the state court found, Kaiser thus provided the "independent confirmation" required by CUDDA. Cal. Health & Safety Code § 7181.

marks omitted). It "provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). Among these rights is a person's liberty interest in making certain decisions about medical treatment. *See id.* at 724–25 (citing *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 279 (1990)).

1. Rights at Stake

When presented with a due process challenge, the court must take care to understand what right or liberty interest is at stake. *See id.* at 721 (referring to a "careful description" of the asserted fundamental liberty interest). Ms. Fonseca would define the interests in question here as Israel's right to live and her right to make decisions about his care; that is, she alleges CUDDA deprives her of a right to make healthcare decisions for Israel. *See* Mot. Prelim. Inj. at 11–16. For all practical purposes, these claims are the same: they are both challenges to California's decision to place brain death on equal footing with the prior legal understanding of death, as linked to breath and heartbeat. Although the court agrees Ms. Fonseca has a fundamental liberty interest "in the care, custody, and control of [her] children," *Troxel v. Granville*, 530 U.S. 57, 65 (2000), it does not follow that any person, parent or not, has a right to demand healthcare be administered to those who are not alive in the eyes of the state. Nevertheless, Ms. Fonseca's fundamental interests in the care of her son likely encompass her challenge to California's determination that he is not alive. For purposes of this motion, the court finds Ms. Fonseca may challenge CUDDA in her own right as well as on Israel's behalf. *But see Pickup v. Brown*, 740 F.3d 1208, 1235–36 (9th Cir.) (finding a parent has no fundamental right "to choose for a child a particular type of provider for a particular treatment that the state has deemed harmful"), *cert. denied*, 134 S. Ct. 2871, *and cert. denied sub nom. Welch v. Brown*, 134 S. Ct. 2881 (2014).

It goes without saying that the right to life is fundamental. The fundamental rights of parents have also been unquestioned for the better part of a century at least. *See, e.g.*, *Troxel*, 530 U.S. at 65. This does not end this court's inquiry; whether a constitutional right has been violated is determined by balancing that right or liberty interest against the "relevant state

interests." *Cruzan*, 497 U.S. at 279 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)). In other words, "[i]n determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance the liberty of the individual and the demands of an organized society." *Youngberg*, 456 U.S. at 320 (citation and quotation marks omitted).

2. Balancing of Interests

The particulars of the required balancing exercise are difficult to describe generally. The Supreme Court has engaged in balancing in three cases that are instructive here. In *Cruzan*, the Court balanced a competent person's "constitutionally protected liberty interest in refusing unwanted medical treatment" against Missouri's decision to require clear and convincing evidence that a person in a persistent vegetative state would have wanted to terminate treatment. 497 U.S. at 278–85. The Court considered the State's interests in safeguarding the deeply personal choice between life and death. *See id.* at 281. In *Youngberg*, the Court balanced a civilly committed person's interests in safety and freedom against the state's interests, for example in protecting others from violence, and concluded that the state was constitutionally required to ensure that the commitment decision was not made in reliance on a "substantial departure from accepted professional judgment, practice, or standards." 457 U.S. at 321–23. And in *Bell v. Wolfish*, 441 U.S. 520 (1979), the Court balanced the rights of pretrial detainees to be free from punishment against the state's interest in ensuring a defendant is present at trial, the state's "operational concerns," and other related interests. *Id.* at 539–40. Similarly, as the Ninth Circuit has observed, a parent's fundamental liberty interest in maintaining the family relationship is not absolute; when the state interferes with that relationship, the parents' interests must be balanced against those of the state. *See, e.g.*, *Woodrum v. Woodward Cty., Okl.*, 866 F.2d 1121, 1125 (9th Cir. 1989); *see also Pickup*, 740 F.3d at 1235 ("Parents have a constitutionally protected right to make decisions regarding the care, custody, and control of their children, but that right is not without limitations." (citation and quotation marks omitted)).

While the historical, common-law understanding, that death occurred after the permanent cessation of breath and blood flow, was generally in effect in this country for many years prior to the late 1900s, *see, e.g.*, *People v. Mitchell*, 132 Cal. App. 3d 389, 396–97 (1982)

(citing *Commonwealth v. Golston*, 373 Mass. 249 (1977)), the understanding of the human body's functioning is different today than it was when death was defined without reference to the brain. The previous legal understanding of death fit within a context when the heart, lungs, and other organs could not be sustained artificially. In the face of changing technology, California has a broad range of legitimate interests in drawing boundaries between life and that reflect current understanding. These interests include: for purposes of criminal law (has a murder occurred and when?), tort liability (has a doctor caused a death and when?), probate and the law of estates (what rights do heirs possess and when?), general healthcare and bioethics (how must the state and private medical providers allocate scarce resources among the ill and injured?), and as relevant here regulation of the medical profession (when may a doctor refuse treatment, and when must a doctor provide treatment?). *Cf. Glucksberg*, 521 U.S. at 731 (recognizing a state's interest in protecting "the integrity and ethics of the medical profession" opposite an asserted fundamental right); *Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975) ("States have a compelling interest in the practice of professions within their boundaries . . . ."); *Varandani v. Bowen*, 824 F.2d 307, 311 (4th Cir. 1987) (recognizing a state's "compelling interest in assuring safe health care for the public").

Nothing before the court suggests CUDDA is arbitrary, unreasoned, or unsupported by medical science. Kansas was the first to adopt a statutory definition of death in 1970, including brain death. *See State v. Shaffer*, 223 Kan. 244, 249 (1977). Other states followed this lead, and the Uniform Determination of Death Act was adopted in 1980 by the National Conference of Commissions on Uniform Laws. David B. Sweet, *Homicide by Causing Victim's Brain-Dead Condition*, 42 A.L.R.4th 742 (orig. pub. 1985). The current version of the Act is the product of a long-debated agreement between the American Medical Association and the American Bar Association. *See id.*; 14 Witkin, Summary 10th, Wills, § 11, p. 69 (2005). Thirty-three states and the District of Columbia have formally adopted the Act. *See* U.L.A., Unif. Determination of Death Act, Refs. & Annos.; *see also In re Guardianship of Hailu*, 361 P.3d 524, 528 (Nev. 2015) ("The UDDA and similar brain death definitions have been uniformly accepted throughout the country."). California adopted the Act in 1982. *See* 1982 Cal. Stat. 3098.

Brain death itself is a widely recognized and accepted phenomenon, including in children and infants. *See, e.g.*, Am. Acad. Pediatrics, *Clinical Report—Guidelines for the Determination of Brain Death in Infants and Children* (2011), ECF No. 36-1 (affirming "the definition of death," the same definition used in CUDDA, which "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"); James L. Bernat, *The Whole-Brain Concept of Death Remains Optimum Public Policy*, 34 J.L. Med. & Ethics 35, 36 (2006) ("The practice of determining human death using brain tests has become worldwide over the past several decades. The practice is enshrined in law in all 50 states in the United States and in approximately 80 other countries . . . .").

At the same time, the court recognizes the unease with which some regard brain death. *See, e.g.*, Bernat, *supra*, at 36 (referring to a "persistent group of critics"); Seema K. Shah, *Piercing the Veil: The Limits of Brain Death as a Legal Fiction*, 48 U. Mich. J. L. Reform 301, 302 (2015) (recognizing the "tremendous value of the legal standard of brain death in some contexts" but arguing brain death is a legal fiction and should not be recognized in certain cases, including where religious and moral objections are raised); D. Alan Shewmon, *"Brainstem Death," "Brain Death" and "Death": A Critical Re-Evaluation of the Purported Equivalence*, 14 Iss. L. & Med. 125 (1998) (advocating for a definition of death that looks to more than the brain). A California Court of Appeal has suggested "[p]arents do not lose all control once their child is determined brain dead," but also expressed uncertainty whether this right was born of the common law, the Constitution, logic, or simple decency. *Dority v. Superior Court*, 145 Cal. App. 3d 273, 279–80 (1983). Ms. Fonseca has presented the declaration of Dr. Paul Byrne, M.D., who believes Israel may recover some cognitive function with time and treatment. *See generally* Byrne Decl., ECF No. 36. Dr. Myette disagrees. *See* Myette Decl. ¶ 15. On balance, a professional doubt surrounding brain death as death, legally or medically, represents a minority position. Such doubt is unlikely to render CUDDA substantively unconstitutional on its face.

C. Procedural Due Process Claim against Dr. Smith

"A procedural due process claim has two elements: deprivation of a constitutionally protected liberty or property interest and denial of adequate procedural protection." *Krainski v. Nev.* ex rel. *Bd. of Regents of Nev. Sys. of Higher Educ.*, 616 F.3d 963, 970 (9th Cir. 2010). Here, as discussed, California is alleged to have deprived Israel of life and Ms. Fonseca of her fundamental interests in the care, custody, and control of her children. These are fundamental rights and interests the Constitution protects. Ms. Fonseca still must demonstrate she is likely to succeed in showing the process provided to Israel and herself has been inadequate.

"Due process, unlike some legal rules, is not a technical conception with a fixed content unrelated to time, place and circumstances. It is compounded of history, reason, the past course of decisions." *Cafeteria & Rest. Workers Union v. McElroy*, 367 U.S. 886, 895 (1961) (citation, alteration, and quotation marks omitted). "The fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner." *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976) (citation and quotation marks omitted). What process is due generally depends on three factors: (1) "the private interest that will be affected by the official action"; (2) "the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards"; and (3) "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." *Id.* at 335.

CUDDA and other provisions of the Health and Safety Code provide several procedural safeguards:

(1) Health & Safety Code section 7180 allows a determination of death only "in accordance with accepted medical standards."

(2) "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician." Cal. Health & Safety Code § 7181.

(3) Physicians involved in the determination of death must not participate in any procedures to remove or transplant the deceased person's organs. *Id.* § 7182.

(4) "Complete patient medical records required of a health facility pursuant to regulations adopted by the department in accordance with [California Health and Safety Code] Section 1275 shall be kept, maintained, and preserved" with respect to CUDDA's requirements in the case of a brain death. *Id.* § 7183.

(5) Hospitals must "adopt a policy for providing family or next of kin with a reasonably brief period of accommodation . . . from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem . . . through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required." *Id.* § 1254.4(a). "[A] 'reasonably brief period' means an amount of time afforded to gather family or next of kin at the patient's bedside." *Id.* § 1254.4(b). "[I]n determining what is reasonable, a hospital shall consider the needs of other patients and prospective patients in urgent need of care." *Id.* § 1254.4(d).

(6) The hospital must "provide the patient's . . . family or next of kin, if available, with a written statement of the [policy regarding a reasonably brief period of accommodation described in section 1254.4(a)], upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent." *Id.* § 1254.4(c)(1). "If the patient's . . . family . . . voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns." *Id.* § 1254.4(c)(2).

(7) Section 1254.4 provides for no private right of action, as plaintiff stresses. *Id.* § 1254.4(e). But a state court may hear evidence and review a physician's determination that brain death has occurred. *See Dority*, 145 Cal. App. 3d at 280 ("The [trial] court, after hearing the medical evidence and taking into consideration the rights of all the parties involved, found

[the patient] was dead in accordance with the California statutes and ordered withdrawal of the life-support device. The court's order was proper and appropriate.").

Ms. Fonseca is unlikely to show the available protections are inadequate. Whether a person has suffered brain death is a medical determination that should involve a doctor, as CUDDA foresees. CUDDA creates a procedure that allows a determination to be verified quickly; false positives may mean a patient in critical condition receives no care. The law requires an independent confirmation of death in the case of suspected brain death; here at least three doctors have independently determined Israel is brain dead. Doctors who make the determination of death cannot be involved in any related transplant procedures; here the doctors are not. Family may gather at a patient's bedside, and hospitals must make reasonable accommodations for the religious or moral concerns of the patient's family or next of kin. The family has been provided more than a brief period of time to gather, and the state court considered and addressed Ms. Fonseca's moral and religious concerns during the time its TRO was in effect.

In addition, although section 1254.4 creates no private right of action, a California appellate court has determined that an interested person has some recourse to judicial review. Ms. Fonseca sought and received immediate protection from the Placer County Superior Court, which entered a TRO and allowed her to present evidence and seek relief over the course of two weeks. Although Ms. Fonseca has not appealed the state court's dismissal of her case, *Dority* signals she could. At hearing, her counsel in this case -- who is not counsel in her state case – suggested that a state appeal would be burdensome or unproductive, and exclaimed that taking that route generally is a "death knell for California working class families." While the full impact of his statement is not clear to this court, nothing in the record before it supports the conclusion that full procedural due process is unavailable with respect to CUDDA.

V. RELIEF SOUGHT

Ms. Fonseca has not borne her burden to show she is likely to succeed on the merits of the claims she relies on at this stage, and she has not presented sufficiently serious

questions to justify a preliminary injunction. This conclusion is bolstered by the fact that her claims do not appear to fit with the relief she seeks.

While Ms. Fonseca requests maintenance of ventilation, she also requests a mandatory injunction. *See* First Am. Compl. ¶¶ 48 (requesting an injunction that requires Kaiser to provide nutrition to Israel); Proposed Order, ECF No. 33-1 at 3. A mandatory injunction "orders a responsible party to take action." *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (citation and quotation marks omitted). This type of relief "goes well beyond simply maintaining the *status quo pendente lite* and is particularly disfavored." *Id.* (citation, quotation marks, and alterations omitted). Mandatory injunctions are incompatible with doubtful cases like this one. *Id.* Moreover, it seems unlikely this court would have jurisdiction to consider the specifics of what care Israel must receive. This question, among others, was the subject of the Placer County Superior Court's orders and hearings last month. The *Rooker-Feldman* doctrine or standard preclusion rules would likely apply. *See, e.g.*, *Cooper*, 704 F.3d at 777; *cf. Exxon Mobil Corp. v. Saudi Basic Indus. Corp.*, 544 U.S. 280, 284, 292–94 (2005) (referring to independent doctrines of preclusion, stay, and dismissal that may arise in the presence of parallel state court proceedings).

As noted, it appears the court lacks subject matter jurisdiction over the § 1983 claims against Kaiser and Dr. Myette, and EMTALA does not provide a basis for enjoining Kaiser on the facts here. Dr. Smith may be the only viable defendant in this action. An order requiring Kaiser to maintain Israel's condition could not properly be issued against Dr. Smith. If indeed CUDDA is facially unconstitutional, the court could at most declare that the certificate of Israel's death is void. Kaiser and its physicians would then remain subject to other provisions of California law that are not before this court. *See, e.g.*, Cal. Prob. Code §§ 4735 ("A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."); *id.* § 4654 ("[Division 4.7 of the Probate Code] does not authorize or require a

health care provider or health care institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or health care institution.").

While Ms. Fonseca's maternal instincts and moral position are completely understandable, the concerns reviewed here suggest she is unlikely to obtain the relief she seeks, and weigh against a preliminary injunction based on the law this court is sworn to apply and uphold.

VI. CONTINUING TEMPORARY RELIEF

To date, the TRO the court previously issued has remained in effect. *See* Order Apr. 28, 2016, ECF No. 9; Minutes, ECF No. 22; Minutes, ECF No. 45. At the May 11, 2016 hearing, Ms. Fonseca indicated she would ask the court stay the effect of an order denying her request for a preliminary injunction to allow her to seek emergency relief from the Ninth Circuit Court of Appeals. The defendants expressed no objection to this request.

"While an appeal is pending from an interlocutory order . . . that . . . denies an injunction, the court may . . . grant an injunction on terms for bond or other terms that secure the opposing party's rights." Fed. R. Civ. P. 62(c). Under this rule, the court considers generally the same factors as in the context of a temporary restraining order or preliminary injunction. *See, e.g.*, *Protect Our Water v. Flowers*, 377 F. Supp. 2d 882, 883 (E.D. Cal. 2004). Nevertheless, when a court has attempted to answer a question of first impression, and when the practical consequences of its decision suggest caution, a plaintiff's likely success on the merits may not play so central a role. *See, e.g.*, *id.*; *Yamada v. Kuramoto*, 744 F. Supp. 2d 1075, 1087 (D. Haw. 2010). And in a case such as this one, "[a]n erroneous decision. . . is not susceptible of correction." *Cruzan*, 497 U.S. at 283.

The court therefore provides that this order will not take effect, and the temporary restraining order will remain in place, until the close of business on Friday, May 20, 2016, to allow Ms. Fonseca time to seek emergency relief from the Ninth Circuit Court of Appeals.

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VII. CONCLUSION

The temporary restraining order currently in effect REMAINS IN PLACE until the close of business on Friday, May 20, 2016, at which point it will be dissolved. The motion for a preliminary injunction is DENIED.

This order resolves ECF Nos. 31 & 33.

IT IS SO ORDERED.

DATED: May 13, 2016.

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE KIMBERLY J. MUELLER, JUDGE

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JONEE FONSECA, an individual parent and guardian of ISRAEL STINSON, a minor,

Plaintiffs,

vs. No. 2:16-CV-0889

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE; MICHAEL MYETTE, M.D., KAREN SMITH, M.D., in her capacity as Director of the California Department of Public Health; and DOES 2 through 10, inclusive,

Defendants.
_____/

REPORTER'S TRANSCRIPT OF PROCEEDINGS

MOTION FOR PRELIMINARY INJUNCTION

WEDNESDAY, MAY 11, 2016, 3:30 P.M.

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SACRAMENTO, CALIFORNIA

WEDNESDAY, MAY 11, 2016, 3:36 P.M.

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THE CLERK: Calling civil case 16-889, Fonseca versus Kaiser Permanente Roseville, et al. This is on for plaintiff's motion for preliminary injunction.

THE COURT: Good afternoon. Appearances, please.

MR. SNIDER: Good afternoon, Your Honor. Kevin Snider for plaintiff Ms. Fonseca, who is here with me in court, as well as her -- along with Nathaniel Stinson, the father.

THE COURT: All right. And who else is at counsel table?

MR. MC REYNOLDS: Matthew McReynolds, Pacific Justice Institute.

MS. SNYDER: Alexandra Snyder with Life Legal Defense Foundation.

THE COURT: All right. Good afternoon to you all.

MR. CURLIANO: Good afternoon, Your Honor. Jason Curliano on behalf of Kaiser and Dr. Myette. And we have several representatives from Kaiser here, I just did not have them come up to counsel table.

THE COURT: All right. Good afternoon, Mr. Curliano.

And there's an appearance for the State?

MS. NORTON: Good afternoon, Your Honor. Ashante Norton with the Attorney General's office representing

defendant Karen Smith.

MR. CASTRO: And Ismael Castro, Your Honor, good afternoon, on behalf of respondent.

THE COURT: All right. Good afternoon to you all.

This is on for a hearing on plaintiff's motion for preliminary injunction. I have received briefing from the plaintiffs and from Kaiser as a defendant. The State has made an appearance on behalf of Dr. Smith, but there's no briefing.

Do I have that correctly, Ms. Norton?

MS. NORTON: Yes, Your Honor, that is correct.

THE COURT: All right. And are you here simply to observe today?

MS. NORTON: We are here, Your Honor, not to take a position on the specific injunctive relief that is being requested today. However, to the extent that the Court is inclined to entertain the plaintiff's facial challenge to the California Uniform Determination of Death Act, then we would like an opportunity to prepare briefing on those issues.

THE COURT: All right. I may have some questions for you then at some point, but we'll cross that bridge when we come to it.

In terms of witnesses, I acknowledge that some testimony has been proffered. Currently I don't anticipate taking testimony. But, again, we can revisit that question at the end of the hearing. The Court can rely on declarations in

this kind of proceeding, and I believe the declarations tell me what I need to know. If someone feels differently when we conclude our discussion based on my questions, and then any argument you want to make, you can let me know.

I just want to acknowledge that the parties have voluntarily participated in mediation with Judge Delaney, and I understand she has had one session and several follow-up phone calls, but as of now there's no resolution. The parties need the Court to decide the pending motion.

Is that correct, Mr. Snider?

MR. SNIDER: That's correct, Your Honor.

THE COURT: All right. Mr. Curliano?

MR. CURLIANO: That is correct, Your Honor.

THE COURT: All right. There was some action in state court. Is that action being appealed?

MR. SNIDER: No, Your Honor. I'm not counsel for that case, that counsel is present in court, but my understanding is it's not being appealed.

