ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):
Thomas E. Still, Esq. / SBN 127065
HINSHAW, MARSH, STILL & HINSHAW, LLP
12901 Saratoga Avenue
Saratoga, CA 95070

TELEPHONE NO.: (408) 861-6500 FAX NO. (Optional): (408) 257-6645
E-MAIL ADDRESS (Optional): tstill@hinshaw-law.com
ATTORNEY FOR (Name): Defendant FREDERICK S. ROSEN, M.D.

FOR COURT USE ONLY

FILED
ALAMEDA COUNTY
MAR 23 2017
CLERK OF THE SUPERIOR COURT
By _____ DEPUTY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF Alameda
STREET ADDRESS: 1221 Oak Street
MAILING ADDRESS: 1221 Oak Street
CITY AND ZIP CODE: Oakland, CA 94612
BRANCH NAME: Administration Building

PLAINTIFF/PETITIONER: LATASHA NAILAH SPEARS, et al.

DEFENDANT/RESPONDENT: FREDERICK S. ROSEN, M.D., et al.

CASE MANAGEMENT STATEMENT

CASE NUMBER: RG 15760730

(Check one): [X] **UNLIMITED CASE** (Amount demanded exceeds $25,000) [ ] **LIMITED CASE** (Amount demanded is $25,000 or less)

A **CASE MANAGEMENT CONFERENCE** is scheduled as follows:

Date: April 3, 2017 Time: 3:00 p.m. Dept.: 16 Div.: Room:

Address of court *(if different from the address above):*

[X] **Notice of Intent to Appear by Telephone, by *(name):*** Thomas E. Still, Esq.

INSTRUCTIONS: All applicable boxes must be checked, and the specified information must be provided.

1. **Party or parties** *(answer one):*
   a. [X] This statement is submitted by party *(name):* FREDERICK S. ROSEN, M.D.
   b. [ ] This statement is submitted **jointly** by parties *(names):*

2. **Complaint and cross-complaint** *(to be answered by plaintiffs and cross-complainants only)*
   a. The complaint was filed on *(date):*
   b. [ ] The cross-complaint, if any, was filed on *(date):*

3. **Service** *(to be answered by plaintiffs and cross-complainants only)*
   a. [ ] All parties named in the complaint and cross-complaint have been served, have appeared, or have been dismissed.
   b. [ ] The following parties named in the complaint or cross-complaint
      (1) [ ] have not been served *(specify names and explain why not):*
      (2) [ ] have been served but have not appeared and have not been dismissed *(specify names):*
      (3) [ ] have had a default entered against them *(specify names):*
   c. [ ] The following additional parties may be added *(specify names, nature of involvement in case, and date by which they may be served):*

4. **Description of case**
   a. Type of case in [X] complaint [ ] cross-complaint *(Describe, including causes of action):*
      Medical malpractice

Form Adopted for Mandatory Use
Judicial Council of California
CM-110 [Rev. July 1, 2011]

Cal. Rules of Court, rules 3.720–3.730

PLAINTIFF/PETITIONER: LATASHA NAILAH SPEARS, et al.	CASE NUMBER:
DEFENDANT/RESPONDENT: FREDERICK S. ROSEN, M.D., et al.	RG 15760730

4. b. Provide a brief statement of the case, including any damages. *(If personal injury damages are sought, specify the injury and damages claimed, including medical expenses to date [indicate source and amount], estimated future medical expenses, lost earnings to date, and estimated future lost earnings. If equitable relief is sought, describe the nature of the relief.)*

Alleged negligent surgical treatment of sleep apnea. Defendant denies any wrongdoing. Defendant met the standard of care at all times.

☐ *(If more space is needed, check this box and attach a page designated as Attachment 4b.)*

5. **Jury or nonjury trial**

The party or parties request ☒ a jury trial ☐ a nonjury trial. *(If more than one party, provide the name of each party requesting a jury trial):*

6. **Trial date**

a. ☐ The trial has been set for *(date):*

b. ☒ No trial date has been set. This case will be ready for trial within 12 months of the date of the filing of the complaint *(if not, explain):*

c. Dates on which parties or attorneys will not be available for trial *(specify dates and explain reasons for unavailability):*
SEE ATTACHMENT

7. **Estimated length of trial**

The party or parties estimate that the trial will take *(check one):*

a. ☒ days *(specify number):* 20 (twenty) court days

b. ☐ hours (short causes) *(specify):*

8. **Trial representation** *(to be answered for each party)*

The party or parties will be represented at trial ☒ by the attorney or party listed in the caption ☐ by the following:

a. Attorney: Thomas E. Still, Esq.
b. Firm:
c. Address:
d. Telephone number:
e. E-mail address:
f. Fax number:
g. Party represented:

☐ Additional representation is described in Attachment 8.

9. **Preference**

☐ This case is entitled to preference *(specify code section):*

10. **Alternative dispute resolution (ADR)**

a. **ADR information package.** Please note that different ADR processes are available in different courts and communities; read the ADR information package provided by the court under rule 3.221 for information about the processes available through the court and community programs in this case.

(1) For parties represented by counsel: Counsel ☒ has ☐ has not provided the ADR information package identified in rule 3.221 to the client and reviewed ADR options with the client.

(2) For self-represented parties: Party ☐ has ☐ has not reviewed the ADR information package identified in rule 3.221.

b. **Referral to judicial arbitration or civil action mediation** (if available).

(1) ☐ This matter is subject to mandatory judicial arbitration under Code of Civil Procedure section 1141.11 or to civil action mediation under Code of Civil Procedure section 1775.3 because the amount in controversy does not exceed the statutory limit.

(2) ☐ Plaintiff elects to refer this case to judicial arbitration and agrees to limit recovery to the amount specified in Code of Civil Procedure section 1141.11.