THE COURT: All right. It does not affect my thinking about the motion. I was just --

MR. SNIDER: I understand that.

THE COURT: -- clarifying that matter because the state action has been referenced in what's before me.

So I understand the motion for preliminary injunction to be based on not every claim in the amended complaint, but it

is based on federal constitutional claims challenging facially the California Uniform Determination of Death Act based on the Fifth and Fourteenth Amendments, Ms. Fonseca's due process rights, and also the Fourth Amendment privacy right.

MR. SNIDER: As well as EMTALA.

THE COURT: Well, I was getting -- so those are the constitutional claims.

MR. SNIDER: Yes, Your Honor.

THE COURT: And also EMTALA.

MR. SNIDER: That's correct.

THE COURT: All right. With respect to standing, just to address that question, I had previously raised whether or not Ms. Fonseca needed to obtain guardian ad litem status at our first hearing, a quick hearing. I think as a matter generally, given her status as Israel's mother, that she has general guardianship rights. And while I note that the formal petition for guardian ad litem status has been filed, upon further reflection and checking the law, I think she has standing by virtue of her status as the mother.

Any disagreement with that, Mr. Curliano?

MR. CURLIANO: No disagreement at all, Your Honor.

THE COURT: All right. So one way or another, she has standing. While I appreciate counsel's having heard what I was asking at that first hearing, I'm prepared to find that she does have standing.

MR. SNIDER: Thank you, Your Honor.

THE COURT: In terms of the privacy right, Kaiser is named as a defendant with respect to the privacy right under the Fourth Amendment, Kaiser and Dr. Myette.

MR. SNIDER: That's correct, Your Honor.

THE COURT: And so my question's currently focused on that claim. Because for the Court to find that it can issue any injunction against Kaiser and Dr. Myette with respect to that claim, I need to find that Kaiser and Dr. Myette are state actors, acting under color of state law. We touched on that briefly at the first hearing.

Having read the parties' briefing and considered the question further, I have these additional questions because I -- frankly I still have a doubt as to whether or not Kaiser and Dr. Myette can be on the hook as state actors on that claim.

So just so I'm clear, Mr. Snider, has any court held that a private doctor working in a private hospital treating a private patient has acted under color of law?

MR. SNIDER: Would the Court like me to approach?

THE COURT: In this case, with no jury proceeding, if you're more comfortable at counsel table, you may remain seated.

MR. SNIDER: Okay.

THE COURT: It's whatever allows you to best argue your

case.

MR. SNIDER: All right. Thank you, Your Honor.

We have cited in our case one example of a doctor that was an independent contractor with a prison that was deemed a private actor. He was not hired by a hospital, and we concede that. So the answer is we think that that is close, that's as close as we could come on the cases out there.

THE COURT: So that's the best case. Would you concede that's not your classic private patient given the prisoner's status as a custodial patient?

MR. SNIDER: We -- we -- under that circumstance, we believe that the analysis was based on the doctor more than the prisoner. But we think, again, that that is -- that is the primary case specifically about a physician that is out there.

THE COURT: All right. Looking at the authority, I cited to you some of the cases I had found at our first hearing. Again, I've reviewed your briefing. I've looked at the series of cases looking at a doctor and whether or not a doctor can be considered a state actor acting under color of law.

The Ninth Circuit Sutton case talks about the need for something more, something more than the receipt of government money as in the Chudacoff case, something more than compliance with state law. We all have to comply with laws. That doesn't turn us into state actors.

And there is even a case out of the Fifth Circuit, Bass v. Parkwood, where a doctor participated in civil commitment of mentally ill persons, and that did not -- the circuit there found that did not convert that doctor into a state actor.

So I heard what you just said about the -- what you think is the best case. How would you say there is that something more in this case looking at the Ninth Circuit's Sutton discussion?

MR. SNIDER: Our position is that is fairly straightforward, and that is that, under Bloom, which was -- did also involve physicians, though that turned out to find no acting under color of state law, that, nonetheless, the holding in that case was that these were independent judgments of medical professionals. In this -- according to standards not set by the State, that that was the holding in the case.

We would argue that by defining death, that the doctors have to work within that framework, and that is something more than mere independent, professional judgment. In other words, their independence is then curtailed by the State. So that is our position on how we would distinguish Bloom.

THE COURT: So their argument is there's a complete elimination of the exercise of discretion?

MR. SNIDER: That the activity -- it's not a complete elimination. What it is is that the doctors, the physicians must act in accordance with the decision -- I'm sorry -- with

the definition of death that the State has provided. They cannot act outside of that, they cannot use independent judgment to go beyond that.

And as the Court has seen in the filings, there are indeed medical professionals, it's out of the academy and whatnot, who disagree on what is death. And indeed, in this case, we have -- even assuming that death is what the State is defining it, that there -- there is evidence that the child has not reached that standard.

THE COURT: I think that goes more to the constitutionality of the state statute, and we'll get there in just a moment.

MR. SNIDER: Correct, Your Honor.

THE COURT: But the doctors aren't mere automatons in making the determination provided by state law. They are still exercising discretion. No?

MR. SNIDER: They -- this is -- they are in a certain sense, but they are held back, the leash is pulled on them quite a bit because they can only act according to the confines of the definition under the law.

THE COURT: The definition in the statute.

MR. SNIDER: Right.

THE COURT: It's not that a state actor is standing next to them and telling them they have to make a decision in a certain way.

MR. SNIDER: That is correct. The State has essentially assigned them to perform a task and told them what the parameters of that task will be. We believe that that is something more.

THE COURT: All right. Mr. Curliano, anything to say in response to what you've heard?

MR. CURLIANO: Yes, Your Honor, a couple points. If Your Honor doesn't mind if I stand, it's just easier for me.

THE COURT: That's fine.

MR. CURLIANO: I'm not aware of any case, in answer to the Court's question, where a private physician working at a private hospital has been found to be a state actor, acting under color of state law. And there is a difference between acting under color of state law under 1983 versus simply following the law.

And I think -- and this is in our briefs, but the definition of death has been defined professionally by a number of professional medical organizations. The State has not defined death and told the physicians how they must define death. In fact, the State specifically leaves it open to accepted medical standards.

And that's what the Kaiser physicians in this case used. It's in the declaration, it's in the testimony in state court, that's what the physician at U.C. Davis used. Three separate physicians who use their own independent judgment,

following well-accepted medical guidelines, well-accepted for well over 30 years, in determining that unfortunately Israel was brain dead.

And I do think the Bloom case -- and that's why we spent time on it in our brief. It is relevant because the court does make a distinction between regulations that may be in place, in that case Medicare, versus physicians exercising their own professional judgment in determining whether or not a physician is a state actor. In that case, they found they were not.

In fact, in the Chudacoff case, the court cautioned this was not a case, and it would be a different issue, if it was a private physician working in a private hospital with respect to whether or not they're acting under color of state law, which is what we have in this case.

So all I'm aware of in this case that might make some very tangential connection between the State, in this case Kaiser's physician, and the statute is not coercive -- there's no intwinement between the State and our physicians in terms of being told what to do -- is the fact that the Uniform Determination of Death Act, which in some form has been enacted in all states including the District of Columbia, provides some safeguards, some things that the physicians are supposed to follow in terms of how the examinations are done by different physicians and the conclusions they have to come to.

But it seems it's fairly clear, at least in the case law, that how you define death as a physician is determined by professional standards in the medical community.

THE COURT: Well, that's an important point. And just so -- you agree with that. In this case, California is effectively relying on guidelines published by professional organizations.

MR. SNIDER: We would take issue with the proposition that California has not defined death, and we would point the Court's attention to the actual language of Section 7180. And it says: An individual who has sustained either -- and I'm quoting -- irreversible cessation of circulation and respiratory functions, or irreversible cessation of all functions of the entire brain, including the brain stem, is death. We believe that that is the State's definition of death. The fact that it is being adopted by a lot of other states is -- and by a good many in the medical profession is interesting, but it does not remove the fact that this is indeed a state definition of death.

California was free to define death this way or another way or not at all.

THE COURT: But it requires a doctor to exercise discretion in determining whether or not someone is dead.

MR. SNIDER: Yes. A doctor has to -- has to make that determination. The State has pointed to doctors to do that

exclusively.

THE COURT: All right. I have no other questions about that, the state action. Is there anything you think that is not covered fully by the briefing or the discussion we've just had that you'd like to say at this point, Mr. Snider? Otherwise I'd like to move on to EMTALA.

MR. SNIDER: No. We would submit it on that issue.

THE COURT: Mr. Curliano?

MR. CURLIANO: Nothing further that isn't covered in the briefs, Your Honor.

THE COURT: All right. On EMTALA, the Emergency Medical Treatment and Active Labor Act, a federal law, for you first, Mr. Snider, I don't think that there's much case law out there that is applicable here. So in particular, has any court applied EMTALA to a patient that a hospital, that a doctor has determined satisfies the definition of death?

MR. SNIDER: Well, there's the Baby K case.

THE COURT: But there anencephaly was the condition. The baby was stabilized before being released to the nursing home.

MR. SNIDER: Correct.

If you look at the language of EMTALA itself, it does talk to the issue of life support. And it's -- and here we have the elements directly in the statute. We have a transfer from one facility to another. They are required to have --

keep the patient stabilized so they don't deteriorate, so their bodily functions and their organs are not harmed. That's all directly from the statute, and that includes life support.

And so we think just on the face of the statute, that this falls under that, and it certainly raises a serious question regarding that.

THE COURT: So Baby K is the case, the only case you can point to that --

MR. SNIDER: Yes. And the Ninth Circuit admittedly has not wrestled with this. The Ninth Circuit has -- there are two cases in the Fourth Circuit that are in the briefings, and we believe that the facts of this case are closer to Baby K than Bryan versus Rectors. And in the Ninth Circuit, they have mentioned the Baby K case. They have not referred to Bryan versus Rectors. So we think, in the Ninth Circuit, Baby K is as close as you're going to get.

THE COURT: But the congressional purpose in enacting EMTALA was to address patient dumping when a patient couldn't afford to pay. Shouldn't I keep in mind that broad purpose?

And the focus was in particular on emergency treatment.

MR. SNIDER: Yes. We would say yes to the extent that you need to look beyond the face of the text. If you have to look to legislative history, then we -- we would caution that that's probably not necessary and not helpful. We believe that the -- the ordinary reading of the text is sufficient, and it

meets the elements then we have at least, ah, raised that crossed the serious questions threshold.

THE COURT: So why hasn't Kaiser complied with EMTALA in its independent confirmation of U.C. Davis's determination of death?

MR. SNIDER: What Kaiser wants to do is remove life support. And we want to keep that life support intact so we can -- so the child remains stable, does not deteriorate and then can be transferred to another facility. That's what we're asking. And so we believe that is within the scope of EMTALA.

THE COURT: But now that Kaiser has determined independently that Israel tragically, as we've acknowledged previously -- it's at least Kaiser's determination that Israel cannot recover, doesn't the question become one of long-term care and not emergency treatment or stabilization?

MR. SNIDER: Well, what we are asking for is not -- and that was the Bryan case. They were asking for essentially an indefinite life support situation, to continue to resuscitate and whatnot. That's not what we're asking for here.

We are asking, again, to keep the child stable during -- and that we would have a preliminary injunction to retain the status quo so the child could simply be transferred to someplace else. This is not a long-term situation.

THE COURT: And I understand that's been the plaintiff's position, including before the state court. But at

this point, what is there before this court to ensure that it's not a period of indefinite duration that the plaintiff is seeking?

MR. SNIDER: Well, and sadly, the answer to that lies in one of the transcripts and indeed the declaration of Dr. Myette, and that is keeping the child alive, even for a couple more weeks, is difficult. And so we're trying to get a preliminary injunction to retain the status quo, to get to a facility that does believe that treatment could help.

And so that's why we don't think this is a long-term -- this is not a Terri Schiavo, Nancy Cruzan or Karen Ann Quinlan case where we're talking years. The truth of the matter is, Your Honor, if the Court grants this, and the other -- and Kaiser or the State files a 12(b) motion, by the time -- a noticed motion, by the time the Court hears this, the preliminary injunction will no longer be needed.

And so that's why we believe just a preliminary injunction is not a -- a grand thing that we're asking about, asking for in terms of the types of preliminary injunctions that this court grants all the time for much longer periods.

And I would make the --

THE COURT: So I want to make certain I understand what you're saying.

MR. SNIDER: Sure.

THE COURT: It's not that you're representing that

there's a concrete plan for transfer that the plaintiff's going to effect within a two-week period. You're not saying that.

MR. SNIDER: We're saying that -- well, according to the evidence, the evidence that the -- that Kaiser has presented in terms of a transcript, Dr. Myette testified that the time to do something is short.

And I don't want to put too --

THE COURT: So what you're saying is that it's not that the time requested is to facilitate transfer. It's to keep Israel on the ventilator for as long as he has. That's what you're saying?

MR. SNIDER: No.

THE COURT: For as long as his body has?

MR. SNIDER: No.

THE COURT: So what are you saying?

MR. SNIDER: I'm sorry. That's not what I am saying, and I apologize to the Court for being misleading in that way.

The idea is to get -- is to effectuate plans for a transfer, and we -- and we need to get that moving quickly because, as things lie currently, he would not be able to continue on much longer than two weeks.

THE COURT: But there are no concrete plans at this point that you can provide to the Court?

MR. SNIDER: No. We are trying very, very hard to get facilities. You know, we've had some near misses, and it's --

no one is more -- we know that the parties are wishing that the process would go faster on this, no one more so than Ms. Fonseca. But the truth of the matter is that we are still working on that and need a preliminary injunction to stay in place while we're trying to do that.

THE COURT: All right. And because this is a court of law, and of course looking at the case law that either binds me or provides some guidance that is persuasive, so I'm looking at the Bryan case, doesn't it seem to say under EMTALA that there is certainly no requirement of indefinite duration, and there it seems to express no concerns about the 12-day period that elapsed? Is that a fair reading of Bryan?

MR. SNIDER: Yes, the -- yes. But, again, we concede that in a death, requiring or asking for an indefinite period would not fall under EMTALA under Bryan, if the Ninth Circuit chose to go with that.

But --

THE COURT: So what's the period you're asking for as of now?

MR. SNIDER: Well, we are asking -- again, we are asking for a preliminary injunction. Umm, how long? Again, we would like to have the child out to another facility this afternoon. But --

THE COURT: So until resolution of this case.

MR. SNIDER: Until resolution. We don't -- just the

physiology of this situation may be very short.

THE COURT: All right. Mr. Curliano, anything to say about what you've just heard?

MR. CURLIANO: A couple points, Your Honor. And before I talk briefly about EMTALA, I would agree with the observation of the Court, and I think counsel also, there isn't a lot of case law out there on this. Because when you read the statute, and the purpose of the statute as it applies to the facts of this case -- that's why I think the facts are important -- that U.C. Davis is where Israel was, it's where the determination that he had clinical findings that were consistent with brain death was made. The parents consented to the transfer of Israel to Kaiser. That in and of itself takes this outside of EMTALA.

But even more so, Israel was transferred. He's been at Kaiser since the 12th, cared for by a dedicated group of physicians, nurses and caregivers. That's not EMTALA. That's not patient dumping. That may be a disagreement about a statute in California. It may be a disagreement about whether or not medicine is at a place where it can improve someone's condition like Israel's. Unfortunately we're not there yet. But it's not EMTALA.

And I think that the reading of the statute, even without in re matter of Bryan -- but I think in re matter of Bryan is very helpful -- tells us that EMTALA is just not an

appropriate claim to make for federal question jurisdiction to ask for an injunction on.

THE COURT: Mr. Snider, on the fact of the consent to transfer to Kaiser, the effect of that, meaning this is not an EMTALA case?

MR. SNIDER: We would disagree. The evidence is very clear that the child was alive at the transfer. And indeed, I would direct the Court's attention to the last substantive document filed with the Court, which was the death certificate, which is document 43-3.

It states, at box 114 under physician certification, that they received the child on April 12th, and that -- and that the child was last seen alive April 14th. So we're not talking under the evidence of transferring a dead person from U.C. Davis to Kaiser. That's not what the evidence is.

THE COURT: But I think the point is that it was beyond a -- it wasn't an emergency room run.

MR. SNIDER: The case law is fairly clear in that the courts have said it doesn't matter which door you enter through to fall under EMTALA. They say -- the courts have said just because you come through a door other than the emergency room does not mean that EMTALA doesn't apply. And we don't know factually -- I don't know -- he was brought by ambulance, so I don't know where he was received.

THE COURT: Was he already stabilized?

MR. SNIDER: Yes. He was -- I believe he was on a ventilator. I could have someone -- I would have to check that, but he was stabilized, and that's what -- and that's what EMTALA requires, is that includes life support and stability.

Under this situation, Kaiser is wanting to remove that while we're trying to transfer the child to someplace else. We think that falls under the plain language of EMTALA.

THE COURT: So what's the authority for the consent? Is that a facial reading of EMTALA and the stabilization and emergency treatment requirements? Is there case law or something in a consent form itself that you're relying on?

MR. CURLIANO: It's the facial reading of the statute with respect -- and it's multifactorial. It's the fact that it is a consent. I would agree, it doesn't matter what door the patient comes through. Typically one thinks of an emergency department, but I don't think that's required. So I think it's the fact that the patient was stable.

And I need to comment on something because it is just not part of this record, and it was adjudicated by a state court judge who -- we had four separate hearings, and plaintiff was given an opportunity to have experts come and testify. She was given an opportunity to have an independent physician, even though arguably that may not be required under CUDDA, to examine Israel. She was given an opportunity to have witnesses testify.

In fact, Dr. Byrne, who submitted a declaration and is actually in this courtroom today, was there at the state court proceeding on multiple days and has never offered to provide any testimony -- and this is what is important -- to call into question the fact that three separate medical providers at two separate institutions determined that Israel was brain dead.

And the reason I mention that is that twice now there has been mention that he was alive, and I think there was even -- it might have been in error that Dr. Myette testified that Israel was alive. That simply is not the case, and it is simply -- it's not what the medical evidence is in this case.

So if we go back to EMTALA --

THE COURT: So looking at that document 43-3, is there some statement in the record saying last seen alive on the 14th?

MR. CURLIANO: My understanding -- and I believe this is U.C. Davis. I don't have the record counsel is referring to. It was a self-populating check-the-box record. But I can tell you there is nothing in the medical records, the chart notes by the physicians at U.C. Davis -- and I would like a representation if there is one -- of a physician who told the family that Israel is alive, he will improve, he's not brain dead. Because that is inconsistent with the findings at U.C. Davis.

I don't know where that is coming from, Your Honor,

and --

THE COURT: And Kaiser completed its portion of a death certificate.

MR. CURLIANO: Dr. Myette completed his portion of a death certificate, I believe it was on April 15th, and he testified about that in the state court action, and he also has that in the declaration that we've submitted in the federal court proceeding.

THE COURT: But that's not disputed, that Kaiser has completed the portion of the death certificate it would as of April 14th.

MR. SNIDER: Yes.

THE COURT: Based on --

MR. SNIDER: Well, it's -- I believe the date, which is neither here nor there, is April 18th. But as far as -- the document actually is attached to the declaration of Dr. Myette.

THE COURT: All right. I'll double-check to make certain I know what you're talking about.

MR. SNIDER: Okay. And I would -- well, may I address the issue of an evidentiary hearing or I don't know if the Court wants to go there.

THE COURT: Let's wait until we get to the end --

MR. SNIDER: Sure.

THE COURT: -- and I'll hear whatever you have to say about the taking of evidence.

MR. SNIDER: I'm sorry, about the state court, because that was raised.

THE COURT: I'm not reviewing what the state court did here.

MR. SNIDER: Okay.

THE COURT: I know you raised Rooker-Feldman, I do have a question about that, but first let's talk about the constitutional challenges.

I understand there's no briefing from the State in front of me. Given the State's request, if I am inclined to grant injunction, you would agree I need to give the State a chance to brief --

MR. SNIDER: Yes, Your Honor.

And just so we're clear, we're -- I believe this was in our brief, but I may be mistaken. We are not asking that this court enjoin the statute for purposes of this hearing. We are limiting this merely to this plaintiff.

Now, at some point, there needs to be briefing and a -- on this issue of the constitutionality of the statute.

THE COURT: Well, here's what -- so let's just jump to this question of relief.