(3) ☐ This case is exempt from judicial arbitration under rule 3.811 of the California Rules of Court or from civil action mediation under Code of Civil Procedure section 1775 et seq. *(specify exemption):*

PLAINTIFF/PETITIONER: LATASHA NAILAH SPEARS, et al. DEFENDANT/RESPONDENT: FREDERICK S. ROSEN, M.D., et al.	CASE NUMBER: RG 15760730

10. c. Indicate the ADR process or processes that the party or parties are willing to participate in, have agreed to participate in, or have already participated in *(check all that apply and provide the specified information):*

	The party or parties completing this form **are willing** to participate in the following ADR processes *(check all that apply):*	If the party or parties completing this form in the case **have agreed** to participate in or have already completed an ADR process or processes, indicate the status of the processes *(attach a copy of the parties' ADR stipulation):*
(1) Mediation	[X]	☐ Mediation session not yet scheduled ☐ Mediation session scheduled for (*date*): ☐ Agreed to complete mediation by (*date*): ☐ Mediation completed on (*date*):
(2) Settlement conference	[X]	☐ Settlement conference not yet scheduled ☐ Settlement conference scheduled for (*date*): ☐ Agreed to complete settlement conference by (*date*): ☐ Settlement conference completed on (*date*):
(3) Neutral evaluation	[X]	☐ Neutral evaluation not yet scheduled ☐ Neutral evaluation scheduled for (*date*): ☐ Agreed to complete neutral evaluation by (*date*): ☐ Neutral evaluation completed on (*date*):
(4) Nonbinding judicial arbitration	☐	☐ Judicial arbitration not yet scheduled ☐ Judicial arbitration scheduled for (*date*): ☐ Agreed to complete judicial arbitration by (*date*): ☐ Judicial arbitration completed on (*date*):
(5) Binding private arbitration	☐	☐ Private arbitration not yet scheduled ☐ Private arbitration scheduled for (*date*): ☐ Agreed to complete private arbitration by (*date*): ☐ Private arbitration completed on (*date*):
(6) Other (*specify*):	☐	☐ ADR session not yet scheduled ☐ ADR session scheduled for (*date*): ☐ Agreed to complete ADR session by (*date*): ☐ ADR completed on (*date*):

PLAINTIFF/PETITIONER: LATASHA NAILAH SPEARS, et al.	CASE NUMBER:
DEFENDANT/RESPONDENT: FREDERICK S. ROSEN, M.D., et al.	RG 15760730

11. **Insurance**
    a. [X] Insurance carrier, if any, for party filing this statement *(name):* Cooperative of American Physicians
    b. Reservation of rights: [ ] Yes [x] No
    c. [ ] Coverage issues will significantly affect resolution of this case *(explain):*

12. **Jurisdiction**
    Indicate any matters that may affect the court's jurisdiction or processing of this case and describe the status.
    [ ] Bankruptcy [ ] Other *(specify):*
    Status:

13. **Related cases, consolidation, and coordination**
    a. [ ] There are companion, underlying, or related cases.
        (1) Name of case:
        (2) Name of court:
        (3) Case number:
        (4) Status:
        [ ] Additional cases are described in Attachment 13a.
    b. [ ] A motion to [ ] consolidate [ ] coordinate will be filed by *(name party):*

14. **Bifurcation**
    [X] The party or parties intend to file a motion for an order bifurcating, severing, or coordinating the following issues or causes of action *(specify moving party, type of motion, and reasons):* Unknown at this time.

15. **Other motions**
    [X] The party or parties expect to file the following motions before trial *(specify moving party, type of motion, and issues):*
    Motion for Summary Judgment on Standard of Care; Motion for Summary Adjudication of Jahi McMath's first cause of action for personal injuries, scheduled for hearing July 13, 2017, 3:00 p.m., Dept. 16.

16. **Discovery**
    a. [ ] The party or parties have completed all discovery.
    b. [x] The following discovery will be completed by the date specified *(describe all anticipated discovery):*

Party	Description	Date
Frederick S. Rosen, M.D.	Written Discovery Depositions of Plaintiffs Percipient Witness Discovery Expert Discovery	Unknown - Pending a resolution of pleadings issues

    c. [ ] The following discovery issues, including issues regarding the discovery of electronically stored information, are anticipated *(specify):*

PLAINTIFF/PETITIONER: LATASHA NAILAH SPEARS, et al.	CASE NUMBER:
DEFENDANT/RESPONDENT: FREDERICK S. ROSEN, M.D., et al.	RG 15760730

17. **Economic litigation**
    a. ☐ This is a limited civil case (i.e., the amount demanded is $25,000 or less) and the economic litigation procedures in Code of Civil Procedure sections 90-98 will apply to this case.
    b. ☐ This is a limited civil case and a motion to withdraw the case from the economic litigation procedures or for additional discovery will be filed *(if checked, explain specifically why economic litigation procedures relating to discovery or trial should not apply to this case):*

18. **Other issues**
    ☒ The party or parties request that the following additional matters be considered or determined at the case management conference *(specify):* Application for continuance of plaintiffs' motion to bifurcate trial until after the hearing on defendant's motion for summary adjudication scheduled for hearing on July 13, 2017. (See Application attached.)

19. **Meet and confer**
    a. ☐ The party or parties have met and conferred with all parties on all subjects required by rule 3.724 of the California Rules of Court *(if not, explain):*

    b. After meeting and conferring as required by rule 3.724 of the California Rules of Court, the parties agree on the following *(specify):*

20. Total number of pages attached *(if any):* 40

I am completely familiar with this case and will be fully prepared to discuss the status of discovery and alternative dispute resolution, as well as other issues raised by this statement, and will possess the authority to enter into stipulations on these issues at the time of the case management conference, including the written authority of the party where required.

Date: March 22 2017

THOMAS E. STILL
(TYPE OR PRINT NAME)

(SIGNATURE OF PARTY OR ATTORNEY)

(TYPE OR PRINT NAME)

(SIGNATURE OF PARTY OR ATTORNEY)

☐ Additional signatures are attached.

ATTACHMENT 6.C.

UNAVAILABLE DATES FOR COUNSEL

2017

March 25-April 1, 2017	Unavailable	
May 15-18, 2017	Isels, M.D. / MBC	Oakland OAH
June 1-12, 2017	Unavailable	
Jul. 10-20, 2017	Zuniga v. Hamilton	San Mateo Superior Court
Aug. 8-23, 2017	Unavailable	
Aug 28-Sept 8, 2017	Zammarchi v. Flemming	Monterey Superior Court
Sept. 11-25, 2017	Barghahn v. Margolis	San Mateo Superior Court

2018

Jan. 8-18, 2018	Granger v. Rasi	Santa Cruz Superior Court

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jstill@hinshaw-law.com

Attorneys for Defendant
FREDERICK S. ROSEN, M.D.

SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

LATASHA NAILAH SPEARS WINKFIELD; MARVIN WINKFIELD; SANDRA CHATMAN; and JAHI McMATH, a minor, by and through her Guardian Ad Litem, LATASHA NAILAH SPEARS WINKFIELD,

Plaintiffs,

vs.

FREDERICK S. ROSEN, M.D.; UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND (formerly Children's Hospital & Research Center of Oakland); MILTON McMATH, a nominal defendant, and DOES 1 THROUGH 100,

Defendants.

Case No. RG15760730

ASSIGNED FOR ALL PURPOSES TO:
JUDGE STEPHEN PULIDO
DEPARTMENT 16

APPLICATION FOR CONTINUANCE OF PLAINTIFFS' MOTION TO BIFURCATE TRIAL UNTIL AFTER THE HEARING ON DEFENDANTS' MOTION FOR SUMMARY ADJUDICATION

Date: April 3, 2017 (Case Management Conf.)
Time: 3:00 p.m.
Dept: 16, Hon. Stephen Pulido

Complaint Filed: March 3, 2015
Date of Trial: None set

Defendant Frederick S. Rosen, M.D., hereby applies for an order that continues plaintiff's motion to bifurcate trial (noticed for hearing on **April 27, 2017**) until after resolution of defendants' motion for summary adjudication of Jahi McMath's First Cause of Action for Personal Injuries (noticed for hearing on **July 13, 2017**). In the motion to bifurcate, plaintiffs seek to have the issues of liability and causation tried separately and prior to the issue of brain death. There is good cause for the continuance: It would be a

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jstill@hinshaw-law.com

Attorneys for Defendant
FREDERICK S. ROSEN, M.D.

SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

LATASHA NAILAH SPEARS WINKFIELD; MARVIN WINKFIELD; SANDRA CHATMAN; and JAHI McMATH, a minor, by and through her Guardian Ad Litem, LATASHA NAILAH SPEARS WINKFIELD,

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waste of the court's limited resources to consider a motion that will be moot in the event defendants' motion for summary adjudication is granted. Plaintiffs' motion to bifurcate is premature.

By way of background, just over a year ago, the court (Judge Friedman presiding) overruled the defendants' demurrer to Jahi McMath's personal injury claim. Defendants argued that Jahi McMath was properly declared deceased under California law in December 2013 and, therefore, lacked standing to sue for personal injuries in a medical malpractice action. In its ruling, the court explained that while collateral estoppel may ultimately bar plaintiffs from relitigating the issue of whether Jahi McMath is dead, ***"a more developed factual record"*** may be necessary to determine whether the changed circumstances exception precludes application of the doctrine of collateral estoppel. Thereafter, defendants petitioned the First Appellate District to issue a writ of mandate. The appellate court denied the petition stating: "Because the trial court found the record at the pleading stage was inadequate for a collateral-estoppel determination and "may require a more developed factual record," we conclude, under the circumstances, that this matter should not be resolved at the pleading stage."

The motion for summary adjudication provides the "factual record" that establishes Jahi McMath is dead under California law and there is no medical or legal basis to review her death. Thus, the pronouncement of death must be given preclusive effect in the instant litigation. Defendants establish that (1) Jahi McMath is dead to a degree of medical certainty, (2) it is not reasonably probable that a mistake was made in the diagnosis of Jahi McMath's brain death in December 2013, and (3) the diagnosis of Jahi McMath's brain death was made in accord with the accepted medical standards. (See *Dority v. Superior Court* (1983) 145 Cal.App.3d 273, 278; Health and Safety Code § 7180.)

Furthermore, plaintiffs cannot create a triable issue of material fact. Defendants establish, through plaintiffs' admissions and the declarations of two distinguished experts in pediatric brain death, **Thomas A. Nakagawa, M.D., FAAN, FCCM**, and **Sanford Schneider, M.D., FAAN, FAAP**, that the *only* accepted neurological criteria for assessing

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McMath's brain function is an examination performed in accordance with the accepted medical standards that are set forth in the Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendation. Although McMath has been in her mother's custody since August 25, 2014, plaintiffs admit that McMath has not been clinically evaluated by a physician in accord with the aforementioned guidelines since December 2013, when McMath satisfied the clinical criteria for brain death during three independent brain death examinations and was appropriately declared deceased under California law. Given the absence of competent evidence that demonstrates McMath no longer fulfills the accepted neurological criteria for brain death, there is no medical or legal basis to review McMath's death.

Defendants' two pediatric brain death experts, Dr. Nakagawa and Dr. Schneider, have reviewed the medical records pertaining to McMath, including all materials produced by plaintiffs that allegedly show that McMath is not dead. Both experts conclude, *to a degree of medical certainty*, that McMath fulfills the criteria for death under California law, and there is no medical possibility that McMath has recovered, or will someday recover, from death.