Assume for sake of argument -- I'm not saying that I've decided this, but just to test what you're asking, assume for sake of argument I find Kaiser and Dr. Myette are not state actors for the privacy right claim, that I can't enjoin based

on the EMTALA claim, I can't issue an injunction based on EMTALA. So that leaves the constitutional challenge to the statute. And the most I could do there would be to declare the statute unconstitutional, which would have the effect, I assume, of nullifying any death certificate.

MR. SNIDER: Well, yes. Putting it in -- those facts in that order then, yes, the Court is correct. I would concede that.

THE COURT: And if it's EMTALA, the only relief really I could grant is to continue stabilization, which is the ventilator.

MR. SNIDER: Correct.

THE COURT: If I were to go any further than that, I would really be revisiting the state court's determination with respect to specific affirmative care. That is, I don't see how under any reading of the motion, the claims, I have the power to tell Kaiser it must provide the affirmative care that Ms. Fonseca understandably wishes.

MR. SNIDER: Yes.

THE COURT: It's beyond my reach. Agreed?

MR. SNIDER: I agree.

And for clarification, I don't know if the -- I have filed a proposed order, and those are often not looked at, but the proposed order does clarify what we are asking.

And the proposed order --

THE COURT: So it's only maintaining respiration.

MR. SNIDER: The proposed order is almost verbatim the order that Judge Nunley had in place. And so, I mean, the only difference is we have -- we followed their A through E. The only difference is that in D, it says other medications necessary for routine maintenance and treatment. That's -- and the other is, as we've clarified, Judge Nunley said continue to provide nutrition to Israel Stinson, and we put including hydration, proteins, fats and vitamins.

If the Court finds that that's too far, you know, so be it. But --

THE COURT: Wouldn't that implicate Rooker-Feldman?

MR. SNIDER: No. Rooker-Feldman, we don't believe, applies at all. And we -- and if the Court would like me to address that, we would point the Court's attention to Exxon Mobil versus Saudi I think it's Basic. It's been mentioned in the briefs of both parties. I could give you the cite to it.

THE COURT: I can find the cite.

MR. SNIDER: Okay. The court -- this is a unanimous Supreme Court that said Rooker-Feldman applies to two cases, Rooker and Feldman. They said we have not applied it in this court to anyone else. And they said, and in Rooker-Feldman, the case -- I'm sorry -- in Exxon, the case was filed two weeks after -- just like in this case, two weeks after the state court case, and the court said Rooker-Feldman doesn't apply.

And the argument was, well, you're just using the federal court system as an insurance policy. And the Supreme Court said, yes, and why is that important? They simply did not see that Rooker-Feldman applies. They said you don't have a judgment in the state court that you're appealing.

And in both Rooker and Feldman -- in Rooker, the 1905 case, the plaintiff was actually essentially appealing a state court adverse judgment, Court of Appeals judgment. And in Feldman, he sued the District of Columbia court, the Court of Appeal, that's the highest court, as a defendant. And the Supreme Court pretty much reined in Rooker-Feldman, so we do not fall under that whatsoever.

THE COURT: Well, the point is, this court is not here to consider appeals directly from a state court, particularly a state trial court. I recognize that case has been dismissed now, but there's no further proceedings.

And in no way is this meant to be an appeal --

MR. SNIDER: Right.

THE COURT: -- of the state court's decision --

MR. SNIDER: Correct.

THE COURT: -- in practical terms.

I'd like to move on to the statute. Anything more you want to say --

MR. CURLIANO: Unless the Court would like a response on Exxon, which we disagree with. We briefed it. It is not on

point at all factually.

In fact, Bianchi that we've cited from the Ninth Circuit deals with the issue of Rooker-Feldman. And the key, just briefly, is the intwinement. If it's a de facto appeal -- you don't need to say it's an appeal, but if you're asking a federal judge to look at undue change or reverse the decision of the trial court judge, that we think a number of points in the plaintiff's brief are asking for, even though they say they're not, I think Rooker-Feldman does become an issue.

And in particular, back to the proposed order, what is being proposed other than if the Court is inclined to look at and evaluate a preliminary injunction and potentially grant one, it would just be the ventilator, maintaining the status quo. The additions to the proposed order are far beyond what Judge Nunley had signed. In fact, June Nunley's order was very close to what was in place at the state court level.

THE COURT: So your position is that's the most I could do under EMTALA is maintain the ventilator.

MR. CURLIANO: If EMTALA applies and, for the reasons stated, I just don't think it does in this case. It just -- it just doesn't on the face of the statute.

THE COURT: All right. I understand that argument.

So on to the statute, looking at the substantive due process challenge to the statute, this is where the State -- I understand the State is not prepared to respond today. If,

once you hear my questions, you would like to say something, Ms. Norton or Mr. Castro, feel free to let me know.

For Mr. Snider, in the meantime, I mean, the process the Court goes through is clear, right? First I identify the fundamental interest at stake, and then I balance that against California's interests in enacting and applying the Uniform Determination of Death Act. And here I can find a fundamental right asserted, Israel's right to life and Ms. Fonseca's liberty interest in her parental interest in the care and control of her child. That's not the end of the inquiry, however. I then need to look at whether or not the statute creates an unconstitutional balance. And so here it's balancing the individual interests versus the demands of, as some courts have said, an organized society which has rules that we all play by.

So is that a fair characterization of my job?

MR. SNIDER: It is, Your Honor.

THE COURT: All right. And the California act, the statute is based on -- even if there are dissenters, it is based on a body of medical science, a reasoned debate, and it does -- that act does represent a clear at least majority view. Right? Since at least the -- I mean, I think Kansas was the first state to adopt some kind of statute.

By the early '80s at the latest, the uniform commission -- I mean, I think the definition of death has

changed.

MR. SNIDER: Certainly.

THE COURT: There is a historic, a historic prior conception that the majority embraced heartbeat and breath. And since the early '80s, at least with this uniform law commission having extensive debate, the majority definition has shifted to this notion of brain death, recognizing the role that medical equipment plays in maintaining and extending lives. Is that fair?

MR. SNIDER: That's correct.

THE COURT: So why -- how is that a substantive due process violation to have adopted the law that represents what is currently a majority view?

MR. SNIDER: The substantive due process problem is that when there is an evidentiary dispute -- in other words, a patient's advocate says I don't think that death has occurred, there's a misdiagnosis. Even taking this as -- without debating brain death, accepting the brain death is what it is, that there is no place in -- there is nothing in place that allows the patient, in this instance the parents of the patient, to independently challenge that with their own physician.

THE COURT: But that's a procedural due process concern.

MR. SNIDER: Yes.

THE COURT: What about substantive? What am I missing about substantive? And California's interests -- California has an interest in defining, in drawing the line between life and death for multiple reasons, right? You would concede that?

MR. SNIDER: Correct.

THE COURT: All right. So what's the substantive due process?

MR. SNIDER: They're depriving someone of life without -- when it is challenged without due process, without --

THE COURT: So let me -- so let's review procedural.

MR. SNIDER: Okay.

THE COURT: Because the law there does provide at least eight safeguards, correct? I'm looking at the California Health and Safety Code, looking at Section 7181 and also -- 7180, 7181, 7182, 7183 and then Section 1254.4 and its subsections.

And in particular, on the one hand, there is no private right of action provided, but an appropriate person can seek review of a decision in a state court.

MR. SNIDER: Well, I don't see -- I don't see the -- I'm not seeing the provision for the state court action, like a writ of mandamus or anything like that.

THE COURT: I'm looking at the Dority case, D-O-R-I-T-Y.

MR. SNIDER: Yeah, that's not within the statutory scheme.

THE COURT: Fair enough. But still the court, at least the appellate court has acknowledged that ability.

MR. SNIDER: Yes. Unfortunately it's not in the statutory scheme, and Kaiser's position has been that parents don't have a right to bring in their own physician to challenge the evidence. And so we think that that is a problem. We're not saying that they are misinterpreting CUDDA. Indeed, the problem is it doesn't -- it doesn't exist in the statute. We think that is fundamentally wrong.

You're essentially taking away a -- moving the goalpost 10 yards in, the goal line 10 yards in. And if someone disputes that -- again, agreeing with the definition of brain death, but disputes that brain death has actually occurred, there is no provision to allow -- to let them bring in their own physician. They can bring in -- if they were in court, they could have their own lawyer. If they were audited by the IRS, they could have their own CPA. But here they can't bring in their own physician, and they're being deprived, someone is being deprived of life, which is at the zenith of government interest.

THE COURT: But the state courts have acknowledged a right for an appropriate person to appeal to the state court.

MR. SNIDER: Yes, in Dority they have. But it's not in

the statute, and Kaiser is not -- on its face, it's not there. And Kaiser has said in court, in state court, that they -- that they don't have a right to do that. And I could -- that's been filed in evidence with the Court by Kaiser.

THE COURT: Given that the state courts have acknowledged the right of someone to appeal, why --

MR. SNIDER: Well --

THE COURT: -- why is that not the proper forum?

I know you've said there's no appeal of the state court action, you're not the attorney of that case. I understand that.

MR. SNIDER: Well, the question -- I'm sorry.

THE COURT: What makes the absence in that context --

MR. SNIDER: Uh-huh.

THE COURT: Again, looking at the language of the statute, are you saying because 1254.4 provides no private right of action, that alone grounds the due process challenge?

MR. SNIDER: It provides no private right of action and -- well, no, not 1254.4. That's just the accommodation, religious and physical accommodation statute. I'm talking about the determination of death, and that's at 7181.

And it says there shall be independent confirmation by another physician. Kaiser's position is they could bring in someone else from Kaiser. Our position is that if parents or an advocate of a patient cannot bring in their own physician to

independently verify this, then there is a problem, a constitutional problem.

THE COURT: I understand that argument.

MR. SNIDER: We do believe --

THE COURT: Is it a federal constitutional argument? I think that's the -- that's the question for purposes of establishing your burden under the preliminary injunction standard.

MR. SNIDER: We believe it is a federal constitutional issue because, of course, it is -- the Fourteenth Amendment says no state shall deprive someone of life without due process of law.

THE COURT: All right. I understand that argument.

Did you want to say something about this, Mr. Curliano?

MR. CURLIANO: Yes, I did, Your Honor. I just wanted to respond to what I believe is probably an inadvertent inaccuracy. And that is that Kaiser -- the representation was that Kaiser has told the parents that they cannot bring a physician in, that you must use a Kaiser physician.

The state court action, both the record and the briefs of which I signed and was part of, offered on numerous occasions, acknowledged by plaintiff's counsel on the record, to have a correctly certified, licensed, appropriate physician to come in, that they would designate. In fact, the court asked several times in four separate hearings have you located

a physician to examine Israel? In fact, Dr. Byrne, who is in the courtroom today, was with Israel I believe just last night at Kaiser, and he is an expert that has been retained by plaintiff.

So it is incorrect to say that Kaiser has said our doctors make the decisions, and your doctor, whoever it might be, does not have an opportunity to look at Israel. On the record in state court, the question was raised by the trial court judge about whether or not the statute on its face requires that the parents or the individual or guardian be given the opportunity to bring their own physician in, and the answer was on its face it does not.

But, under Dority, it clearly does. Because Dority says the process, the safeguards we're going to provide you as a court in California is, if you can show mistake, or you can show that the appropriate medical procedures in doing the evaluation were not followed, i.e. have a physician, an expert, someone come in and dispute that, then we as a court will evaluate whether or not the determination of death under CUDDA was appropriately done.

That was all done in the state court. There was a full opportunity to be heard. I just wanted to correct that one point that counsel had made.

THE COURT: All right. Any dispute with that clarification of the record?

MR. SNIDER: I would dispute that in two ways.

Number one --

THE COURT: Again, this is a facial challenge to the statute.

MR. SNIDER: That's correct.

THE COURT: So --

MR. SNIDER: That's correct.

And under -- under document 14-14 that's been filed with the Court, at page 36, starting at line 9, there was an interesting colloquy in the state court. The attorney for Kaiser was a Mr. Jones, and he says that:

(Reading.)

Under Health and Safety Code Section 7180 and 81, Israel has been found to be dead.

The Court: Therefore, the parents should not have the opportunity to have an independent evaluation.

Mr. Jones: We are the independent -- the court cuts him off.

The Court: They're not entitled to have their own independent evaluation at this point in time, somebody outside of Kaiser?

And the answer -- Mr. Jones: No.

So we think that that is an accurate representation.

THE COURT: But Kaiser is not on the hook for this claim, right?

MR. SNIDER: No, but --

THE COURT: For the constitutional claims.

I understand that you're clarifying the record here, but I'm looking at the facial challenge, and I -- Dority was a California appellate court decision. I know, again, you're not the state attorney, but a state appellate court could have been or could be available to review that, whatever happened in the state court below. Right?

What I'm looking at is the statute, and I don't think there's really -- I mean, you can't dispute what the statute says. A determination of death can only be made in accordance with accepted medical standards. Once an individual is pronounced dead, there shall be independent confirmation by another physician. That's the statutory language.

Physicians involved in the determination must not participate in any procedures to remove or transplant, so under girding the independence of the determination. Complete medical records must be maintained and preserved. Hospitals must have a policy for providing family with a reasonably brief period of accommodation, during which time the hospital is required to continue only previously ordered cardiopulmonary support. The hospital must provide a written statement of its policy. And if the family voices any special religious or cultural practices and concerns, then those need to be reasonably accommodated.

So that's the -- that, with the ability to appeal to a state court, why does that not provide for procedural due process?

MR. SNIDER: Absent from the face of the statute is a -- is a --

THE COURT: A private right of action.

MR. SNIDER: A private right of action. Not only private right of action, but some sort of a right to bring in your own private physician.

For example, Dr. Byrne was not allowed to examine the child and is here to testify.

THE COURT: That's not in the statute.

MR. SNIDER: That's not in the statute, yeah. But --

THE COURT: I'm looking at the statute.

MR. SNIDER: Sure. Okay.

And regarding the -- if it's Kaiser's position that simply going to state court is enough, we would say that that is a death sentence, for all practical purposes, for working class families. And if the Court would look at the two cases, umm, that were mentioned in the brief. One is Goldberg versus Kelly, and the other one is the Joint Anti-Fascist Committee.

It says notice -- a person has to have notice of the case against him or her and an opportunity to meet it, and it has to be tailored to the capacities and circumstances of those who are to be heard.

Going into -- if you have an emergency situation or where a hospital is saying someone is brain dead, and the parent is saying I don't think so and has medical -- has medical evidence that may not be the case, it is a monumental task to have to go into court to try to get a hearing on that.

You have -- in this case, you have a 23-year-old mother in pro per who files what she calls a petition in the state court. It's not even a complaint. And the -- and how is she going to be able, a working class family going to reasonably be able to -- to meet that process in court and their tremendous time constraints.

I mean, look, she goes up -- she's going up against very fine counsel and also -- who has now brought in a former Solicitor Attorney General -- a Solicitor General and also the Attorney General. It's very difficult. And to be able to simply say you can go to state court and sue, if you like, we don't think that that is due process.

THE COURT: All right. I believe I understand that argument.

Ms. Norton, is there anything you wish to say at this point in time? I understand that, if I'm inclined to or if I'm seriously considering granting the injunction based on the constitutional attack on the statute, that you're requesting a chance to brief, and I would provide that opportunity.

MS. NORTON: Yes, Your Honor. There's nothing else

that we'd like to add at this time.

THE COURT: All right. Mr. Curliano, anything further?

MR. CURLIANO: One last thing briefly, Your Honor.

There were some sound bites during argument, and if the Court has any questions, certainly we provided an entire transcript from the state court case, not just the exchange with Mr. Jones that was taken out of context.

And one thing I go back to, kind of where we started, which is in response to what counsel has argued, Kaiser has done nothing wrong. We did everything right in this case. This is not like some of the other cases that the people hear about and have talked about. This child came from U.C. Davis after being at another hospital even before he went to Davis, and was actually brought to Kaiser independent, stable and the condition he was in. A determination at Davis had been made, at U.C. Davis, by competent physicians that he had clinical signs of brain death, and they did the tests that are appropriate.

When he comes to Kaiser, Kaiser is in this particular case that independent body, that wasn't involved in any way in the medical treatment being provided or not provided that caused whatever condition Israel has, and we had two separate physicians. So we didn't even rely on what U.C. Davis did, but we believe it's correct. We had two different physicians at our facility perform the tests pursuant to guidelines that are

accepted by a number of medical organizations, and they both came to the same conclusion.

And unless there are any particular points, Your Honor, that you'd like me to address, I think we've fairly commented on the points.

THE COURT: All right. I have no further questions.

Is there anything else you want to say, Mr. Snider?

MR. SNIDER: Just briefly, and I will not burden the Court.

There is -- of course, we are here on a preliminary injunction to have the -- have the TRO superseded by preliminary -- by preliminary injunction. There are four prongs. There's only one prong that is really at issue, and that is the serious questions. And we believe that with EMTALA and the -- and the state -- or I'm sorry -- the state actor claim, we believe that we have crossed that threshold. It is not a -- it is not an insurmountable obstacle.

And I would just close with, when there's a sliding scale, and we have three of the prongs which are very profoundly in favor of a plaintiff, and the only other prong left is serious questions, we again think we've met that.

And I would close with this, if I may, if the Court will indulge me, to read a very brief passage from Cruzan.

An erroneous decision not to terminate results in the maintenance of the status quo. The possibility is subsequent

developments such as advancements in medical science, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible to correction.

Thank you, Your Honor.

THE COURT: All right. Let me just ask you one last question procedurally.

I've asked the State -- if I'm inclined to grant, I'll give the State an additional chance to brief, and I'll have you back here most likely with a reply and allow further argument. If I deny, would you be asking for a stay of that decision so you can seek immediate review from the circuit?

MR. SNIDER: Yes, that's correct, Your Honor.

THE COURT: All right. All right. I assumed as much, but I wanted to make certain I understood that.

All right. I do -- I understand I have an important decision to make. I will make it as quickly as I can. You will likely see an order before the end of the week.

MR. SNIDER: All right.

THE COURT: All right. Thank you very much.

MR. CURLIANO: Thank you, Your Honor.

MR. SNIDER: Thank you, Your Honor.

THE CLERK: Court is in recess.

(Proceedings were concluded at 4:38 p.m.)

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I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Kathy L. Swinhart
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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA,

Plaintiff,

v.

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, DR. MICHAEL MYETTE M.D., KAREN SMITH, M.D. in her official capacity as Director of the CALIFORNIA DEPARTMENT OF PUBLIC HEALTH and DOES 1 THROUGH 10, INCLUSIVE,

Defendants.

Case No: 2:16-CV-00889-KJM-EFB

KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

Date: May 11, 2016
Time: 3:30 p.m.
Courtroom: 3
Hon. Kimberly J. Mueller

Complaint Filed: April 28, 2016

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I. INTRODUCTION

A consensus opinion has existed in the medical community for well over thirty years that an individual who has sustained irreversible cessation of all functions of the entire brain, including the brain stem, is dead.[1] During two separate examinations the physicians at Kaiser Roseville[2] exercised their sound clinical judgment and followed well established medical guidelines in concluding that Israel Stinson had experienced irreversible brain death. These guidelines were formulated and adopted by professional medical organizations and they have become well accepted in the medical community.[3] [4] The determinations made by the physicians at Kaiser Roseville were consistent with a separate, clinical diagnosis of brain death that had been made earlier by physicians at the University of California Davis Medical Center in Sacramento ("UCD Medical Center").

Having unsuccessfully challenged these determinations before a California state court, Plaintiff Jonee Fonseca now seeks to have a second legal forum adjudicate many of the same issues, under the premise that California's Uniform Determination of Death Act ("CUDDA") violates her rights, as Israel's mother, to procedural and substantive due process under the Fourteenth Amendment. Plaintiff's claims must be rejected. First, neither Kaiser Roseville nor its physicians are state actors subject to constitutional attack. Just as a priest does not become a state actor when he signs a marriage license, neither do Kaiser Roseville or its doctors become state actors when they attest to the medical fact of death on a death certificate pursuant to CUDDA.