Defendants' motion for summary adjudication is based on the records in the underlying probate case, plaintiffs' admissions, and the declarations of Dr. Nakagawa and Dr. Schneider, both experts on pediatric brain death. Dr. Nakagawa is the lead author of the published guidelines currently used by physicians in hospitals nationwide to determine pediatric brain death under the law. The expert declarations, appended hereto, are submitted to demonstrate that defendants' motion for summary adjudication is well-founded.

DATED: March 22, 2017 HINSHAW, MARSH, STILL AND HINSHAW, LLP

By _____
JENNIFER STILL
THOMAS E. STILL
Attorneys for Defendant
FREDERICK S. ROSEN, M.D.

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DECLARATION OF JENNIFER STILL, ESQ.

I, Jennifer Still, Esq., declare:

1. I am an attorney at law duly licensed to practice before the courts of the State of California. I am a member of the law offices of Hinshaw, Marsh, Still & Hinshaw, attorneys for defendant Frederick S. Rosen, M.D.

2. True and correct copies of the declarations of defendants pediatric brain death experts, Thomas A. Nakagawa, M.D., FAAN, FCCM, and Sanford Schneider, M.D., FAAN, FAAP, filed by defendants in support of their motion for summary adjudication of Jahi McMath's First Cause of Action for Personal Injuries are appended hereto, without the accompanying exhibits. The complete declarations were filed on March 23, 2017.

3. While plaintiffs' counsel graciously agreed to continue the hearing date of the motion to bifurcate due to my office's unavailability on the date originally noticed, we were unable to reach an agreement to have the motion to bifurcate postponed until after resolution of defendants' motion for summary adjudication.

I declare under penalty of perjury under the laws of the State of California that all of the foregoing is true and correct, and as to those matters stated on my information and belief, I believe them to be true, and if called upon to testify to the matters herein, I can competently testify thereto.

Executed on March 22, 2017, at Saratoga, California.

By Jennifer Still
JENNIFER STILL

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Attorneys for Defendant
FREDERICK S. ROSEN, M.D.

SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

LATASHA NAILAH SPEARS WINKFIELD; MARVIN WINKFIELD; SANDRA CHATMAN; and JAHI McMATH, a minor, by and through her Guardian Ad Litem, LATASHA NAILAH SPEARS WINKFIELD,

Plaintiffs,

vs.

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Defendants.

Case No. RG15760730
ASSIGNED FOR ALL PURPOSES TO:
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DEPARTMENT 16

DECLARATION OF THOMAS A. NAKAGAWA, M.D., FAAP, FCCM

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INDEX OF EXHIBITS

Exhibit A:	Curriculum Vitae of Thomas A. Nakagawa, M.D., FAAP, FCCM
Exhibit B:	Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations, published in *Pediatrics* (2011) 128:3 e720-e740, referred to herein as Guidelines
Exhibit C:	Medical records of Jahi McMath from Children's Hospital of Oakland, Bates Stamp Nos. CHO 40-44, 90-91, 161-163, 181-184, 208-211, 220-225, 231-233, 237, 252-253, 256-259, 295, 8805-8807, 17332, 17349, 17369, 17370, 17415-17416, 26604, 26606-26608, 26620-26621, 26649-26664, referred to herein as "CHO"
Exhibit D:	Supplemental medical records of Jahi McMath from Children's Hospital of Oakland, Page Nos. 343-345, 401-402, 407-413, referred to herein at "CHO Supp"
Exhibit E:	Physician Declaration of Robin Shanahan, M.D.
Exhibit F:	Division Chief Declaration (Sharon Williams, M.D.)
Exhibit G:	Physician Declaration of Robert Heidersbach, M.D.
Exhibit H:	Medical records of Jahi McMath from Kaiser Permanente- Oakland
Exhibit I:	Records prepared by Paul Fisher, M.D., filed on December 23, 2013, re: Paul Fisher, M.D.'s brain death evaluation of Jahi McMath on December 23, 2013
Exhibit J:	Select medical records of Jahi McMath from Saint Peter's University Hospital, Page Nos. 1-3, 5, 483-484, 493-498, 500,-501, 527, 532, 555-558, 560, 585, 608, 616-617, 712, 735, 754, 766, 778-779, 780-781, 800, 821-823
Exhibit K:	Medical records of Jahi McMath from University Hospital
Exhibit L:	Reporter's Transcript of Proceedings on December 24, 2013

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I, Thomas A. Nakagawa, M.D., FAAP, FCCM, declare:

1. I am a physician licensed to practice medicine in the State of California since 1989. I am also licensed to practice medicine in Virginia, North Carolina, and Florida. I am Board Certified by the American Board of Pediatrics in Pediatric Critical Care Medicine. I am currently employed as the Chief of the Division of Critical Care Medicine and Director of the Pediatric Intensive Care Unit at Johns Hopkins All Children's Hospital in St. Petersburg, Florida. I am a Professor of Anesthesiology and Critical Care (PAR) at Johns Hopkins School of Medicine in Baltimore, Maryland. I currently have medical staff privileges at Johns Hopkins All Children's Hospital. A copy of my Curriculum Vitae is appended hereto as Exhibit A.

2. In 1981, I obtained my Bachelor of Science Degree with a microbiology major at Texas Tech University in Lubbock, Texas. In 1986, I obtained my Medical Degree at Texas Tech University School of Medicine. Thereafter, I completed a one-year postdoctoral internship in Pediatrics in 1987, followed by a two-year residency in Pediatrics in 1989, at Phoenix Hospitals Affiliated Pediatrics Program, Phoenix Children's Hospital, and Maricopa Medical Center where I also served as a Pediatric Chief Resident. In 1992, I completed my three-year fellowship training in Pediatric Critical Care Medicine at Children's Hospital Los Angeles, in Los Angeles, California, where I also served as an administrative fellow in the Pediatric Intensive Care Unit.

3. I have specialized in Pediatric Critical Care Medicine for the last twenty-five years. I have overseen clinical, research, and educational programs in Pediatric Critical Care. From 2002 to April 2016, I was the Medical Director of Pediatric Critical Care Medicine at Wake Forest Baptist Health, Brenner Children's Hospital. During my fifteen-year employment at Wake Forest School of Medicine, I was a Professor of Anesthesiology and Pediatrics and served as the Section Head of Pediatric Critical Care and Medical Director of the Pediatric Intensive Care Unit and Pediatric Respiratory Therapy. From July 1992 to May 2002, I was an attending staff physician in the Pediatric Intensive Care Unit at Children's Hospital of the King's Daughters in Norfolk, Virginia. During my ten-year employment at Children's Hospital of the King's Daughters, I served as the Resident Education Coordinator in the Pediatric Intensive Care Unit, the Director of the Pediatric Transport Team, the Division Director of Pediatric Critical Care Medicine, and was

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also faculty in the Division of Forensic Pediatrics.

4. My interests as a clinician, educator and researcher include determination of death, standardizing the process of brain death determination for children and infants, the ethical considerations in the determination of death, improving end-of-life care, traumatic brain injury, organ donation and transplantation, and acute lung injury and pulmonary hypertension. I was the lead author of the revised pediatric guidelines for determination of brain death in children, published in 2011. These multi society guidelines from the Society of Critical Care Medicine, American Academy of Pediatrics, and Child Neurology Society represent a consensus opinion of a panel composed of national experts in pediatric critical care, pediatric neurology, pediatric neurosurgery, neonatology, pediatric radiology, and pediatric critical care nursing. In 2013, I chaired the brain death determination and testing committee for the Secretary of Health and Human Services Advisory Committee on Transplantation (ACOT), which made a formal recommendation (Recommendation 56) to The Secretary of Health and Human Services to standardize brain death testing in children and adults using currently accepted medical guidelines. I have published in recognized high impact peer review journals including Pediatrics, The Journal of Pediatrics, Pediatric Critical Care Medicine, Pediatric Infectious Disease, Critical Care Medicine, Chest, American Journal of Respiratory Care and Critical Care Medicine, Pediatric Cardiology, and Transplantation.

5. I am the current Chair of the Pediatric Section and Pediatric Executive Steering Committee of the Society of Critical Care Medicine (SCCM), the largest non-profit medical organization dedicated to promoting excellence and consistency in the practice of critical care. SCCM is the only organization that represents all professional components of critical care medicine, and has members in more than 100 countries. SCCM has been instrumental in reviewing and updating the guidelines for determining brain death in children and infants.

6. I am aware that the State of California adopted the Uniform Determination of Death Act, which states that an individual is dead if he or she has sustained an irreversible cessation of all functions of the entire brain, including the brain stem. I am aware that when an individual is pronounced dead by determining that the individual has sustained an irreversible

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cessation of all functions of the entire brain, including the brain stem, there must be independent confirmation by another physician. In California, as well as all other states, the determination of death, including brain death, must be made in accordance with "accepted medical standards."

7. I am familiar with the "accepted medical standards" for determining brain death in children and infants. The clinical criteria for determining the irreversible cessation of all functions of the entire brain, including the brain stem, in children and infants were initially published by a multi-society task force in 1987 entitled Report of Special Task Force: Guidelines for Determination of Brain Death in Children, which was published in *Pediatrics* 1987;80(2):298–300, *Pediatr. Neurol.* 1987;3(4):242–243, and the *Annals of Neurology* 1987; 21:616-617. Several years ago, I recommended that SCCM and American Academy of Pediatrics, in conjunction with the Child Neurology Society, form a multi-disciplinary committee of medical and surgical sub-specialists under the auspices of the American College of Critical Care Medicine to review and update the 1987 pediatric brain death guidelines. I was Chair of this multi-society committee charged with updating the 1987 guidelines for determining pediatric brain death and the lead author for the published guidelines.

8. The multidisciplinary committee produced revised guidelines. I was the lead author of the guidelines that resulted from the work of this committee. Our report, entitled Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations, was published in 2011 in *Critical Care Medicine* (2011) 39:2139-2155; *Pediatrics* (2011) 128:3 e720-e740; and *Annals of Neurology* (2012) 71:573-585 (hereinafter "Guidelines.) These Guidelines were endorsed by the three contributing societies along with multiple medical societies including American Association of Critical Care Nurses, National Association of Pediatric Nurse Practitioners, Society of Pediatric Anesthesia, Society of Pediatric Neuroradiology, World Federation of Pediatric Intensive and Critical Care Societies along with multiple sub sections from the American Academy of Pediatrics. A true and correct copy of the Guidelines is appended hereto at Exhibit B. Appendix 1 of the revised Guidelines is the "Brain Death Examination Checklist." (Ex. B, at p. e735.) The checklist is a form designed to assist physicians in determining brain death in children/infants and helps ensure that all

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components of the examination, and ancillary studies if needed, are completed and documented appropriately. It is recommended that the examining clinicians utilize the Checklist to standardize the process to determine brain death in infants and children. Failure to use the Checklist does not invalidate a brain death determination.