Second, plaintiff's constitutional claims are without factual or legal support. Plaintiff's procedural due process claim disregards the extensive process CUDDA affords, and which plaintiff

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[1] The determination of death by neurological criteria, e.g., "brain death", has been determined to constitute death in all jurisdictions in the United States and in most other developed countries. *See* J.L. Bernat, The Whole-Brain Concept of Death Remains Optimum Public Policy, 34(1) J.L. Med. & Ethics 35-43 (2006), Dec. Curliano, Ex. M; D. Gardner, *et al.*, International Perspective on the Diagnosis of Death, 108 British J. Anesthesia i14-i28 (2012), Dec. Curliano, Ex. N.

[2] The use of "Kaiser Roseville" in the brief refers to the specific Kaiser Permanente medical facility where Israel was transferred.

[3] See Nakagawa, TA. *Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations –Executive Summary*, Annals of Neurology, 2012, Vol. 71, pp. 573-585 9 (hereinafter referred to as "Guidelines"). Dec. Curliano, Ex. L.

[4] Israel met the clinical criteria for brain death as laid out and accepted by the medical community, including the: 1) Pediatric Section of the Society of Critical Care Medicine, Mount Prospect, IL; 2) Section on Critical Care Medicine of the American Academy of Pediatrics, Elk Grove Village, IL; 3) Section on Neurology of the AmericanAcademy of Pediatrics, Elk Grove Village, IL; and 4) Child Neurology Society, St. Paul, MN.

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was given in state court. During the state court proceedings, plaintiff was provided a full evidentiary hearing, the ability to present witnesses and evidence, and continuances by the trial court to locate and retain qualified physicians competent to testify that Israel had not experienced brain death. [5] At the end of these proceedings, the state court concluded there was no factual or legal basis for calling into question the findings made by the physicians at two separate medical facilities. In fact, plaintiff failed to present a single live witness to dispute the detailed testimony from Dr. Myette, Israel's primary physician at Kaiser Roseville, regarding his medical determination that Israel had an irreversible cessation of all brain functions such that in his opinion, and the opinion of his colleagues, Israel had experienced irreversible brain death. [6]

Plaintiff's substantive due process claim is equally weak. Plaintiff cannot point to a single case or constitutional provision that would justify an extraordinary judicial action overriding the considered judgment of the California Legislature, the larger medical community, and the medical professionals at Kaiser Roseville. The Constitution and the court system are not appropriate vehicles for seeking to overrule the medical judgment of physicians at two separate medical facilities, as well as the determination made in the state court case that this clinical judgment was exercised appropriately, professionally, and in conformity with well-established standards in the medical community.

Plaintiff also asserts that Kaiser Roseville and Dr. Myette violated the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd. EMTALA mandates that hospitals treat living patients with "emergency conditions." It does not require doctors to disregard

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[5] The Reporter's Transcript from the state court proceedings is attached as Exs. C, E, G and K to the Declaration of Jason J Curliano ("Dec. Curliano") filed on May 1, 2016 (DOC. #14). The relevant portions of the filings in state court are attached as Exs. A, B, D, F, H, I, and J to Dec. Curliano. The record from the state court action shows that Kaiser Roseville was ready to provide medical privileges at its facility to an appropriately qualified physician identified by plaintiff. The record also shows that Kaiser Roseville worked with plaintiff and her attorneys in putting the staffing in place to assist in transferring Israel to a medical facility that agreed to accept him. Plaintiff was apparently unable to obtain confirmation from an appropriate medical facility that it would accept Israel.

[6] The only "medical" evidence presented by plaintiff in the state court action was in the form of a declaration from D. Paul Byrne, a retired pediatrician and neonatologist. This same declaration was submitted by plaintiff as part of the papers she filed in federal court. Dr. Byrne is not licensed to practice in the State of California and he has no specialty in neurology. Additionally, his opinions are essentially that California law, the law of other states, and the medical community in general, are all wrong in using brain death as a medical definition of death. He believes there can be no finding of death if a patient still breaths and has a beating heart. In Israel's case, these functions are being sustained by artificial means.

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their own clinical opinions and ethical obligations by performing unnecessary and invasive procedures on a deceased patient. Indeed, as many courts have made clear, EMTALA does not impose the type of unlimited duty to provide medical treatment that plaintiff seeks in this case.

Finally, plaintiff's claims essentially ask this Court for a redo of the state court proceedings. Despite plaintiff's assurances that "this Court is not being asked [by plaintiff] to reconsider or reverse any aspect of the [California] Superior Court's actions," the vast majority of plaintiff's amended complaint, motion, and the accompanying declarations simply attack the medical determinations made by the physicians at Kaiser Roseville and UCD Medical Center, and thus the ruling made by the state court accepting those determinations as sound and in compliance with California law. The *Rooker-Feldman* doctrine precludes relitigation of these questions.

For this reason, and those discussed above, plaintiff's request for a preliminary injunction should be denied and the temporary restraining order that is currently in place dissolved.

II. STATEMENT OF RELEVANT FACTS AND PROCEDURAL HISTORY

A. Chronology of medical treatment.

Israel presented to the emergency room at Mercy Hospital on April 1, 2016. Given the severity of his condition, Mercy Hospital transferred Israel to the Pediatric Intensive Care Unit at UCD Medical Center. While undergoing care at UCD Medical Center, Israel suffered a severe respiratory attack, which progressed to a cardiac arrest. While Israel's caregivers struggled to save his life, his lungs were so weak, and his health so poor, that he could not adequately respond to medical treatment. After more than 40 minutes of CPR, UC Davis physicians managed to restore cardio-pulmonary functioning with mechanical support. Given the length of time Israel was without oxygen, UC Davis physicians were concerned the anoxic episode had resulted in brain death. The physicians performed an examination to determine his neurological status. The results were consistent with brain death. In addition, a nuclear medicine flow study showed no evidence of cerebral profusion.

UC Davis physicians advised Israel's parents they intended to perform a second brain death examination. They explained an unfavorable result in a second brain death examination would result

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in Israel being declared legally dead. Prior to UC Davis physicians performing a second brain death examination, Israel's parents arranged to have him, while on mechanical cardio-pulmonary support, transferred to Kaiser Roseville for a second opinion.

On April 12, Kaiser Roseville admitted Israel with his parent's consent to perform a second brain death examination. That evening, Kaiser Roseville performed a brain death examination, which included a clinical exam, neurological evaluation and apnea test. The results indicated brain death.[7] On April 14, the physicians at the hospital performed yet another examination, Israel's third determination for brain death. The third examination once again confirmed brain death. The family was notified, and the "reasonably brief period of accommodation" under Health and Safety Code § 1254.4, which is intended to allow the family and next of kin time to gather at the patient's bedside, began.

In accordance with well-accepted medical standards, a declaration of death was issued. Israel's primary attending physician, Dr. Myette, identified the primary causes of death, then fulfilled his administrative duties as a physician by filling out the State's preprinted Certification of Death form. Dr. Myette had no interaction with anyone from the State and his determination of Israel's cause of death was based upon his own education, training, experience and clinical judgment. The Certification was then transmitted to the California Department of Public Health on April 18 by Decedent Affairs, a department at Kaiser Roseville that handles issues relating to the passing of a patient at the facility. Although a medical determination of brain death has been made, the Certification is not completed. Israel's parents have not completed the remaining part of the form identifying their wishes with respect to the transfer of Israel's body. The Certification remains with the Department of Public Health until such time as the parents complete the form or a final decision is rendered in state or federal court.

B. Plaintiff's state court action.

Shortly after Israel was declared brain dead on April 14, plaintiff petitioned a California Superior Court for a temporary restraining order preventing Kaiser Roseville from withdrawing

[7] Sedative medication was last administered on April 2, 2016.

cardio-pulmonary support. Plaintiff also requested time for an independent neurological exam and requested that Kaiser Roseville maintain the level of care Israel had been receiving prior to being declared dead. The court granted plaintiff's request for a temporary restraining order and set the matter for a full hearing on April 15. The order required Kaiser Roseville to continue providing cardio-pulmonary support and to continue providing medications currently administered, with necessary adjustments to maintain his condition.

On April 15, the parties, including plaintiff and Israel's father, appeared for the hearing in state court. Represented by counsel, plaintiff requested a two-week continuance of the TRO in order to have an independent brain death determination performed. Counsel represented that the family was being advised by an out-of-state physician who would find a physician licensed in California to perform an independent examination. During the proceeding, Kaiser Roseville offered testimony from Dr. Myette, Israel's attending physician. Dr. Myette described Israel's clinical course starting from April 1, 2016, explained that a determination of brain death in children is a clinical diagnosis based on the absence of neurologic function, and testified that the Guidelines recommend two examinations, including apnea testing, with each examination separated by an observation period.

The neurological examination described by Dr. Myette during the hearing involves a finding of complete loss of consciousness, vocalization, and volitional activities. The patient must lack evidence of responsiveness with an absence of eye opening or moving in response to noxious stimulant.[8] The examination also assesses for the loss of all brainstem reflexes including: no response by the pupils to light, the absence of movement of bulbar musculature including facial and oropharyngeal muscles, no grimacing or facial movements in response to deep pressure on the condyles and supraorbital ridge, the absence of gag, cough, sucking and rooting reflex, the absence of corneal reflexes, and the absence of oculovestibular reflexes. The apnea test measures the existence or absence of a patient's breathing drive (the ability to draw a breath) by challenging the respiratory system with CO2. Taken together, the clinical evaluation, neurological examination and

[8] Even in brain death, certain non-purposeful muscular movements may occur. These movements do not negate the diagnosis of brain death. Plaintiff has not identified any California licensed physician who will provide competent medical testimony to the contrary. No such testimony or evidence was provided in the state court case

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apnea test evaluate for brain death. After listening to Dr. Myette and giving plaintiff the opportunity to present any competent evidence or testimony in support of her case (an opportunity plaintiff did not take advantage of), the court issued an order continuing the restraining order for one week to April 22, 2016. The additional time was to provide plaintiff with an opportunity to have an independent examination performed.

On April 22, plaintiff's counsel advised the court that the family intended to transfer Israel to Sacred Heart Medical Center in Spokane, Washington. To facilitate the transfer, the parties entered into a detailed stipulation, which the court incorporated into an order. The restraining order and related conditions were to stay in effect until April 27, 2016. The parties agreed and were ordered to work together to facilitate the transfer, which they did. Ultimately, Sacred Heart declined Israel's admission. Israel continued to remain at Kaiser Roseville.

On April 27, plaintiff's counsel requested an additional two-week continuance to continue her efforts to find a suitable facility to transfer Israel to and to find a physician who would perform another brain death evaluation. Plaintiff also requested that Kaiser Roseville be ordered to install a percutaneous endoscopic gastrostomy tube or "PEG tube" and a tracheostomy tube. Plaintiff represented that these procedures would help to facilitate transfer to another facility or to home care. Plaintiff only provided declarations from Dr. Byrne (see ft. nt. 6) and a critical care coordinator to support her request for an additional continuance. The court denied plaintiff's request and found that plaintiff failed to present competent medical evidence showing a mistake in the determination of brain death or a failure to use accepted medical standards in making that determination. The court ordered that the TRO would remain in effect until April 29, in order to fulfill Kaiser Roseville's obligation to provide the family with a reasonable period of time under Health & Safety Code § 1254.4 to gather at Israel's bedside.

On April 29, the parties appeared in state court again. At this final hearing, the court dissolved the TRO and ruled that "Health and Safety Code sections 7180 and 7181 have been complied with" by Kaiser Roseville and its physicians. Plaintiff made no request to keep the TRO in place so that plaintiff could file an appeal in state court, nor has she since requested the state

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appellate court to keep it in place until such an appeal could be heard.

Although there is no winner in a case like this, plaintiff's claim that she "did not lose in state court" is clearly not supported by the record and the state court's rulings. The determinations of brain death made by physicians at UCD Medical Center and Kaiser Roseville that are being challenged by plaintiff were found by the state court to have been made in conformity with accepted medical standards and protocol.

C. The inaccurate factual claims in plaintiff's motion.

In her motion, plaintiff makes a number of factual assertions and claims against Kaiser Roseville that have no evidentiary support and in most instances are simply wrong. For example, plaintiff asserts that "KPRMC has refused to provide such treatment [nutrition, including protein and fats] stating that they do not treat or feed brain dead patients." Putting aside the fact this statement overlooks the exemplary care that has been provided by physicians, nurses and caregivers at Kaiser Roseville since Israel was admitted on April 12, it fails to acknowledge that the physicians have been using their clinical judgment in managing what is admittedly a difficult situation for all involved. This includes the administration of medications needed to keep Israel's heart and lungs working. It also includes clinical management of the ventilator, without which Israel would be unable to breathe. In state court, plaintiff requested that the court direct the physicians to do more, including introducing protein and fats into Israel's non-functioning gut. The court found there was no medical or legal basis for directing physicians at Kaiser Roseville to take these steps. The court also acknowledged that given the medical determination of brain death, certain procedures that were being requested by plaintiff raised serious medical ethical concerns in the court's mind since the court was being asked to direct physicians to provide treatment they felt was not medically warranted or appropriate.

Plaintiff states in her motion that Israel "has taken breath[s] off of the ventilator" and that he "has also begun moving his upper body in response to his mother's voice and touch." Although it is understandable that a parent in plaintiff's position would want to look for any signs of improvement or brain function, in the case of Israel, what plaintiff may be noticing has nothing to do with Israel's

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brain function. The injury to his brain and brain stem is irreversible. As Dr. Myette explains in his declaration, the "breath[s]" that plaintiff believes she sees are not Israel breathing on his own, but rather they are caused by an artificial triggering of the reading on the ventilator given the sensitivity of the settings. Dec. Dr. Myette, Para. 14. Approximately a week ago when plaintiff first pointed out what she believed were signs Israel was breathing on his own, Dr. Myette suggested he could perform another apnea test that would confirm what the three (one at UCD Medical Center and two at Kaiser Roseville) previous apnea tests had confirmed—which is that Israel's lungs cannot inhale or exhale without being hooked up to a ventilator. Plaintiff stated she did not want the test to be done. Dec. Dr. Myette, Para. 14. With respect to any movement seen on the videos, these involuntary movements are spasms that emanate from the spine. Dec. Dr. Myette, Para. 10, 11, 12. They do not indicate that his brain is responding to external stimuli. Dec. Dr. Myette, Para. 10, 11, 12.

D. The process associated with completing and filing a death certificate.

California has developed a statutory framework that covers the administrative act of completing and recording a Death Certificate once a medical determination has been made that an individual is deceased. The California Department of Public Health is required to maintain birth, marriage, and death certificates. Health & Safety Code § 102100. Pursuant to Health & Safety Code § 102755, within eight days of death, each death must be registered with the local registrar of births and deaths "in the district in which the death was officially pronounced or the body was found." A funeral director, or person acting in lieu of a funeral director, is required to prepare the death certificate. A certification by a physician is required to be completed within fifteen hours of death, if completed by the attending physician, or within three days of the examination of the body if completed by the coroner. Health & Safety Code § 102800. An attending physician must notify the coroner's office of the death in cases in which the death occurs without medical attendance; during the continued absence of the treating physician or surgeon, where the attending physician cannot determine cause of death; where suicide is suspected; following an injury or accident; or under any circumstances as to afford a reasonable ground to suspect the death was caused by a

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criminal act. Health & Safety Code § 102850; Govt. Code § 27491. The local registrar is required to accept the registration of the death certificate and note the date of acceptance. Health & Safety Code § 102875(a)(8).

A coroner is charged with determining the cause of death in a variety of circumstances, none of which are present in this case. Health & Safety Code § 102850. In any case in which the coroner performs an inquest into cause of death, the coroner shall sign the death certificate. Govt. Code § 27491(a). In cases in which a coroner is not involved, a funeral director prepares the death certificate. The death certificate is registered with the local county registrar and then maintained by the California Department of Public Health Vital Records.

IV. LEGAL ANALYSIS

A. Plaintiff is unable to establish a substantial likelihood of success on the merits or that there are serious questions going to the merits of her claims.

A plaintiff moving for injunctive relief "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008), citing *Munaf v. Geren,* 553 U.S. 674, 689-690 (2008); *Amoco Production Co. v. Gambell,* 480 U.S. 531, 542 (1987); *Weinberger v. Romero–Barcelo,* 456 U.S. 305, 311–312 (1982).

a. Kaiser Roseville and Dr. Myette are not state actors.

Plaintiff argues that Kaiser Roseville and Dr. Myette are state actors given the "coercive nature of the challenged statute and the degree to which the state and KPRMC are entwined in these types of life-and-death decisions." In addition, plaintiff alleges in her amended complaint that "KPRMC receives funding from the state and federal government which is used to directly and indirectly to provide healthcare services to individuals including but not limited to Israel Stinson."

Neither of plaintiff's claims establishes that Kaiser Roseville or Dr. Myette is a state actor. First, the mere fact a hospital or private institution receives funds from the state or federal government does not turn a private party into a state actor. In *Jackson v. East Bay Hospital,* 980 F. Supp. 1341, 1357-58 (N.D. Cal. 1997), the Court ruled that a private hospital "cannot be deemed a

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state actor merely because they are recipients of state or federal funding . . . such as Medicare, Medicaid, or Hill-Burton funds." *See also Taylor v. St. Vincent's Hospital,* 523 F.2d 75, 77 (9th Cir. 1975) [receipt of public funds under the Hill-Burton Act was not proper grounds for finding a private hospital to be a state actor for purposes of 42 U.S.C. § 1983]; *Rendell-Baker v. Kohn,* 457 U.S. 830, 840 (1982) [privately operated school not deemed to be a state actor even though "virtually all of the school's income was derived from government funding"].

Nor has plaintiff established that the involvement of an admittedly private medical facility like Kaiser Roseville and a private citizen like Dr. Myette with the state on issues of "life-and-death" transform either private party into state actors. *See Blum v. Yaretsky,* 457 U.S. 991, 1004 (1982). Plaintiff argues that defendants made a medical determination that Israel was dead, they completed the necessary paperwork after this medical determination was made, and that this medical decision was based upon the definition of death contained in CUDDA.

But, as plaintiff concedes, state regulation of the medical profession, including promulgating guidelines that must be followed, does not make a private party a state actor. Instead, where, as here, a private party exercises their judgment according to professional standards not dictated by the state, that party cannot be said to be a state actor. In *Pinhas v. Summit Health, Ltd.,* 894 F.2d 1024 (9th Cir.1989), the plaintiff filed suit claiming the medical facility violated his right to due process under the Fourteenth Amendment by revoking his medical privileges. As here, the plaintiff argued in *Pinhas* that the statutory scheme followed by the hospital in terminating his privileges, including its submission of a report to the state, made the hospital a state actor. The court rejected that argument, stating that "[t]he central inquiry in determining whether a private party's actions constitute 'state action' under the fourteenth amendment is whether the party's actions may be 'fairly' attributed to the State." *Id.* at 1033. Because the decision in question "ultimately turned on the judgments made by private parties according to professional standards that are not established by the State," the Court held that plaintiff had not demonstrated that the regulated party had been converted into a state actor. *Id.* 1034, quoting *Blum v. Yaretsky,* 457 U.S. at 1004 (1982).

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The same is true in this case. As in *Pinhas*, licensed physicians, like those caring for Israel at UCD Medical Center and Kaiser Roseville, exercise their own clinical judgment in making a medical determination that an individual has experienced brain death. This determination was made on three separate occasions in Israel's case. No one from the State was involved in the medical decision making process at either facility. Additionally, CUDDA, and in particular Health & Safety Code § 7180(a)(2), defers to physicians in determining whether death has occurred by providing that "A determination of death must be made in accordance with accepted medical standards." CUDDA and the California Legislature have not defined those standards, nor have they coerced private parties into adopting or using a particular set of standards mandated by the State. *See* ft. nt. 1, 3 and 4. Under such circumstances, it simply cannot be said that Kaiser Roseville or Dr. Myette's actions are "fairly attributed to the state." *See also Safari v. Kaiser Foundation Health Plan,* 2012 WL166935 (N.D. Calif. 2012).

The Supreme Court in *Blum, supra,* addressed a claim similar to the one plaintiff is making in this case: Does a state's implementation and enforcement of certain regulatory requirements covering healthcare facilities makes the actions of the private facilities those of the state for purpose of creating liability under 42 U.S.C. § 1983? The Court in *Blum* held that regulations imposed by the state, including the use of particular forms in making decisions regarding the level of care to be provided under Medicare (42 U.S.C. § 1396 *et seq.*), did not make the state liable for the actions of the private medical facilities. The Court rejected the argument that healthcare providers were "affirmatively commanded" by the State to make medical decisions regarding the discharge or transfer of patients. The Court noted that, "the physicians, and not the forms, make the decision about whether the patient's care is medically necessary....We cannot say that the State, by requiring completion of a form, is responsible for the physicians decision." *Id.* at 1006. The Court also found it significant that the decisions by the providers that were alleged to be state action "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008, citing to and quoting *Polk County v. Dodson,* 454 U.S. 312, 318 (1981).