9. The Guidelines represent the "accepted medical standards" for determining brain death in infants and children. The Guidelines outline the minimum requirements to make a determination of brain death in infants and children. The Guidelines have been endorsed and accepted by relevant medical societies nationwide. Hospitals have adopted the Guidelines as the standard for determining pediatric brain death, and attending pediatric critical care specialists, neurologists, neuro and trauma surgeons utilize the Guidelines in determining whether a child is deceased after meeting and fulfilling brain death criteria. From a legal, medical and societal perspective, it is uniformly accepted that a person, including a child, is legally dead when the neurologic diagnostic criteria of total and irreversible cessation of brain function in the Guidelines are fulfilled. The Guidelines do not challenge the legal definition of death.

10. It is the medical and legal consensus that brain death is the criterion for death of that individual. 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 determine brain death. This diagnosis should be made by physicians who have evaluated the history and completed the neurologic examinations. In addition to the neurologic examination, an apnea test should be completed demonstrating no respiratory effort. If the apnea test or components of the clinical examination cannot be safely completed, an ancillary study should be performed to assist with determination of death. Accepted ancillary studies for infants and children include four-vessel cerebral angiography, electroencephalogram (EEG), or a radionuclide cerebral flow (CBF) study. Clinical determination of brain death in infants and children requires two examinations by different physicians and two apnea tests. The first examination determines the child has met neurologic criteria for brain death. The second examination confirms brain death based on an unchanged and irreversible condition. The Guidelines provide the minimum requirements to make a determination of brain death.

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11. In general terms, a brain death examination in accord with the Guidelines consists of (1) identifying the cause and presence of irreversible coma, i.e., complete loss of consciousness, vocalization, volitional activity, and lack of response to painful stimuli, (2) normalizing physiologic parameters prior to the clinical examination, (3) a physical examination that demonstrates the absence of brainstem reflexes, and (4) apnea testing demonstrating the absence of respiratory control system reflexes in the brainstem. An observation period of twelve hours between the first and second examination is recommended for children older than 31 days of age. A 24 hour observation period between examinations is recommended for children less than 31 days of age.

A. Prior to the clinical examination, the examining physician must confirm the patient is eligible for a brain death examination, i.e., the prerequisites for initiating a brain death evaluation. Hypotension, hypothermia, metabolic disturbances, and medications, which can interfere with neurologic examination and apnea testing, must be identified and should be corrected before proceeding with the brain death evaluation.

B. The physical examination consists of neurologic tests that document loss of all brain stem reflexes, including (1) midposition or fully dilated pupils which do not respond to light; typically fixed in a mid-size or dilated position (4-9mm), (2) absence of movement of bulbar musculature including facial or oropharyngeal muscles, (3) absent gag, cough, sucking and rooting reflexes, (4) absent corneal reflexes, and (5) absent oculovestibular reflexes.

C. The two examinations must include apnea testing with each examination unless there is a medical contraindication or hemodynamic instability. The apnea test must be performed safely. A properly performed apnea test demonstrating no respiratory effort is an essential sign of definitive loss of brain function. The main objective of apnea testing is to prove the absence of respiratory reflexes in the brainstem when intense physiologic stimulation to breathe takes place. Apnea testing requires documentation of arterial blood gases in a critical care or intensive care setting. A patient is considered to meet apnea test criteria for brain death if (1) there are no spontaneous respiratory efforts during the test and (2) the patient's $PaCO2 \geq 60$ mm Hg and at least 20 mmHg above baseline.

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D. Noxious stimuli should not produce a motor response other than spinal cord reflexes. The clinical differentiation of spinal responses from retained motor responses associated with brain activity requires expertise.

E. Accepted ancillary studies for infants and children include four-vessel cerebral angiography, electroencephalogram (EEG), or a radionuclide cerebral flow (CBF) study. Ancillary studies are not required to establish brain death. Ancillary studies are not a substitute for the neurologic examination. However, ancillary testing may be used to assist the clinician in making the determination of brain death (i) when the 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 as to the results of the neurologic examination, (iii) if a medication effect may be present; or (iv) to reduce the inter-examination observation period. Ancillary studies may also be helpful for social reasons to allow the family members to better comprehend the diagnosis of brain death. These ancillary tests must be performed in a hospital setting by technicians possessing the requisite education, training and experience. Electroencephalographic documentation of 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. EEG testing must be performed in accordance with standards established by the American Electroencephalographic Society. 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. Further, similar to the neurologic examination, hemodynamic and temperature parameters should be normalized before obtaining EEG or cerebral blood flow studies.

F. Brain MRI and MR angiography are not validated tests to assist with determination of brain death in infants and children. The Guidelines state: "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." (Ex. B, p. e729.)

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12. The only accepted criteria for determination of pediatric brain death are those set forth in the Guidelines. Brain death is a clinical assessment made by qualified physicians using a standardized approach that relies on a clinical examination and apnea testing with a known cause of coma. The diagnostic criteria in the Guidelines were established to provide uniformity in the determination of brain death. The methodology allows physicians to pronounce brain death in a precise and orderly manner. It ensures that all components of the examination are performed and appropriately documented. Adherence to the uniform criteria in the Guidelines protects the health and safety of pediatric patients and provides family members and society at large with the assurance that determination of brain death is reliable and lawful. There is no substitute for a brain death evaluation. Ad hoc testing of brain function is not a substitute to a brain death evaluation performed in accordance with the accepted medical standards. Indeed, a physician's assessment of brain death made pursuant to ad hoc testing would be a violation of the standard of care, a breach of professional responsibility as well as a violation of California's Uniform Determination of Death Act.

13. I have over 25 years of experience in the evaluation and care of children with neurological disorders. As a specialist in the practice of pediatric critical care medicine, I am responsible for diagnosing and treating children who have unstable, life-threatening and end-of-life conditions, including cardiopulmonary failure and brain trauma. I have significant professional experience in applying the accepted medical standards for determining brain death in children. During the course of my practice as a pediatric intensivist, I estimate that I have performed, or been involved in more than 175 examinations utilizing the accepted medical standards for determining brain death in children. My education, training and experience render me qualified to provide an expert opinion on whether the accepted medical standards were correctly applied to Jahi McMath and if diagnostic error occurred in the determination of brain death for this child.