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Plaintiff makes an unsubstantiated assertion that CUDDA "coerces" California physicians to practice medicine in a particular manner and that it prevents them from exercising their own clinical judgment in accordance with well accepted medical standards. There is absolutely no legal analysis to support this argument, nor is there any evidence that the Legislature in enacting CUDDA dictates or intended to dictate to physicians how they should practice medicine or exercise their clinical judgment in caring for patients. The fact CUDDA provides very general procedural guidelines for the testing associated with determining whether there is brain death does not convert the actions of a private party into those of the state. *See Blum*, 457 U.S. at 1006, 1008 (1982). Nor is it true that "CUDDA defines death," for it is clear that physicians and professional organizations, of which California physicians are members, establish when brain death occurs. These organizations also promulgate medical guidelines that are used by physicians when making this determination. See ft. nts. 1, 3 and 4.

Accepting plaintiff's argument that the State, through CUDDA, has allegedly "defined" death (as opposed to simply adopting the definition developed by the medical community) such that all medical institutions and physicians making this determination become state actors would expand the definition of a state actor beyond constitutional limits. Would plaintiff also argue that a pastor or priest who performs a marriage and signs the marriage license pursuant to state law is a state actor? Does the fact that the state sets parameters for issuing birth certificates transform the medical care a hospital and its doctors provide during birth, and the later administrative functions of issuing a birth certificate, mean that the hospital and doctors are state actors? Although birth, marriage and death are all regulated and defined by states, the actions of private parties in complying with these statutory guidelines does not convert those actions into actions of the state. In the context of this case, plaintiff's argument, taken to its logical conclusion, would mean that almost all medical treatment and services provided by a private medical facility is conduct by the state. Every procedure and treatment, including the exercise of clinical judgment by physicians, would carry with it potential constitutional implications. Plaintiff has not provided any legal support for such an expansive definition of what constitutes a state actor.

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b. Plaintiff has not established a likelihood of success that Fourteenth Amendment Due Process is implicated by the medical decisions made in this case.

Plaintiff's due process claims are wholly without merit. Kaiser Roseville and Dr. Myette respect plaintiff's sincerely held beliefs and do not seek to change or override them in any way. But those beliefs do not create any affirmative obligation on the part of the hospital and its dedicated medical professionals to act contrary to medical science and their own — and their profession's — ethical standards. *Cf. Pickup v. Brown*, 42 F. Supp. 3d 1347, 1373 (E.D. Cal. 2012) ["[W]hile parents have a fundamental right to decide whether to avail themselves of state-regulated mental health professionals, they do not have a fundamental right to direct the state's regulation of those professionals."].

Plaintiff points to nothing in the Constitution or in case law that would justify an extraordinary judicial action overriding the considered judgment of the California Legislature, the larger medical community, and the medical professionals involved in this case. Nothing plaintiff cites supports the novel proposition that there is a constitutional right to force medical providers to impose treatment on a deceased individual—treatment that is unwarranted, futile and unethical.

Plaintiff is unable to point to a single state or federal court decision that holds or even suggests that a parent's right to make medical decisions for her child includes the right to tell the state and the physicians practicing in the state how they must define death. And understandably so, as all fifty states (and the District of Columbia) have adopted some statutory definition of death like the one contained in CUDDA. Recognizing plaintiff's argument in this case would render all of those statutes facially unconstitutional. *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997) [refusing to strike down Washington's ban on physician assisted suicide on substantive due process grounds where to do so would have invalidated "the considered policy choice of almost every State"].

Accepting plaintiff's position would leave states and medical professionals without any way to determine when, as a legal matter, one of its citizens has died. That is not and cannot be the law. Determining when an individual has died is a fundamental obligation of the medical community and the states in which the community practices. Fulfilling that obligation serves many

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important functions including (1) protecting the dignity of a state's citizens; (2) promoting public health; (3) upholding the integrity of the medical profession by not forcing physicians to provide treatment and perform invasive procedures on deceased individuals; and (4) providing for the orderly administration of estates and death benefits. *See Glucksberg*, 521 U.S. at 731 ["The State . . . has an interest in protecting the integrity and ethics of the medical profession"]; *Rubin v. Coors Brewing Co.*, 514 U.S. 476, 485 (1995) ["[T]he Government has a significant interest in protecting the health, safety, and welfare of its citizens."]; *Cunnuis v. Reading School District*, 198 U.S. 458 (1905) [upholding state statute relating to the administration of estates of persons presumed to be dead]. Plaintiff's procedural due process claim fares no better. Under CUDDA, a patient can only be declared legally brain dead upon the independent determination of two physicians, according to accepted medical standards. Health and Safety Code §§ 7180 and 7181. If there is still a dispute as to those independent determinations, a party can seek review in state court. *Dority v. Superior Court*, 145 Cal. App. 3d 273, 280 (1983). As plaintiff was afforded here, the party seeking review can obtain a full evidentiary hearing, has the ability to present their own witnesses and evidence, including the ability to retain qualified physicians to testify on her behalf. This type of pre-deprivation, court adjudication is the gold standard of procedural due process.

c. Plaintiff is unable to establish a likelihood of success on her EMTALA claim.

The plain language of EMTALA makes clear that it does not apply to the administration of medications and artificial mechanical support to maintain Israel's physiological condition. He is not presenting to an emergency department in need of "medical screening" or "stabilizing" medical treatment. *See* EMTALA, 42 U.S.C. § 1395dd. Israel has been determined to have suffered brain death, an irreversible condition that medicine cannot stabilize or cure. Nothing in EMTALA covers the treatment of a patient like Israel who was transferred to Kaiser Roseville almost a month ago.

It is undisputed that Israel was admitted to Kaiser Roseville on April 12. It is also undisputed that Israel has been at the facility since that time. He has not been transferred or moved to any other medical facility, but rather has received exemplary care from the physicians, nurses and caregivers at Kaiser Roseville. Plaintiff disregards the reality of the admission and care that has been provided

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in making an unsubstantiated and factually meritless claim in her complaint and motion that Kaiser Roseville has not complied with EMTALA.

In support of its EMTALA claim, plaintiff erroneously relies on *In the Matter of Baby K,* 16 F.3d 590 (4th Cir.1994) to argue that Kaiser Roseville and its physicians are required to perform procedures on Israel in contravention of their medical opinion and ethics. *Baby K* is easily distinguishable from this case and no longer even good law for the principle for which plaintiff cites to it. In *Baby K*, the Fourth Circuit held that EMTALA required the hospital to continue to stabilize and, if necessary, admit an anencephalic child presented to the emergency department. There was no suggestion that Baby K was brain dead. To the contrary, in support of its decision, the Court noted the hospital admitted that "Baby K [had] reside[d] at [a] nursing home for months at a time without requiring emergency medical attention." *Id.* at 596. In other words, when the child presented to the emergency department she was in need of treatment to stabilize her condition simply so she could return to the nursing home.

Subsequent to its decision in *Baby K*, the Fourth Circuit revisited the reach of EMTALA as it relates to a patient that was admitted to a hospital where she resided for twenty days before passing away. *Bryan v. Rectors and Visitors,* 95 F.3d 349 (4th Cir. 1996). In *Bryan*, the District Court found that EMTALA did not apply once the patient was stabilized and admitted to the hospital. The Fourth Circuit affirmed the lower court's ruling. The Court rejected plaintiff's argument that once admitted, EMTALA required the hospital to continue to "stabilize" the patient for an indefinite period of time. In reviewing a number of cases interpreting EMTALA, the Court recognized that EMTALA is "a limited 'anti-dumping' statute, not a federal malpractice statute." *Id.* at 351. This means that "[o]nce EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition . . . the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law.. . " *Id.*

The clear statutory language in EMTALA and Court's decision in *Bryan* supports the conclusion that EMTALA simply does not apply where, as here, the patient has experienced irreversible brain death. Accordingly, there is no likelihood that plaintiff will prevail on this claim

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or her request for injunctive relief premised on an alleged violation of the statute.

B. Plaintiff's request that defendants do more than maintain the status quo while the legal issues are decided should be denied.

a. Under California law, physicians are not required to participate in medical procedures they believe would not improve the condition of the patient.

Plaintiff provides no legal support for her request to have physicians perform invasive medical procedures on Israel who has been declared legally dead. There is nothing in the language of Health & Safety Code § 1254.4 that requires this to be done. California enacted a detailed statutory framework governing when a physician may refuse to provide medical care that the physician believes would not improve the condition of the patient. Probate Code § 4735 provides: "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution." In addition, Probate Code § 4654 provides, "This division does not authorize or require a health care provider or health care institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or health care institution." Finally, Probate Code § 4736 provides guidelines for the transfer of a patient with respect to pain medication and palliative care.

In *Barber v. Superior Court*, 147 Cal.App.3d 106, 1018 (1983), a criminal case against two physicians, the court affirmed the general principle that a physician has no duty to continue treatment that is ineffective:

> A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless.... If the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery. (Horan, Euthanasia and Brain Death: Ethical and Legal Considerations (1978) 315 Annals N.Y.Acad. **217 Sci. 363, 367, as quoted in President's Commission, supra, ch. 5, p. 191, fn. 50.)

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b. Plaintiff has not provided any legal authority to support her argument that defendants can be ordered to do more than maintain the status quo for a patient that has been declared to be legally brain dead.

Plaintiff suggests that her request for a preliminary injunction is one that only concerns enjoining the removal of cardiopulmonary "life-support." See Pltf's Notice of Motion, pg.2:12-13. However, her motion and amended complaint clearly indicate that plaintiff is seeking to require Kaiser Roseville and Dr. Myette to affirmatively undertake certain medical actions. An injunction which "'affirmatively require[s] the nonmovant to act in a particular way, is mandatory and disfavored." *Newland v. Sebelius,* 881 F.Supp.2d 1287, 1293 (D. Colo. 2012).) "When a mandatory preliminary injunction is requested, the district court should deny such relief ' "unless the facts and law clearly favor the moving party." ' " *Stanley v. University of California,* 13 F.3d 1313, 1320 (9th Cir. 1994). Mandatory injunctions are not granted in doubtful cases. Rather, it must be shown the plaintiff has a strong likelihood of success on the merits. *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.,* 571 F.3d 873, 879 (9th Cir. 2009). The Ninth Circuit has concluded that a mandatory injunction "goes well beyond simply maintaining the status quo Pendente lite." *Anderson v. U.S.,* 612 F.2d 1112, 1112 (1980). The status quo is ''the last, uncontested status which preceded the pending controversy." *Regents of Univ. of California v. Am. Broad. Companies, Inc.,* 747 F.2d 511, 514 (9th Cir. 1984), quoting *Tanner Motor Livery, Ltd. v. Avis, Inc.,* 316 F.2d 804, 809 (9th Cir. 1963).

The terms of the proposed preliminary injunction requires Kaiser Roseville and its physicians to perform medical procedures and treatment that go far beyond that needed to maintain the status quo. Moreover, these procedures and treatment will not change Israel's irreversible medical condition. As Dr. Myette explained in the state court action, Israel's organs, such as his kidneys, "are not receiving the signals [from the brain] to do their job." Dec. Curliano , Ex. C, pg. 24:18-26:20. Dr. Myette also testified that they are required to constantly micro adjust Israel's vasopressin infusion, to prevent sodium levels from becoming out of balance, and microadjust norepinephrine, "a synthetic cousin to our own adrenaline that our own body secretes." "Israel's body does not secrete [adrenaline] anymore." Dec. Curliano, Ex. C, pg. 31:1-17. The constant adjustments require "moment-to-moment, minute-to-minute, and hour-to-hour management of his

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blood pressure, and that moment-to-moment, hour-to-hour management of his salt and free water levels in his body are something that requires a physician be present virtually all the time." Dec. Curliano, Ex. C, pg. 32:10-14. As Dr. Myette explained, he is "working very hard, but we're on top of this. But the notion that he is stable and sitting in a corner and everything is running on autopilot is -- is a notion that is not grounded in reality. He is aggressively, acutely managed moment to moment." Decl. of Curliano, Ex. C, pg. 33:15-19.

Plaintiff has not provided any legal support or competent medical opinion to support her request that this Court direct Kaiser Roseville, Dr. Myette, and the doctors, nurses and caregivers working with Israel to perform medical procedures and treatment that are medically unnecessary and that go beyond providing the level of support necessary to maintain the status quo. Israel has been determined to be brain dead. There is nothing medically that can be done to change this unfortunate fact. Controlling case law supports a finding that other than maintaining the status quo, in the event further injunctive relief is granted, defendants should not be required to engage in acts of medical futility or provide care and treatment that are at odds with their medical and ethical beliefs.

C. The *Rooker-Feldman* doctrine precludes this Court from effectively reviewing the state court's determination.

Much of plaintiff's complaint and motion effectively ask this Court to review the state court's approval of the procedures followed by Kaiser Roseville and the considered medical judgment of its physicians in this case. For example, plaintiff cites the declaration of Dr. Paul Byrne to support the statement in her motion that "the facts are that a physician believes that the child is not dead and Israel's condition can improve with further treatment." This is nothing but a direct attack on the medical determinations made by physicians at Kaiser Roseville and UCD Medical Center, and thus also an attempted end-run around the state court's ruling accepting those determinations as sound and in compliance with California law. Indeed, Dr. Byrne was present at the state court proceeding – plaintiff just elected not to call him as a witnesses to testify or to contradict the testimony that was given by Israel's primary physician, Dr. Myette.

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The Rooker-Feldman doctrine precludes relitigation of these questions. See *Exxon Mobil Corp. v. Saudi Basic Indus. Corp.*, 544 U.S. 280, 283 (2005) [Rooker-Feldman doctrine bars plaintiffs from "essentially invit[ing] federal courts of first instance to review and reverse unfavorable state-court judgments."] It is "immaterial" that plaintiff "frames [her] federal complaint as a constitutional challenge" to the state court's determinations, "rather than as a direct appeal of those determinations." *Bianchi v. Rylaarsdam,* 334 F.3d 895, 900 n.4 (9th Cir. 2003); *Cooper v. Ramos,* 704 F.3d 772, 781 (9th Cir. 2012).

V. CONCLUSION

For all the foregoing reasons, the requested injunctive relief should be denied. In the alternative, the Court should abstain from taking any action, and instead require that plaintiff litigate her claims in state court.

DATED: May 10, 2016

BUTY & CURLIANO LLP

By: _____
JASON J. CURLIANO
Attorneys for Defendants
KAISER PERMANENTE MEDICAL CENTER ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

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CERTIFICATE OF SERVICE

I am employed in the County of Alameda, State of California. I am over the age of eighteen years and not a party to the within entitled cause; my business address is 516 16th Street, Oakland, CA 94612.

On May 10, 2016, I caused to be served the following document:

KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

on the interested parties in said cause, by causing delivery to be made by the mode of service indicated below:

Kevin T. Snider, State Bar No. 170988 Michael J. Peffer, State Bar. No. 192265 Matthew B. McReynolds, State Bar No. 234797 PACIFIC JUSTICE INSTITUTE P.O. Box 276600 Sacramento, CA 95827 Tel. (916) 857-6900 Fax (916) 857-6902 Email: ksnider@pji.org	Ashante L. Norton Ismael A. Castro Office of the Attorney General 1300 I. Street, Suite 1101 Sacramento, CA 94244-2550 Tel. (916) 323-82013 Fax (916) 324-5567 Email: Ashante.Norton@doj.ca.gov Email: Ismael.Castro@doj.ca.gov
Alexander M. Snyder (SBN 252058) Life Legal Defense Foundation P.O. Box 2015 Napa, CA 94558 Tel: (707) 224-6675 asnyder@lldf.org	

X I caused a true and correct copy of the aforementioned document(s) to be transmitted electronically to all parties designated on the United States Eastern District Court CM/ECF website.

___ (By Email): On May 10, 2016 I caused a copy of the document(s) described on the attached document list, together with a copy of this declaration, to be emailed listed on the attached service list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 10, 2016, at Oakland, California.

SUSAN TRUAX

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ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA, Plaintiff, v. KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, DR. MICHAEL MYETTE M.D., and DOES 1 THROUGH 10, INCLUSIVE, Defendants.	Case No: 2:16-CV-00889-KJM-EFB **DECLARATION OF DR. MICHAEL S. MYETTE IN SUPPORT OF KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO PRELIMINARY INJUNCTION AND FURTHER INJUNCTIVE RELIEF** Date: May 11, 2016 Time: 1:30 p.m. Courtroom: 3 Hon. Kimberly J. Mueller Complaint Filed: April 28, 2016

I, Michael S. Myette, M.D., hereby declare:

1. I am a physician employed by The Permanente Medical Group, Inc. I have practiced medicine for over ten years. As the Medical Director for the Pediatric ICU at Kaiser Permanente in Roseville ("Kaiser Roseville"), I oversee and care for the most critically ill and unstable children admitted to the facility. I am Board Certified in Pediatrics and Pediatric Critical

Care Medicine. All of the facts stated herein are within my personal knowledge and if called as a witness, I could competently testify thereto.

2. On April 12, 2016, I received and admitted Israel Stinson as an inpatient at Kaiser Roseville from U.C. Davis Medical Center ("U.C. Davis"). I have reviewed Israel's medical records from U.C. Davis, his Kaiser Roseville medical records, and continue to follow and oversee his cardio-pulmonary support at Kaiser Roseville.

3. On April 15, 2016, I testified in Placer County Superior Court regarding Israel's condition and clinical course. I reviewed the transcript of the state court proceeding and determined the information I provided regarding Israel's condition and the circumstances surrounding his anoxic event were accurate and correct. A true and correct copy of relevant portions of the April 15, 2016 transcript taken in the Superior Court are attached hereto as Exhibit A.

4. Since April 15, 2016, I have found no clinical change in Israel's condition. Pursuant to various court orders, Israel's cardio-pulmonary functioning has been maintained through a variety of medications, glucose, hormones, water, electrolytes and mechanical support.

5. As Israel's brain is not telling his organs how to function, medical intervention is required for all critical metabolic functions. His blood pressure is wholly dependent on the administration of dopamine and norepinephrine at constantly changing levels. Without these drugs and a ventilator, his heart would cease to function within minutes.

6. Israel's hypothalamus and pituitary gland are dead. The hypothalamus is a portion of the brain that maintains the body's internal balance (homeostasis). It releases or inhibits hormones controlling the body's heart rate, temperature, fluid and electrolyte balance, weight, glandular secretions, pituitary gland and thyroid. Israel has no functioning of internal neuro-endocrine regulation. Absent the administration of artificial hormones and a warming blanket, Israel's body temperature would fall to the ambient level.

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7. Israel is receiving exogenous temperature regulation, exogenous thyroid hormone, exogenous anti-diuretic hormone, and exogenous catecholamines. Still, he demonstrates no signs of recovery. His serum thyroid hormone level is normal due to exogenous replacement. The argument Israel's current state was caused by hypothyroidism (as opposed to hypothyroidism resulting from brain death) is completely unfounded and disproven given the fact his serum thyroid level is now at a normal level (again due to exogenous replacement) with no improvement. Moreover, since Israel is not hypothyroid, the argument endocrine abnormalities preclude a reliable evaluation of brain functioning is medically unsound.

8. Israel's gastrointestinal system shows no signs of any functionality. As a result, complications are likely to arise if enteral feeding were attempted. Enteral feeding refers to the delivery of a nutritionally complete supplement, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach, duodenum or jejunum. If Israel's GI system is not functioning, enteral feeding could result in infection. Since Israel's body would not respond to an infection with a fever, we would likely not know of an infection until he was septic.

9. Since his admission at Kaiser Roseville, Israel has received dextrose for nutrition. Despite getting only dextrose calories, he has not lost weight in over 23 days since his admission. Israel has not had a bowel moment since being in the hospital.