14. I have been retained by defense counsel to review the medical records and other materials pertaining to Jahi McMath. Along with plaintiffs' First Amended Complaint, I have received and reviewed the following materials pertaining to Jahi McMath in connection with my

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review:

- CD containing the imaging studies of the brain MRI (without contrast), MR angiogram (without contrast) and MRV (without contrast) performed at University Hospital (New Jersey) and the reports of these imaging studies dated 9-26-14 (pp. 1-9)
- CD containing 7 chest x-rays and 1 ultrasound produced by Saint Peter's University Hospital
- CD containing the imaging studies performed at Children's Hospital Oakland including the chest x-rays on 12-10-13 and 12-11-13, the head CT on 12/11/13, and the radionuclide cerebral blood flow study on 12-23-13
- A CD containing the 4 EEG recordings performed at Children's Hospital Oakland on 12-11-13, 12-12-13, 12-17-13 and 12-23-13
- UCSF Benioff Children's Hospital Oakland records
- Saint Peter's University Hospital records (New Brunswick, New Jersey) (pp.1-12702)
- Kaiser Permanente Hayward records (pp.1-94)
- Kaiser Permanente Oakland records (pp. 1-7)
- Med Life Pharmacy records (pp. 1-36)
- Preferred Home Health Care records (pp. 1-350)
- Thi Nguyen, M.D. records (pp. 1-368)
- Alieta Eck, M.D. records (pp. 1-151)
- Bayada Home Health Care records (pp. 1-4655)
- University Hospital records (Newark, New Jersey)
- A CD containing video recordings numbered 1 to 34 produced by plaintiffs
- A CD containing video recordings numbered 1 to 17 produced by plaintiffs
- Photographs produced by plaintiffs numbered 1-288
- Paul Byrne, M.D., declaration dated 12-20-13
- Updated declaration of D. Alan Shewmon, M.D., dated 12-10-14
- Calixto Machado, M.D., declaration dated 10-5-14, and curriculum vitae

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- Calixto Machado, M.D., letter to Philip De Fina dated 9-29-14
- Letter from Alieta Eck, M.D., dated 4-10-16
- Philip De Fina, PhD declaration dated 10-2-14
- The EEG report authored by Elena Labkovsky
- Ivan Mikolaenko, M.D., declaration dated 10-7-14
- Charles Prestiacomo, M.D., declaration dated 10-8-14
- Latasha Winkfield declaration filed 12-20-13
- Paul Fisher, M.D.'s curriculum vitae
- Paul Fisher, M.D.'s letter dated 12/23/13 and brain death exam notes and checklist dated 12/23/13, prepared by Paul Fisher, M.D.
- Amended Order filed 1-2-14
- Order filed 10-1-14
- Writ of Error Corum Nobis filed 10-3-2014
- D. Alan Shewmon,M, D.,declaration dated 10-3-2014 and curriculum vitae
- Philip De Fina, PhD, declaration and curriculum vitae
- Calixto Machado. M.D., declaration and curriculum vitae
- Charles Prestigiacomo declaration and curriculum vitae
- Elena B. Labkovsky declaration and curriculum vitae
- Court order Appointing Paul Fisher filed on 10-6-14, including Dr. Fisher's CV, and Dr. Fisher's letter dated 10-6-14, which includes Dr. Fisher's examination and consultation finding of Jahi McMath on December 23, 2013, and a copy of the Guidelines
- Declaration of Sharon Williams, M.D. filed December 20, 2013, and attachment
- Declaration of Robin Shanahan, M.D., filed December 20, 2013
- Declaration of Robert Heidersbach, M.D., filed December 20, 2013
- Declaration of Christopher Dolan, filed December 30, 2013
- Opposition to Ex Parte Application filed by Children's Hospital on December 30, 2013

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- Declaration of Dr. Ann Petru filed January 3, 2014
- Declaration of Dr. Heidi Flori filed January 3, 2014
- Declaration of Dr. Sidney Gospe, Jr., filed January 3, 2014

15. I have also read the Reporter's Transcripts of the December 23, 2013 and December 24, 2013, hearings involving Ms. Winkfield's opposition to the hospital's withdrawal of McMath mechanical ventilator following the pronouncement of death on December 12, 2013. Two physicians testified at the December 24, 2013, hearing, Robin Shanahan, M.D., and Paul Fisher, M.D., regarding the specifics of their brain death examinations, performed on December 11, 2013 and December 23, 2013, respectively.

16. My review of above materials reflects the following:

A. During the evening of December 9, 2013, while in the Pediatric Intensive Care Unit ("PICU") at Children's Hospital Oakland ("CHO"), McMath began to bleed from the mouth and nose. At approximately 12:30 a.m. on December 10, 2013, McMath appeared to gag and stop breathing. She was unresponsive and went into cardiopulmonary arrest. A code blue was initiated at 12:35 a.m. During the approximate 2 hour and 33 minute code, there was considerable difficulty with oxygenation. McMath continued to bleed from the mouth and nose throughout the code, and had bloody secretions noted in the endotracheal tube, preventing prompt and adequate oxygenation. (CHO Chart, pp. 90-91, 295, 8805-8807, 26607-26608, 26649-26664, Exhibit C appended hereto; and CHO Supp. Chart, pp. 343-345, Exhibit D appended hereto.)