10. Israel's pupils are fixed, dilated and unresponsive. He does exhibit a single, stereotypic spinal reflex. The movement is always the same. A spinal reflex is a reflexive action mediated by cells in the spinal cord, bypassing the brain altogether. The kneejerk or patellar reflex, where the leg jerks when the kneecap is struck with a brisk tap, is a classic example of a reflex. Reflexes allow the body to respond quickly to threats and hazards without the time delay involved when the brain is consulted about how to respond to a stimulus. In a spinal reflex, a sensation is felt at the site and relayed to neurons in the spinal cord via a sensory pathway. The spinal cord returns a signal along a motor pathway, signaling a movement in response to the sensation. This happens in fractions of a second, allowing people to jerk away before the brain is even aware of a problem.

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11. Unfortunately, Israel's mother, family, and attorneys, all non-medical professionals, interpret Israel's spinal reflex as a sign his brain may be functioning or even that he is recovering. They are incorrect. The videos offered by Israel's mother merely show the single, stereotypic spinal reflex.

12. Aside from the spinal reflex, Israel is unresponsive to any stimuli. He does not respond to his mother's voice, or the voice of anyone else. Israel's stereotypic spinal reflex occurs due to very light touch, including bumping the side of his bed.

13. Israel's heart rate does not increase in response to stimulation. His heart rate and blood pressure increase and decrease as a result of medical intervention with drugs and hormones. His heart rate and blood pressure increase and decrease throughout the day. Israel's heart rate dropped to 70 beats per minute on May 5, 2016. A child of Israel's age typically has a heart rate of 110 to 120 beats per minute. Unfortunately, we are approaching the maximum effective dosage of beta-stimulating medications.

14. Israel's mother told me she believes he took a breath on one or more occasions when she was holding him. Sadly, Israel lacks the ability to take a breath because the portion of his brain designed to draw a breath is dead. An apnea test, as described in my previous testimony on April 15, 2016, is designed to test a person's ability to take a breath. Physicians have administered three apnea tests on Israel. Israel failed to draw a breath in each of these tests. When I recently offered Israel's mother another apnea test to see whether Israel was breathing, she declined. The so-called spontaneous breaths his mom claims to have seen are due to a well-known and well-understood artificial triggering of the ventilator. Israel has been given ample opportunities to demonstrate he can breathe and has repeatedly and consistently failed to do so.

15. The argument Israel, with proper medical treatment, is likely to continue to live, and may find limited to full recovery of brain function, and may possibility regain consciousness is medically unsound. Absent from this view is any explanation of the MRI/CT scans showing diffuse cerebral edema, global hypoxemic injury and transforaminal herniation through the foramen magnum (a portion of his brain moved through the hole in the base of his skull through

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which the spinal cord connects to the brain). Neurological recovery from a transforaminal herniation through the Foramen Magnum due to this process is unprecedented.

16. Since his admission at Kaiser Roseville, Israel shows absolutely no improvement in his condition, despite the aggressive medical intervention and cardio-pulmonary support provided to date. In fact, he continues to slowly deteriorate from a cardiovascular standpoint and we are reaching the effective limits on medications used to keep his heart beating.

17. Brain death is widely accepted in the medical community. While there are different tests used to determine brain death, multiple tests are considered proper and accepted by the medical community. The protocol I used to determine Israel is brain dead is widely accepted among medical professionals who specialize in neurology and pediatric critical care. My determination of brain death for Israel was made in accordance with accepted medical standards. Israel would be considered brain dead by any medically recognized and accepted criteria for making such a determination.

18. As my determination that Israel is brain dead was made according to accepted medical standards, no personnel or agents of the State of California (or any other governmental body) influenced, affected or contributed to my determination. In fact, I had no interactions with anyone from the State of California or any government body in order to arrive at my determination of brain death. Filling out paperwork for a death certificate is an administrative task performed after I have made a determination of death. Such an administrative function merely documents my medical determination of death, which was made based solely on my training, observations and examination, and is completely independent of the State of California or any governmental body. A true and correct copy of Israel's certificate of death is attached hereto as Exhibit B.

I declare under penalty of perjury that the foregoing is true and correct. Executed on May 10, 2016, in Roseville, California.

MICHAEL S. MYETTE, M.D.

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CERTIFICATE OF SERVICE

I am employed in the County of Alameda, State of California. I am over the age of eighteen years and not a party to the within entitled cause; my business address is 516 16th Street, Oakland, CA 94612.

On May 10, 2016, I caused to be served the following document:

DECLARATION OF DR. MICHAEL S. MYETTE IN SUPPORT OF KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO PRELIMINARY INJUNCTION AND FURTHER INJUNCTIVE RELIEF

on the interested parties in said cause, by causing delivery to be made by the mode of service indicated below:

Kevin T. Snider, State Bar No. 170988 Michael J. Peffer, State Bar. No. 192265 Matthew B. McReynolds, State Bar No. 234797 PACIFIC JUSTICE INSTITUTE P.O. Box 276600 Sacramento, CA 95827 Tel. (916) 857-6900 Fax (916) 857-6902 Email: ksnider@pji.org	Ashante L. Norton Ismael A. Castro Office of the Attorney General 1300 I. Street, Suite 1101 Sacramento, CA 94244-2550 Tel. (916) 323-82013 Fax (916) 324-5567 Email: Ashante.Norton@doj.ca.gov Email: Ismael.Castro@doj.ca.gov
Alexander M. Snyder (SBN 252058) Life Legal Defense Foundation P.O. Box 2015 Napa, CA 94558 Tel: (707) 224-6675 asnyder@lldf.org	

X I caused a true and correct copy of the aforementioned document(s) to be transmitted electronically to all parties designated on the United States Eastern District Court CM/ECF website.

___ (By Email): On May 10, 2016 I caused a copy of the document(s) described on the attached document list, together with a copy of this declaration, to be emailed listed on the attached service list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 10, 2016, at Oakland, California.

SUSAN TRUAX

BUTY & CURLIANO LLP
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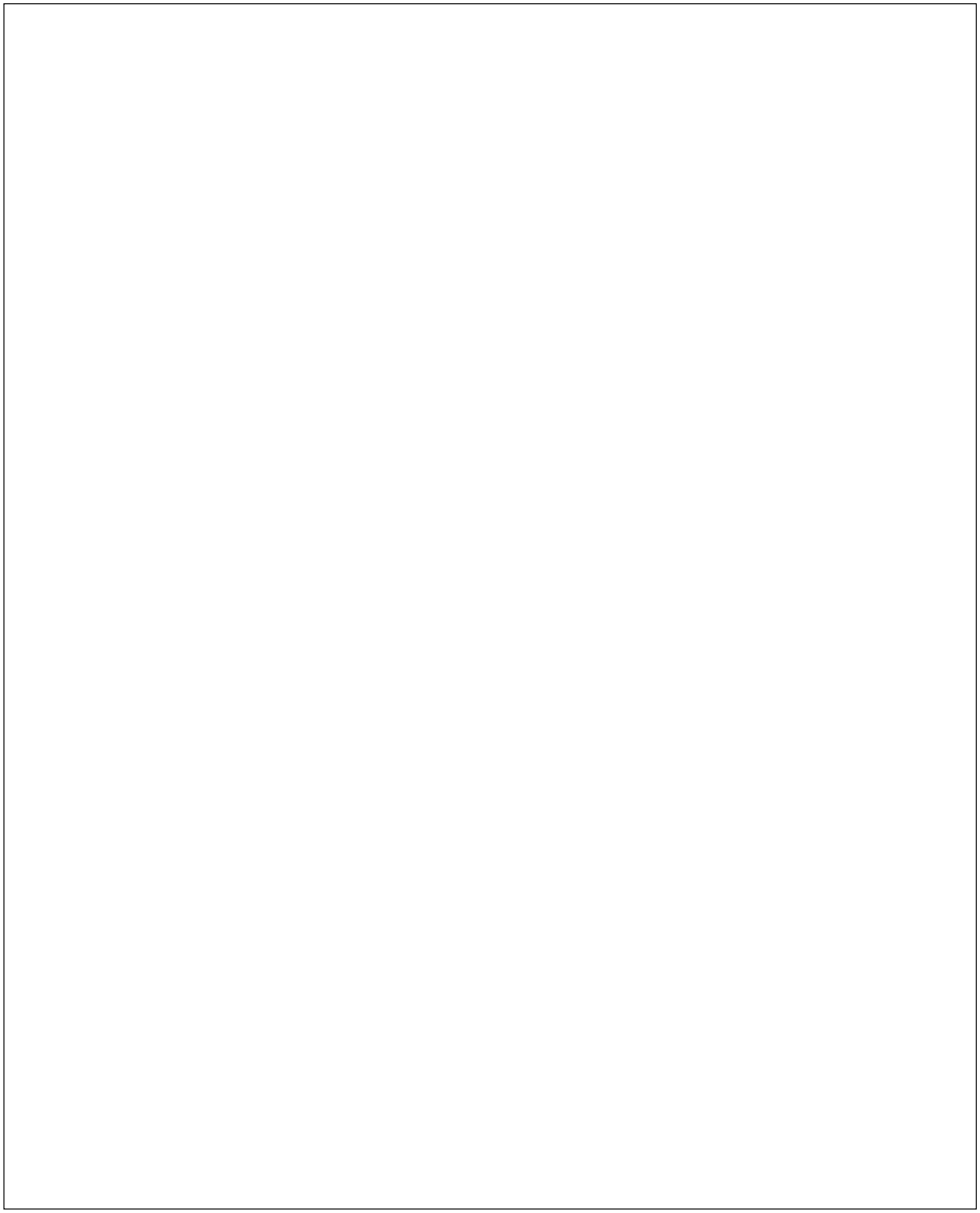


So, Dr. Myette, I'm going to ask that you please stand, sir, and be sworn.

(Whereupon the witness was sworn.)

THE WITNESS: I do.

THE CLERK: Please state your full name for the record.

THE WITNESS: Michael Steven Myette.

THE CLERK: Please be seated.

THE COURT: All right. You can just remain there for this purpose, sir.

Go ahead

DIRECT EXAMINATION

BY MR. JONES:

Q. Doctor, first off, what is your title?

A. I am a pediatric intensivist, and I'm board-certified in pediatrics and in pediatric critical care medicine. And I'm the medical director for the pediatric ICU at Kaiser Permanente in Roseville.

Q. And how long have you practiced medicine?

A. I have -- I have worked at Kaiser for -- it will be 11 years this July. Prior to that, I did my critical care in fellowship at U.C. San Francisco. And prior to that, I did a pediatric residency at U.C. Davis.

MR. JONES: Your Honor, I'd like to qualify this witness as an expert witness as well as a treating

physician.

MS. SNYDER: Excuse me. I'm sorry, Your Honor. But I was under the -- we were under the understanding that we would not be calling witnesses, specifically medical witnesses, because of the short time frame, that there would be no time for us to call a witness.

In fact, Kaiser asked us if we would call a medical witness, and we said we would not. And the understanding was that they would not either because their witness is ten minutes from here and ours is 2,000 miles from here. So -- and we had 15 hours to prepare for this hearing this morning.

THE COURT: I understand.

MS. SNYDER: Okay.

THE COURT: What I'm doing at this point in time is Kaiser wants to present some further information for the Court on these issues. And in terms of me receiving that information, since we have the doctor here, I might as well receive it in a proper fashion under oath.

MS. SNYDER: Okay.

THE COURT: Would you agree with that, that if he is going to say something, it might as well be --

MS. SNYDER: I do agree with that, yes.

THE COURT: Okay. Thank you. Go ahead, sir.

BY MR. JONES:

Q. And have you been involved with the care of Israel Stinson?
A. Yes. I received him in transfer from U.C. Davis Medical Center on April 12th and cared for him through yesterday. I -- I documented his time of death yesterday at 12:00 noon.
Q. Have you had an opportunity to review the medical records from U.C. Davis?
A. Yeah. I -- I extensively reviewed the medical records at U.C. Davis, the course of his care there, which I can summarize, if you want me to.
THE COURT: That's okay.
BY MR. JONES:
Q. Can you summarize the care.
A. Okay. Israel presented with a condition called status asthmaticus to an outside hospital in the Mercy system.
The emergency physicians treating him were concerned at the severity of his asthma. He was initially treated with medicines to take care of that. Ultimately, it was determined that he required assistance with a ventilator.
THE COURT: How old is Israel?
THE WITNESS: Israel is a 30-month-old boy. He is 2 1/2 years old.

THE COURT: Okay.

THE WITNESS: So he had an intratracheal tube placed in his trachea and was put on a ventilator. This intervention placed the child beyond the scope of care of the facility in the Mercy system. So they contacted U.C. Davis Medical Center who agreed to accept the patient in transfer.

BY MR. JONES:

Q. And what date was that, Doctor?

A. April 1st.

Q. And the transfer was April 2nd?

A. The transfer was April 1st.

Q. Okay.

A. The patient was cared for overnight in the pediatric ICU at U.C. Davis Medical Center.

On the 2nd of April, the physicians determined that he had improved and the intratracheal tube, breathing tube, was removed.

He was continued to be treated for his asthma at that point with Albuterol and other medications.

A few hours after excavation, he began to develop a very acute respiratory distress. The doctors attempted to treat that with rescue medications, but he developed a condition called a bronchospasm where his airway squeezes down so tight that air can't pass through

it.

The U.C. Davis doctors did multiple rescue attempts including replacing the intratracheal -- the breathing tube.

Even with the intratracheal breathing tube in place, they could not adequately force air into the portion of his lung where oxygen is exchanged.

During this episode, Israel's heart stopped. He was resuscitated with cardiopulmonary resuscitation, chest compressions, and continued attempts to force air into his lungs through the intratracheal tube.

Q. For how long?

A. 40 minutes this went on.

I spoke directly with one of the physicians of record who told me that they had a terrible time trying to get air in his lungs.

As hard as they pushed, they could not seem to bypass this -- the spastic airway and get air into the portion of his lung where it would be life sustaining.

After 40 minutes of cardiopulmonary resuscitation, he was cannulated for a machine called ECMO. It's spelled E-C-M-O. It is a machine. It stands for Extracorporeal Membrane Oxygenation.

ECMO is a machine that is analogous to a heart-lung bypass machine when somebody is getting heart

surgery. But unlike that machine, it is used in an intensive care unit to act in lieu of a heart and lungs when the heart and lungs aren't functional but the physicians believe that the condition is reversible.

He remained on the ECMO circuit for four days at U.C. Davis Medical Center.

The asthma and the subsequent cardiac arrest were, in fact, reversible. And his heart functioned -- started to function on its own after -- after a time as did the -- the bronchospasm in his lungs improved also over time with medication.

He was decannulated, which is to say taken off of the ECMO circuit on April 6th.

On April 7th, he had a procedure, a nuclear medicine procedure at U.C. Davis, called radionuclide. It's spelled r-a-d-i-o-n-u-c-l-i-d-e, I believe.

Radionuclide scan, which is a scan which measures uptake of oxygen and nutrients, glucose and such, into the brain. That is often used as an ancillary test. It is not a test that you can use to determine brain death in and of itself. It doesn't substitute for a brain death exam. But in cases where a complete brain death exam is not -- is not able to be done, it can be an ancillary piece of information. That's why I bring it up because it's supporting information.

The radionuclide scan was read by a radiologist and confirmed as showing no -- no uptake of oxygen or nutrients by Israel's brain.

On the 8th of April, one of the U.C. Davis Medical Center pediatric intensivists, somebody who is trained in the same manner and board-certified in the same manner that I am, performed an initial neuro exam attempting to see if there is any evidence of brain function.

That exam, including an apnea test, suggested that there was -- that there was no -- no brain activity. It was consistent with brain dead -- brain death.

Q. What's an apnea test?

A. An apnea test is a test whereby you take a patient off of a ventilator. You get them physiologically into a -- into a normal state as possible, normal oxygen in their blood, normal CO2 in their blood.

And you cease blowing air into their lungs. You place them on ambient, 100 percent oxygen, so that they are still able to deliver oxygen to their body during this test.

But the human body doesn't -- doesn't use oxygen or lack of oxygen to drive our desire to breathe. Our desire to breathe is driven by carbon dioxide in the

blood.

So this test is a test whereby we -- without letting a patient become dangerously deoxygenated, we allow the carbon dioxide to increase to a point where the portion of their brain that regulates carbon dioxide and tells the body to take a breath will respond. We actually go way beyond that.

The specifics of that test are available in the paper, and I can -- I can go into more detail if you want.

But the apnea test went on for -- I don't remember exactly how long she documented, but I think it was somewhere in the neighborhood of six to eight minutes, which is fairly typical for an apnea test.

The recommendations, as put forth by the American Academy of Pediatrics, the Society of Child Neurology, and the Society of Critical Care Medicine, who have issued a joint statement on how to go about these things states that you need to have normal CO2 at the beginning of the test. And you need to have a jump of at least 20 millimeters of mercury during the course of the test for the test to be valid.

The test was done -- was documented blood gasses before and after the apnea, the period of nonbreathing, were done and confirmed that there was an adequate reason

in Israel's CO2 that should have triggered his body to take a breath if that portion of his brain that -- that regulates when to take a breath was -- was functional.

On the 8th, the clinical neuro exams were conducted.

It is customary and it is recommended somebody -- somebody that is Israel's age you have to wait a minimum of 12 hours in between two separate exams of this nature.

The first exam establishes that there is no function. The second exam is supposed to confirm that whatever caused the first exam results to be what they are is -- was not, in fact, reversible.

In terms of Israel, he has not received any medications for pain or sedation since April 2nd.

He has not received any -- anything that would depress brain function since April 2nd.

Q. Was there a second test conducted at U.C. Davis?

A. There was not a second test done at U.C. Davis. The family -- well, the family requested some scans be done.

They asked for -- on the 9th or 10th -- I don't remember which day. But on the 9th or 10th, they requested a CT scan of the head be done and an MRI of the

brain be done.

U.C. Davis complied with this request and actually did both scans. The CT scan of the brain, which they sent to us also with his medical records, was read as showing diffused brain swelling, effacement of the basal cisterns, and herniation of the brain stem out the foramen magnum.

The foramen magnum is the hole at the base of the skull where the spinal cord comes out. And if the brain swells enough, then a portion of the brain, just by the pressure from all that swelling, can be forced down through that hole.

While that is not part of a brain death exam, per se, that is an unsurvivable event.

Q. Irreversible?

A. Irreversible.

Q. Then what happened?

A. The MRI also confirmed severe global injury to the brain and also confirmed the transforaminal, across the foramen herniation of brain tissue of the brain stem.

Q. Did the parents object to a second test at U.C. Davis?

A. The U.C. Davis doctors document that there was objection to doing a confirmatory brain death test.

The family requested that Israel be transferred

to U.C. Davis -- excuse me -- to Children's Hospital and Research Center in Oakland -- or now, I guess, the UCSF Benioff Children's Hospital in Oakland is the current name.

The physicians at U.C. -- or at UCSF Benioff Oakland Children's Hospital refused the transfer. They declined to take the patient in transfer.

Then -- I don't know -- the circumstances aren't 100 percent clear to me, but I came into the -- into the fold when I received a call from our outside services and asking me if I would be willing to take -- to take Israel in transfer.

Realizing that this was a difficult and tragic set of circumstances and understanding that probably the family had mistrust of the physicians at U.C. Davis because that's where the initial event, the initial cardiopulmonary arrest occurred, was likely to make it very difficult for them to accept whatever U.C. Davis was going to tell them, I agreed to transfer the patient to my intensive care unit and to evaluate him on my own.

Q. For brain death?

A. For brain death, correct.

Understand that I -- I evaluate a patient not looking for brain death, per se, but looking for absence of brain death. It is a vital part of information for me

to be able to figure out what the nature of care I need to deliver to this boy.

Had I done my initial exam on him and discovered that there was some activity in his brain, we wouldn't be here. I'd be -- we'd be -- we would not have declared him dead, and we would be attempting to facilitate whatever recovery he would have been capable of.

Q. When was he transferred to Kaiser?

A. He was transferred to Kaiser on April 12th. He arrived in the early afternoon.

Q. When was -- when was the first test conducted?

A. The first test done at Kaiser -- I did that test, but it wasn't done until about 11:00 o'clock p.m. that night.

The delay was that, as I had mentioned earlier, a patient has to be in a normal physiologic state for a brain death exam to be valid.

And Israel is unstable. The portions of his brain that autoregulate all the things that we take for granted, his brain is not doing that.

So illustration: When he came to me, his body temperature was 33 degrees centigrade. Normal body temperature is 37 degrees centigrade. He doesn't regulate his body temperature. If he gets cold, he doesn't shiver. If he gets cold, his body won't alter

its metabolic rate to increase heat production.

And so he is not -- if left alone, he will drift to ambient temperature, room temperature.

So when he got there, he had dropped from 36 to 37 degrees at U.C. Davis. The transfer, being in the ambulance and being in a -- in that environment was enough to drop his temperature four degrees centigrade.

So I had to spend several hours gently warming his body back up, which we instituted shortly after arrival. This is not something you want to do quickly because you can overshoot. And somebody who has a brain injury who gets a fever is likely to have a worsening of that brain injury. So we have to be very careful not to cause a fever.

So at that point, I began gentle warming. Another problem that had occurred when he arrived was that -- our pituitary gland in our brain regulates our water and salt balance in our body. To simplify, sodium and free water.

A hormone called vasopressin secreted by the pituitary gland keeps all of us in -- in normalcy for water and sodium. Well, his brain doesn't -- isn't doing that now. His pituitary gland is not functioning. So he was placed on an infusion of -- of manufactured -- of pharmaceutical vasopressin, which we have. And that is a

hormone that the body has this variable sensitivity to. And so you have to monitor him very closely.

When he had his brain death exam at U.C. Davis, his sodium was in the normal range. But by virtue of time, when he got to me, his sodium level was elevated, also elevated to a point at which I couldn't have done a valid brain death exam. So I had to -- I had to manage that level of sodium by altering the level of vasopressin I was infusing into his body to get his sodium into a physiologic range.

Q. Doctor, let me just ask this: Is the function of those organs not occurring because the brain is just not sending any signals of how organs have to operate?

A. That's correct. The kidneys regulate sodium and water based on signals they receive from the brain.

So while -- while Israel's kidneys in and of themselves are fine, they are not receiving the signals to do their job.

So that was the problem. He has wild fluctuations in his level of free water in his body, which can drive his sodium dangerously low or if we take away -- if we don't supplement that hormone, then he will pee out -- for lack of a better word, will urinate all the free water in his body and will go into cardiovascular collapse and die, and we will see that --

we would see that based on his sodium drifting up into levels that are not physiologic.

Q. So what test did you perform on the 12th?

A. So after getting his body warmed up to physiologic temperature, between 36 and 37 degrees centigrade, and after readjusting his vasopressin infusion to make sure that his sodium was between 130 and 145, I achieved that physiologic state at about 11:00 o'clock p.m., and then I performed a comprehensive neurologic exam looking for evidence of brain function.

I can go into the specifics of that test, if you want.

Q. What were the results of the test?

A. The results of my tests were consistent with no brain function. There was no evidence of his brain receiving any signals from his body, nor was there any evidence that his brain was regulating any organs in his body.

Q. And you performed an apnea test as well?

A. Correct. My apnea test lasted for seven and a half minutes with Israel on 100 percent oxygen. And his carbon dioxide in his blood at the beginning of the test was in the normal range, between 35 and 45. And at the end of the test, his carbon dioxide was 85. So there was a significant increase in that -- a level of increase

that would, in anybody with any function of their brain stem, cause them to draw a breath. And we -- we had a monitor on his intratracheal tube looking for any CO2, any exhale or there were -- there were sensors on his body sensing any inhale of breath.

Q. Did you also repeat that test yesterday?

A. Yes. So I did not do -- I want to be clear, I didn't do the confirmatory brain death exam. The recommendations by National is for two separate physicians to do the two different exams so that you have a fresh set of eyes.

And one of my colleagues, Dr. Masselink, spelled M-a-s-s-e-l-i-n-k, who is a board-certified pediatric neurologist performed the confirmatory neurologic test yesterday at 11:00 o'clock in the morning. That was a full 36 hours after the first test.

In the room accompanying and witnessing that test with him was Israel's great aunt and one of his grandmothers. And also Dr. Shelly Garone, who is one of -- one of my bosses -- one of the -- they're called at Kaiser -- they're called APIC. It stands for Associate Physician In Chief. And she -- she was also present for that.

Q. What were the results of the tests?

A. The results of that test, as documented by

Dr. Masselink, were that there was no -- no evidence of any brain function, that the exam was consistent with brain death.

Q. And was there a declaration of death made?

A. Yeah. Well, let me add one more thing.

A second apnea test was done as is -- as is in the recommendations put forth by the National Societies, as I previously mentioned.

So I did a second apnea test. The rules of brain death say that the same physician can do both apnea tests because it's appropriate that either a pediatric critical care doctor or a pediatric anesthesiologist, somebody with advanced airway skills, perform the apnea test. That's the one part of the exam that is beyond the scope of a pediatric neurologist.

So after Dr. Masselink completed his exam, the final piece was a confirmatory apnea test, and I did a confirmatory apnea test. This time I actually let it go for a full nine minutes, waiting to see if Israel would [Witness makes a descriptive sound] -- would draw a breath.

And after nine minutes, and CO2 that went above 90, he did not draw a breath.

At that point, I terminated the apnea test, and it met requirements for a valid test.

Q. And at that point --
A. At that point, I documented -- I wrote a death note and documented Israel's time of death at 12:00 noon, yesterday.
Q. How difficult is it to maintain, essentially, the body -- now that there's been a declaration of death, what efforts are required in order to keep Israel in the condition that he currently is, which I understand is not very stable?
A. Yeah. That's -- that's a good question. I mentioned earlier that the brain sends the signals that regulate our salt and free water.

And try as we might, doctors are not as good as a working brain at doing this. We're certainly doing our best.

But I can tell you that between Israel's arrival on the 12th and when I signed off to my colleague, another pediatric intensivist last night at 8:00 o'clock p.m., that I did not leave the hospital. I was always either in -- in the ICU, in the room with Israel, or over in my office, which is in the same building right around the corner. I took a couple of two- or three-hour naps in the sleep room, which is within 30 feet of the intensive care unit.

The reason being that throughout the night, from

the time he arrived until the time I signed him off, I was microadjusting his vasopressin infusion, making sure that his sodium did not drift too high or too low. I was adjusting another infusion that I hadn't mentioned yet, a medicine called norepinephrine or noradrenaline. It is a synthetic cousin to our own adrenaline that our body secretes.

Israel's body doesn't secrete that anymore. As a result, his blood pressure without this medicine will drift low to the point where he will not perfuse his coronary arteries, and his heart will stop. He is absolutely 100 percent dependent on this infusion of norepinephrine to keep that heart beating.

So if you give too much of that medicine, again, people have varying sensitivities to it. It's not a simple dose, and you get a blood pressure. You have to see what dose will produce a blood pressure.

He has an invasive arterial line in his femoral artery that gives us a moment-to-moment reading of his blood pressure. And using that catheter and transducing that pressure onto a monitor continuously, I adjust the norepinephrine.

He has -- I can't tell you exactly how many times, but I can tell you it's more than 20 that I've adjusted that medicine. Okay. I am trying to keep his

main arterial pressure, which is somewhere between the systolic and diastolic. I can get more specific than that if you need but that's probably adequate. I want to keep that main at least 60 and not above 100.

Below 60, and I don't adequately perfuse his kidneys or his heart.

Above 100, and the pressure in the arteries is high enough that I run the risk of him having a bleeding -- a bleeding episode or a hemorrhage.

So that moment-to-moment, minute-to-minute, and hour-to-hour management of his blood pressure, and that moment-to-moment, hour-to-hour management of his salt and free water levels in his body are something that requires a physician be present virtually all the time.

Q. Are Israel's organs essentially beginning to atrophy? Are they failing?

A. The -- this is what we normally see happen. There are exceptions to this. I think there's a -- Mom and Dad mentioned a case where somebody who had seen total cease of brain function has continued for a long time to have a beating heart. I don't know the specifics of that case.

But I can tell you in my experience -- I have precedent for trying to keep the heart beating after somebody has been declared dead. The specific situation

where we do this is when a family wishes organ donation. Because if the heart keeps beating and keeps delivering oxygen and glucose to the organs that are still functional, then those organs can be transplanted into somebody who needs them.

And so in situations where families wish organ donation, often when somebody has been declared brain dead, we, intensivists, as a bridge to get these organs to transplant, will work very hard to keep a patient alive or -- that's not -- scratch that. Not to keep -- to keep a patient's organs functioning and keep a patient's heart beating. And it does get more challenging the longer we do it.

Now, we're on top of this right now with Israel. We're working very hard, but we're on top of this. But the notion that he is stable and sitting in a corner and everything is running on autopilot is -- is a notation that is not grounded in reality. He is aggressively, acutely managed moment to moment.

THE COURT: And is nutrition an aspect of that?

THE WITNESS: So nutrition is a little bit problematic. So I can tell you -- we are providing him with a constant infusion of glucose to make sure that his blood sugar remains in normal range.

His intestines -- and intestines in situations

where there's a prolonged resuscitation often suffer a pretty significant injury.

And before we put nutrition into the gut, into the intestines, we need to know that those intestines have healed. If you put a bunch of sugar and protein and fat into a gut that is severely injured, that sets up a situation where pathological bacteria can grow in that nonfunctioning gut. And you can have catastrophic complications.

So we are not feeding him into his intestine right now because his intestines have not yet indicated to us that they are capable of handling and absorbing nutrition and putting -- putting nutrition into the intestines at this point is -- would be a very risky thing to do.

Now -- I guess I'll leave it at that.

So the short answer is beyond IV glucose infusions and IV infusions of salts and electrolytes, that's the only nutrition he is getting right now.

THE COURT: Okay. Mr. Jones, anything further?

BY MR. JONES:

Q. What -- what is the likelihood that you would be able to maintain Israel's body in this state for a two-week period of time?

A. It will be difficult. I guess that's the best I

can say. I don't -- I don't know, you know. I don't know what he is going to do. I can tell you that last night that Israel's sodium dropped to a level that in somebody with a functioning brain would have caused seizures. And the doctor who was taking care of him last night had to stop the vasopressin infusion altogether because his sensitivity to it suddenly went up.

And the sodium is coming back up now because the body is starting to get rid of that free water that was holding on, was diluting the sodium in his body.

So we are -- we are monitoring him very closely. But as I said earlier, no physician is as good as a functioning brain at regulating the physiology of a human body. And anyone who thinks they are is naive or arrogant. But, you know, we'll try. We're going to keep trying, but I can tell you that those kinds of fluctuations are going to happen. And it may be that one of them happens and his body just shuts down.

Often what I see in kids who go on to transplant is that at some point their body stops responding to the adrenaline that we infuse and their blood pressure starts to drop. And that also can be problematic. That has not happened yet with Israel, but it could happen today. It could happen tomorrow, and we could pour more and more into him and try our best to keep that blood pressure up.

In my experience, sooner or later, our efforts to mimic the brain starts to fall short.

THE COURT: I understand. Anything further, Mr. Jones?

MR. JONES: Just with that background -- I just want to point out to the Court that -- so we're here to determine whether or not the temporary order should be continued.

And my comment is that under Health and Safety Code Section 7180 and 7181, Israel has been found to be dead.

THE COURT: And, therefore, the parent should not have the opportunity to have an independent evaluation?

MR. JONES: They had. We are the independent --

THE COURT: They're not entitled to have their own independent evaluation at this point in time, somebody outside of Kaiser?

MR. JONES: I think if they -- if you look at the Dority case --

THE COURT: Just answer my question. Are the parents entitled to have an independent evaluation outside of Kaiser at this point in time?

MR. JONES: No. No. Because there's no --

THE COURT: Your position is no?

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF PLACER

---o0o---

ISRAEL STINSON,
Plaintiff,
vs. Case No. S-CV-0037673
U.C. DAVIS CHILDREN'S HOSPITAL,
Defendant,

I, JENNIFER F. MILNE, Certified Shorthand Reporter of the State of California, do hereby certify that the foregoing pages 1 through 42, inclusive, comprises a true and correct transcript of the proceedings had in the above-entitled matter held on April 15, 2016.

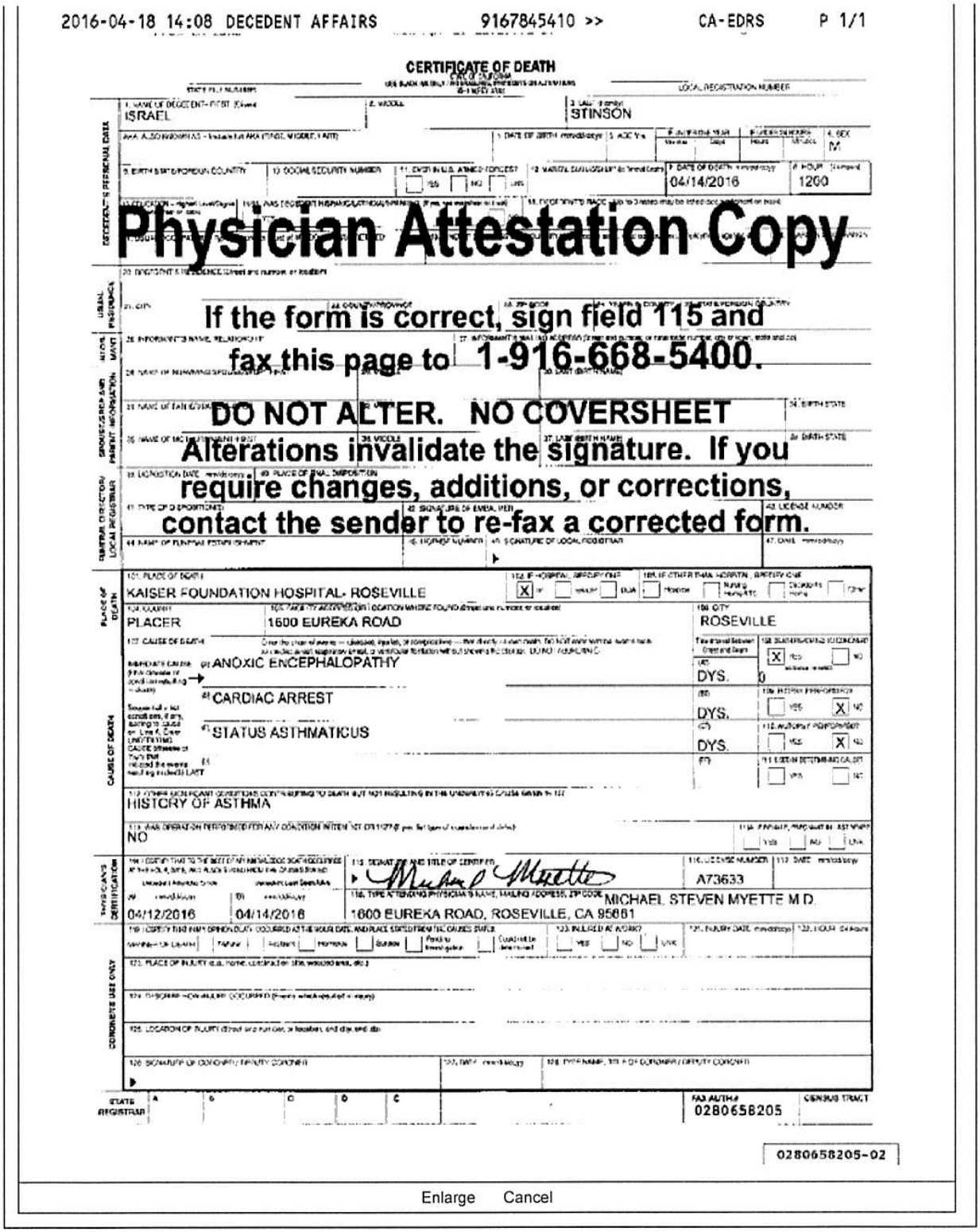
I also certify that portions of the transcript are governed by the provisions of CCP237(a)(2) and that all personal juror identifying information has been redacted.

IN WITNESS WHEREOF, I have subscribed this certificate at Roseville, California, this 19th day of April, 2016.

_____

JENNIFER F. MILNE, CSR

License No. 10894



2016-04-18 14:08 DECEDENT AFFAIRS 9167845410 >> CA-EDRS P 1/1

CERTIFICATE OF DEATH

Physician Attestation Copy

If the form is correct, sign field 115 and fax this page to 1-916-668-5400.

DO NOT ALTER. NO COVERSHEET

Alterations invalidate the signature. If you require changes, additions, or corrections, contact the sender to re-fax a corrected form.

1. NAME OF DECEDENT-FIRST: ISRAEL
3. LAST: STINSON
4. SEX: M
7. DATE OF DEATH: 04/14/2016
8. HOUR: 1200
101. PLACE OF DEATH: KAISER FOUNDATION HOSPITAL- ROSEVILLE
102. IF HOSPITAL: X
104. COUNTY: PLACER
105. FACILITY ADDRESS: 1600 EUREKA ROAD
106. CITY: ROSEVILLE
107. CAUSE OF DEATH
(a) ANOXIC ENCEPHALOPATHY — DYS. 0
(b) CARDIAC ARREST — DYS.
(c) STATUS ASTHMATICUS — DYS.
112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107: HISTORY OF ASTHMA
113. WAS OPERATION PERFORMED FOR ANY CONDITION IN 107 OR 112? NO
115. SIGNATURE AND TITLE OF CERTIFIER: Michael Myette
116. LICENSE NUMBER: A73633
116. TYPE OR PRINT NAME, MAILING ADDRESS, ZIP CODE: MICHAEL STEVEN MYETTE M.D. 1600 EUREKA ROAD, ROSEVILLE, CA 95661
117. DATE SIGNED: 04/14/2016
STATE REGISTRAR: 0280658205
0280658205-02

Enlarge Cancel

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11a(REV 3/06)

STATE FILE NUMBER | LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT– FIRST (Given)	2. MIDDLE	3. LAST (Family)
ISRAEL	--	STINSON

AKA. ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	IF UNDER ONE YEAR Months	IF UNDER ONE YEAR Days	IF UNDER 24 HOURS Hours	IF UNDER 24 HOURS Minutes	6. SEX
10/05/2013	2					M

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/SRDP* (at Time of Death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 Hours)
		☐ YES ☐ NO ☐ UNK		04/14/2016	1200

13. EDUCATION – Highest Level/Degree (see worksheet on back)

14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back) ☐ YES ☐ NO

16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)

17. USUAL OCCUPATION – Type of work for most of life. DO NOT USE RETIRED	18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19. YEARS IN OCCUPATION

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location)

21. CITY	22. COUNTY/PROVINCE	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
	--			

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)

SPOUSE/SRDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP*–FIRST	29. MIDDLE	30. LAST (BIRTH NAME)	
31. NAME OF FATHER/PARENT–FIRST	32. MIDDLE	33. LAST	34. BIRTH STATE
35. NAME OF MOTHER/PARENT–FIRST	36. MIDDLE	37. LAST (BIRTH NAME)	38. BIRTH STATE

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION	
41. TYPE OF DISPOSITION(S) --	42. SIGNATURE OF EMBALMER ▶	43. LICENSE NUMBER
44. NAME OF FUNERAL ESTABLISHMENT	45. LICENSE NUMBER / 46. SIGNATURE OF LOCAL REGISTRAR ▶	47. DATE mm/dd/ccyy

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
KAISER FOUNDATION HOSPITAL- ROSEVILLE	[X] IP ☐ ER/OP ☐ DOA	☐ Hospice ☐ Nursing Home/LTC ☐ Decedent's Home ☐ Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
PLACER	1600 EUREKA ROAD	ROSEVILLE

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events --- diseases, injuries, or complications --- that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Time Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(A) ANOXIC ENCEPHALOPATHY	(AT) DYS.
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(B) CARDIAC ARREST	(BT) DYS.
	(C) STATUS ASTHMATICUS	(CT) DYS.
	(D)	(DT)

108. DEATH REPORTED TO CORONER?	109. BIOPSY PERFORMED?	110. AUTOPSY PERFORMED?	111. USED IN DETERMINING CAUSE?
[X] YES ☐ NO REFERRAL NUMBER 0	☐ YES [X] NO	☐ YES [X] NO	☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107
HISTORY OF ASTHMA

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)	113A. IF FEMALE, PREGNANT IN LAST YEAR?
NO	☐ YES ☐ NO ☐ UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attended Since (A) mm/dd/ccyy	Decedent Last Seen Alive (B) mm/dd/ccyy	115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
04/12/2016	04/14/2016	▶MICHAEL STEVEN MYETTE M.D.	A73633	04/18/2016

118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE
MICHAEL STEVEN MYETTE M.D.
1600 EUREKA ROAD, ROSEVILLE, CA 95661

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. MANNER OF DEATH	120. INJURED AT WORK?	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)
☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending Investigation ☐ Could not be determined	☐ YES ☐ NO ☐ UNK		

123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)

125. LOCATION OF INJURY (Street and number, or location, and city, and zip)

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▶		

STATE REGISTRAR	A	B	C	D	E	Printed on: 04/21/2016 10:44 AM By JENKINS, TERRY (TJENKINS1)	FAX AUTH.#	CENSUS TRACT

05/10/2016	42	MINUTES (Text Only) for proceedings before Magistrate Judge Carolyn K. Delaney: CONTINUED INFORMAL CONFERENCE CALL re further settlement discussions held on 5/10/2016. No additional progress made. Plaintiffs Counsel Alexandra Snyder present. Defendants Counsel Jason Curliano present. (Owen, K) (Entered: 05/10/2016)

05/09/2016	39	MINUTES (Text Only) for proceedings before Magistrate Judge Carolyn K. Delaney: INFORMAL CONFERENCE CALL held on 5/9/2016 re further settlement discussions. Court set a further informal conference call for 5/10/2016 at 10:00 AM before Magistrate Judge Carolyn K. Delaney. Parties are instructed to connect to the call using the same dial-in information previously provided. Plaintiffs Counsel Alexandra Snyder present. Defendants Counsel Jason Curliano present. (Owen, K) (Entered: 05/09/2016)

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Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **DECLARATION OF DR. ALAN SHEWMON**

DECLARATION OF ALAN SHEWMON, MD

I, Alan Shewmon, MD, am not a party to the above-encaptioned case and if called upon, I could and would testify truthfully, as to my own person knowledge, as follows:

1. I am a pediatric neurologist with triple board certification: in Pediatrics, Neurology (with special competence in child neurology), and Electroencephalography. I have had a particular interest in brain death and have published and lectured extensively on the topic, nationally and internationally. I recently retired as Professor of Neurology and Pediatrics at the David Geffen School of Medicine at UCLA and Chief of the Neurology Department of Olive-UCLA Medical Center (a county hospital affiliated with UCLA), while remaining clinically active.
2. I am willing to testify as to my expertise in brain death in this case.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 6th Day of May, 2016.

_S/ Alan Shewmon, MD
Dr. Alan Shewmon, Plaintiff

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Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **DECLARATION OF PAUL BYRNE, MD**

DECLARATION OF DR. PAUL BYRNE

I, Paul Byrne, MD, am not a party to the above-encaptioned case and if called upon, I could and would testify truthfully, as to my own person knowledge, as follows:

Declarant, Paul A. Byrne, M.D., states as follows:

1. I have personal knowledge of all the facts contained herein and if called to testify as a witness I would and could competently testify thereto.

2. I am a physician licensed in Missouri, Nebraska and Ohio. I am Board Certified in Pediatrics and Neonatal-Perinatal Medicine. I have published articles on "brain death" and related topics in the medical literature, law literature and the lay press for more than thirty years. I have been qualified as an expert in matters related to central nervous system dysfunction in Michigan, Ohio, New Jersey, New York, Montana, Nebraska, Missouri, South Carolina, and the United States District Court for the Eastern District of Virginia.

3. I have reviewed the medical records of Israel Stinson, a 2-year-old boy, a patient in Kaiser Permanente, Roseville Hospital. I have visited Israel Stinson several times. On April 22 when I visited him, he was in the arms of his mother. A ventilator was in place.

4. I have continued to be in touch with Israel's parents. I have reviewed the videos that have been sent to me. Israel does move in these videos. If Israel were a cadaver, this is not possible, Thus Israel is alive.

5. The Guidelines of the AAN that the hospital claims to be following are not fulfilled. The Guidelines require that "Patients must lack all evidence of responsiveness." Israel is responsive.

6. Israel's intake has been only sugar, comparable to 7-Up since April 1. For more than a month Israel has been starved of protein, fat and vitamins.

7. Israel has had a tube is his trachea (ET tube) for more than a month. Every doctor knowledgeable in ENT and intensive care knows that a tracheostomy should have been done long before now.

8. Israel receives treatment for diabetes insipidus by medication administered intravenously. I have not been provided records as to how much and how often he has been given this medication. The patient's family and I agree this treatment should continue.

9. On April 4, Cranial Doppler showed "Near total absence of blood flow into the bilateral cerebral hemispheres." "Near total absence" is not evidence of no blood flow.

10. An apnea test has been done on Israel 3 times. Every time he was made acidotic and hypercapneic (increase in carbon dioxide). These tests could not have helped Israel. Further, the third time was after Israel's parents requested that such testing not be done again.

11. Endocrine abnormalities including hypothyroidism preclude any reliable evaluation of functioning of the brain. Thyroid blood studies were done on April 18. Results showed that Israel has hypothyroidism. Thyroid was started on April 18, but only once a day.

12. Prior to April 18 Israel was not tested or treated for his hypothyroidism, which has probably been present since his cardiorespiratory arrest. Thyroid hormone is necessary for ordinary normal health and healing of the brain. Thyroid medication that has been given to Israel can be a cause of his recent movements of his body. I recommend continued treatment and testing of thyroid functions.

13. The results of test of thyroid function of Israel Stinson are:

4/17/16 TSH: 0.07 (normal 0.7-5)

4/17/16: T4: 0.4 (Normal .8-1.7)

Israel's brain (hypothalamus) is not producing sufficient TSH, thyroid stimulating hormone, which has a half-life of only a few minutes. But he does have some TSH.

14. T4 is low and brain edema has turned into brain myxedema. When thyroid is given, brain circulation can increase and resume normal levels, thereby restoring normal neurological and hypothalamic function.

15. With proper medical treatment as proposed by his parents, Israel is likely to continue to live, and may find limited to full recovery of brain function, and may possibly regain consciousness.

16. Israel has a beating heart without support by a pacemaker or medications. Israel has circulation and respiration and many interdependent functioning organs including liver, kidneys and pancreas. In spite of low thyroid Israel's body manifests healing. Israel Stinson is a living person who passes urine and would digest food and have bowel movements if he were fed through a nasogastric or PEG tube. These are functions that do not occur in a cadaver after true death.

17. The criteria for "brain death" are multiple and there is no consensus as to which set of criteria to use (Neurology 2008). The criteria supposedly demonstrate alleged brain damage from which the patient cannot recover. However, there are many patients who have recovered after a declaration of "brain death." (See below.) Israel is not deceased; Israel is not a cadaver. Israel has a beating heart with a strong pulse, blood pressure and circulation. Israel makes urine and would digest food and have bowel movements if he is fed. These are indications that Israel is alive.

18. The latest scientific reports indicate that patients deemed to be "brain dead" are actually neurologically recoverable. I recognize that such treatments are not commonly done. Further it is recognized that the public and the Court must be wondering why doctors don't all agree that "brain death" is true death. Israel, like many others, continues to live in spite of little or no attention to detail necessary for treating a person on a ventilator. Israel, like all of us needs thyroid hormone. Many persons are on thyroid hormone because they would die without it.

19. Israel Stinson may achieve even complete or nearly complete neurological recovery if he is given proper treatment soon. Every day that passes, Israel is deprived of adequate nutrition and careful administration thyroid hormone required for healing.

20. The questions presented here refer to (1) the unreliability of methods that have been used to identify death and (2) the fact that no therapeutic methods that would enable brain recovery have been used so far. In fact, the implementation of nutrition and adequate therapeutic methods are being obstructed in the hope that Israel's heart stops beating, thereby precluding his recovery through the implementation of new therapeutic methodologies.

21. Israel Stinson's brain is probably supplied by a partially reduced level of blood flow, insufficient to allow full functioning of his brain, such as control of respiratory muscles and production of a hormone controlled by the brain itself. This is called thyroid stimulating hormone, TSH, which then stimulates the thyroid gland to produce its own hormones. With insufficient amount TSH Israel has hypothyroidism. The consequent deficiency of thyroid hormones sustains cerebral edema and prevents proper functioning of the brain that control respiratory muscles.

22. On the other hand, partially reduced blood flow to his brain, despite being sufficient to maintain vitality of the brain, is too low to be detected through imaging tests currently used for that purpose. Employing these methods currently used for the declaration of "brain death" confounds NO EVIDENCE of circulation to his brain with actual ABSENCE of circulation to his brain. Both reduced availability of thyroid hormones and partial reduction of brain blood flow also inhibit brain electrical activity, thereby preventing the detection of brain waves on the EEG. The methods currently used for the declaration of "brain death" confound flat brain waves with the lack of vitality of the cerebral cortex. It is noted that EEG has not been done on Israel Stinson.

23. In 2013, Jahi McMath was in hospital in Oakland, CA. When I visited her in the hospital in Oakland, Jahi was in a condition similar to Israel. A death certificate was issued

on Jahi on December 12, 2013. Jahi was transferred to New Jersey where tracheostomy and gastrostomy were done and thyroid medication was given. Multiple neurologists recently evaluated Jahi and found that she no longer fulfills any criteria for "brain death. Since jahi has been in New Jersey, she has had her 14th and 15th birthdays. The doctors in Oakland declared Jahi dead and issued a death certificate. Jahi's mother said no to taking Jahi's organs and no to turning off her ventilator. Israel's parents are saying no to taking Israel's organs and to taking away his life support. Just like Jahi's mother!

24. Even a person in optimal clinical condition would be at risk of death after weeks of hypothyroidism and only sugar (similar to only 7-up). Israel Stinson needs a Court order requiring Kaiser Permanente to actively promote the implementation of all measures necessary for Israel's survival and neurological recovery, including tracheostomy, gastrostomy, thyroid hormone, and proper nutrition to prevent death.

25. Israel Stinson needs the following procedures done:

a. Tracheostomy and gastrostomy

b. Serum T3, T4, TSH and TRH (thyroid releasing hormone).

c. Levothyroxine 25 mcg nasoenterically, nasogastrically or IV every 6 hours the first day; dose needs to be adjusted thereafter in accord with TSH, T3 and T4.

d. Samples for lab tests for growth hormone (maybe serum samples can be frozen for future non-STAT tests).

e. Serum insulin-like growth factor I (IGF-I) to evaluate growth hormone deficiency.

f. Parathormone (PTH) and 25(OH)D3 to evaluate vitamin D deficiency and replacement.

g. Continue to follow electrolytes (sodium, chloride, potassium, magnesium, total and ionized calcium), creatinine and BUN.

h. Continued monitoring of blood gases.

i. Serum albumin and protein levels.

j. CBC including WBC with differential and platelet count.

k. Urinalysis (including quantitative urine culture and 24-hour urine protein).

l. Continue accurate Intake and Output.

m. Diet with 40 g of protein per day (nasoenterically or nasogastrically). Fat intravenous until feedings are into stomach.

n. IV fluids (volume and composition to be changed according to daily serum levels of electrolytes (sodium, chloride, potassium, magnesium, total and ionized calcium) and fluid balance.

o. Water, nasoenterically or nasogastrically, if necessary to treat hypernatremia – volume and frequency according to serum sodium.

p. Fludrocortisone Acetate (Florinef®) Tablets USP, 0.1 mg - one tablet (nasoenterically or nasogastrically) per day;

q. Prednisone 10 mg (nasoenterically or nasogastrically) twice per day;

r. Continue Vasopressin IM, or Desmopressin acetate nasal spray (DDAVP – synthetic vasopressin analogue) one or two times per day according to urinary output;

s. Human growth hormone (somatropin) [0.006 mg/kg/day (12 kg = 0.07 mg per day)] subcutaneously;

t. Arginine Alpha Ketoglutarate (AAKG) powder 10 g diluted in water (nasoenterically or nasogastrically) four times per day;

u. Pyridoxal-phosphate ("coenzymated B6", PLP) - sublingual administration four times per day;

v. Taurine 2 g diluted in water (nasoenterically or nasogastrically) four times per day;

w. Cholecalciferol 30.000 IU three times per day (nasoenterically or nasogastrically) for 3 days. Then 7,000 IU three times per day (nasoenterically or nasogastrically) from day 4.

x. Riboflavin 20 mg four times per day (nasoenterically or nasogastrically)

y. Folic acid 5 mg two times per day (nasoenterically or nasogastrically).

z. Vitamin B12 1,000 mcg once per day (nasoenterically or nasogastrically).

aa. Concentrate / mercury-free omega-3 (DHA / EPA) 3 cc four times per day (nasoenterically or nasogastrically).

bb. Chest physiotherapy

cc. Blood gases; adjust ventilator accordingly.

dd. Keep oxygen saturation 92-98%

ee. Air mattress that cycles and rotates air.

ff. Pressor agents to keep BP at 70-80/50-60.

26. In a situation such as this where continued provision of life-sustaining measures such as ventilator, medications, water and nutrition are at issue, it is my professional judgment that the decision regarding their appropriateness rests with the family, not the medical profession.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 6th Day of May, 2016.

S/ Paul Byrne, MD
Paul Byrne, MD

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

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

abstract

FREE

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

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.

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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 $\geq$ 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 $\geq$ 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[14-18]

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 $\geq$ 20 mm Hg above the baseline $Paco_2$ level and $\geq$ 60 mm Hg. If no respiratory effort is observed from the initiation of the apnea test to the time the measured $Paco_2 \geq 60$ mm Hg and $\geq$ 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 $\geq$ 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.[34,54–65] 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.[36,54,55,57,59,60,63,64–68] 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 ($n = 119$).[36,54–56,58–68]

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[54,65,70] 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	☐ Yes	☐ No	☐ Yes	☐ No
Sucking and rooting reflexes are absent (in neonates and infants)	☐ Yes	☐ No	☐ Yes	☐ 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)

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[79–81]	Infants have faster clearance[81–83]
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[86]
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)[79,89–91]
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.[57]

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)[40]	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)[42]	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, 1986[55]	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[56]	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[65]	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[66]	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, 1986[55]	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[67]	32	83% (6/6)	83% (6/6)	NA	NA
Ashwal &Schneider, 1989[65]	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[68]	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.

APPENDIX 6 EEG and CBF Diagnostic Screening Yield by Age Groups

	ECS	EEG$^+$	Total	Diagnostic Screening Yield
All children (n = 149)*				
No CBF	86	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	

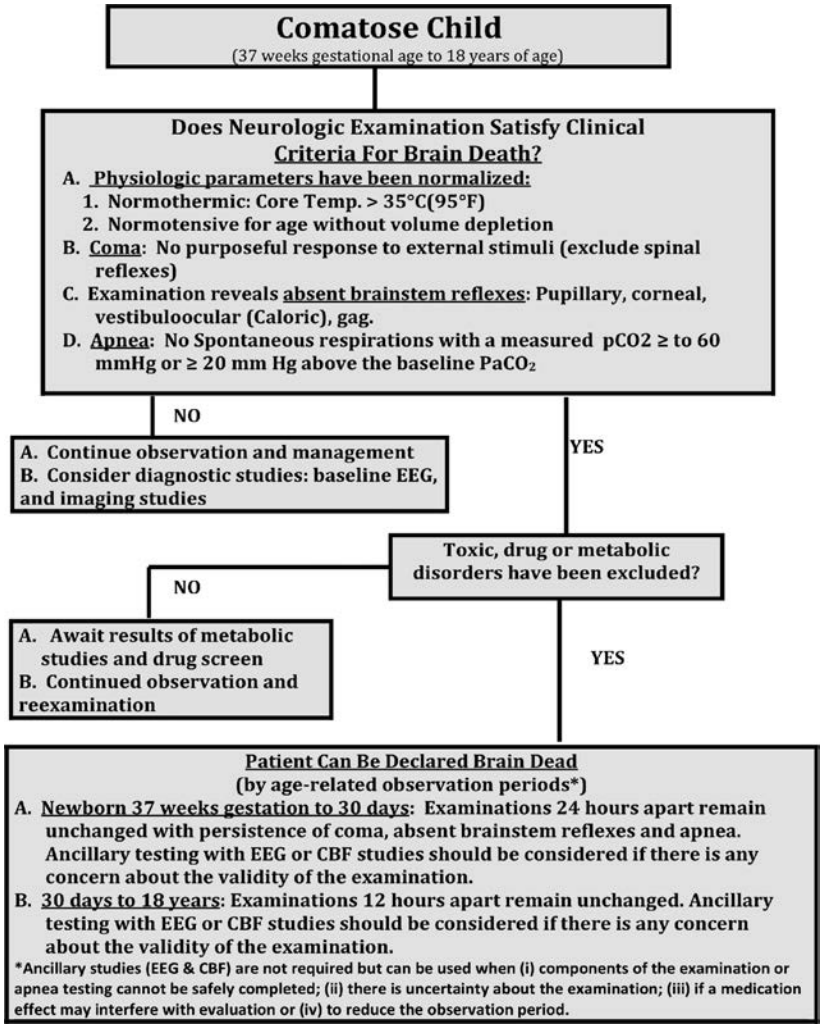
* Data extracted from references cited in Appendix 4,5.
** Data extracted from references cited in Ashwal S.[35]
*** Data represent the differences between "All children" and "just newborns" groups.
ECS Electrocerebral silence.
CBF Cerebral blood flow.
EEG$^+$ Activity on EEG.
CBF$^+$ Cerebral blood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



APPENDIX 9 Taskforce Organization

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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

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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

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D., Karen Smith, M.D. in her official capacity as Director of the California Department of Public Health and Does 2 through 10, inclusive, Defendants.	Case No.: 2:16-cv-00889 – KJM-EFB **DECLARATION OF JONEE FONSECA REGARDING ISRAEL STINSON TAKING A BREATH**

DECLARATION OF JONEE FONSECA

I, Jonee Fonseca, am the plaintiff in the above-encaptioned case and if called upon, I could and would testify truthfully, as to my own person knowledge, as follows:

1. I am Israel Stinson's mother.

2. On April 22, 2016, I was able to hold Israel in my arms for the first time since he arrived at Kaiser. The minute he was placed in my arms, I heard him take a deep breath apart from the ventilator. He also moved his neck, shoulders, and head, as if he was trying to get comfortable. Approximately 30 minutes later, as I was still holding him, he took another deep breath apart from ventilator. I held him for a total of about one hour.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 6th Day of May, 2016.

_S/ Jonee Fonseca
Jonee Fonseca, Plaintiff

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

Jonee Fonseca, an individual parent and guardian of Israel Stinson, a minor, Plaintiff, Plaintiffs, v. Kaiser Permanente Medical Center Roseville, Dr. Michael Myette M.D. and Does 1 through 10, inclusive, Defendants.	Case No.: DECLARATION OF ALEXANDRA SNYDER REGARDING DISPUTES CONCERNING BRAIN DEATH

DECLARATION OF ALEXANDRA SNYDER

I, Alexander Snyder, declare as follows:

I am an attorney admitted to the State Bar of California (SL# 252058), and am not a party to the above-encaptioned case. If called upon, I could and would testify truthfully, as to my own person knowledge, as follows:

1) I have personally read the attached article (Exhibit 1, Piercing the Veil) by Seema K. Shah, JD, a bioethicist with the National Institutes of Health. I have also read Shah's Curriculum Vitae. (Exhibit 2, Shah CV)
2) Shaw cites the "persistent controversy and recent conflicts between hospitals and families over the treatment of brain-dead patients [which] demonstrate the need for clearer limits on the legal fiction of brain death." (Exhibit 1, "Piercing the Veil: The Limits of Brain Death as a Legal Fiction")
3) Shah notes that "Some scholars, and even the members of the Harvard Ad Hoc Committee themselves, were uneasy with the concept of brain death from the beginning."
4) Because of the ongoing dispute about death, Shaw argues that "judges and legislators should sometimes "pierce the veil" of brain death and should not use the legal fiction in cases involving: (1) religious and moral objections, (2) insurance reimbursement for extended care of brain-dead patients, (3) maintenance of pregnant, brain dead women, and (4) biomedical research.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 6th day of May, 2016.

S/ Alexandra Snyder
Alexandra Snyder, Declarant

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Piercing the Veil: The Limits of Brain Death as a Legal Fiction

Seema K. Shah
Department of Bioethics, National Institutes of Health