B. On December 11, 2013 at 2:08 a.m., Sharon Williams, M.D., ordered a head CT scan due to a change in McMath's neurological status. The impression of the head CT scan, performed early in the morning on December 11, 2013, was (1) Diffuse cerebral edema and abnormal low attenuation in the basil ganglia and presumed basilar herniation, consistent with sequelae of anoxia; and (2) Global linear high attenuation within the subarachnoid spaces, basal cisterns, and along the tentoriurn felt to represent pseudosubarachnoid hemorrhage on the basis of cerebral edema. (CHO Chart, pp. 237, 17415-17416, 17332 and 26606-16607, Exhibit C appended hereto.)

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C. An electroencephalogram ("EEG") lasting 41 minutes was performed the morning of December 11, 2013. There was no reaction to stimulation. There was no discernible cerebral activity. No brain wave activity was seen. The EEG fulfilled the diagnostic criteria for electrocerebral inactivity. (CHO Chart, pp. 26620-26621, Exhibit C appended hereto; and Reporter's Transcript, pp. 31:1-13, 66:5-25, and 67:1-6, Exhibit L appended hereto)

D. On December 11, 2013, a brain death evaluation was ordered for McMath to determine whether McMath had sustained an irreversible cessation of all functions of her entire brain, including the brain stem. On December 11, 2013, Robin Shanahan, M.D., an attending pediatric neurologist at CHO, performed the first of three brain death evaluations performed on McMath at CHO. Dr. Shanahan had performed over 300 brain death examinations prior to her evaluation of McMath.

(1) Dr. Shanahan correctly applied the accepted medical standards for evaluating brain death in children as set forth the Guidelines. There was (1) confirmation that all of the prerequisites for a brain death evaluation were met, (2) a physical examination demonstrated no cerebral or brain stem reflexes, and (3) an apnea test demonstrated lack of spontaneous breathing. Dr. Shanahan found there was no evidence of any cerebral or brain stem function. (Shanahan Decl., Exhibit E appended hereto; Williams Decl., Exhibit F appended hereto; CHO Chart, pp. 40-41, Exhibit C appended hereto; and Reporter's Transcript, pp. 55-57, 60:13-68:2 and 100-104, Exhibit L appended hereto.)

(2) Based on my education, training, knowledge and experience in pediatric brain death and the accepted medical standards set forth in the Guidelines, as well as my review of the records in this matter, on December 11, 2013, McMath met neurologic criteria for brain death. There is no evidence of any diagnostic error occurring during the examination process. Dr. Shanahan used the level of skill, knowledge and care in applying the accepted medical standards that other reputable pediatric neurocritical care specialists would use in similar circumstances.

E. Pediatric critical care specialist Robert S. Heidersbach, M.D., the PICU attending physician at CHO, also examined McMath the morning of December 11, 2013, to

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evaluate her clinical and radiographic evidence of early cerebral herniation. On exam, McMath's pupils were dilated and fixed. Dr. Heidersbach reported that McMath had likely progressed to brain death secondary to anoxic injury during the code. (CHO Chart, pp. 256-259, Exhibit C appended hereto.)

F. McMath was re-examined by Dr. Shanahan at approximately 9:00 a.m. on December 12, 2013, at the request of the PICU staff. Throughout the night McMath had some spontaneous right arm movements and some dramatic triple flexion withdrawal movements with extremity stimulation. The ICU staff wanted Dr. Shanahan to confirm that these movements were not of cortical origin coming from the brain, but rather spinal reflexes. On examination, McMath remained unchanged with unreactive, dilated pupils, fixed at 7mm, no spontaneous breathing and absent cough and gag reflexes. She remained comatose with no environmental reaction. She had absent corneal reflexes. When fingernails were pressed into her occiput (back of the head/skull), no spontaneous movement was elicited. She had easy to obtain deep tendon reflexes. With plantar stimulation there was a subtle triple flexion of both legs. One spontaneous arm jerk was observed without any stimulation. Dr. Shanahan reported that the movements she observed during her repeat evaluation were consistent with spinal withdrawal and spinal myoclonus. (CHO Chart, pp. 252-253, Exhibit C appended hereto; Reporter's Transcript, pp. 68:3-15; 72:8-24; 82:6-21; 86:12-25, Exhibit L appended hereto; and Shanahan Decl., Exhibit E appended hereto.)

G. In an attempt to satisfy the family's concerns, a second EEG was ordered the morning of December 12, 2013, to demonstrate that McMath's movements during an EEG had no cortical correlate. The second EEG, performed on December 12, 2013, lasted approximately 30 minutes. The technician described episodes of spinal movements including right arm movement, left arm tremors, and jerking. None of the movements had any electrographic correlation. Auditory, photic and painful stimulation did not change the background. There were no EEG changes during blood pressure elevation. The EEG fulfilled the criteria for electrocerebral inactivity. Dr. Shanahan and Dr. Heidersbach confirmed that the spinal movements seen during EEG testing were not associated with brain function. (CHO Chart, pp. 252-253, and 26604, Exhibit C appended hereto; and CHO Supp. Chart, pp. 401-402, Exhibit D appended hereto.)

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H. During the second brain death examination conducted on December 12, 2013, attending PICU physician, Robert S. Heiderbach, M.D., applied the accepted medical standards for determining brain death in children and concluded that McMath met clinical criteria for brain death as set forth in the Guidelines.

(1) Dr. Heidersbach first confirmed there were no metabolic disorders that would interfere with the neurologic examination. He found McMath exhibited a complete loss of consciousness, with no vocalizations and no volitional activity. She did not open or move her eyes to noxious stimuli. Her pupils were unreactive to light and dilated at 5mm. Corneal reflexes were absent. There was an absence of movement of bulbar musculature including facial oropharyngeal muscles. There was no grimacing or facial muscle movement when deep pressure was applied on the condyles at the level of the temporomandibular joints and at the supraorbital ridge. There was no gag or cough reflex. 60 mL of ice water was instilled in each ear elicited no movement of the eyes during an observation period of one minute. During the apnea test McMath demonstrated a complete absence of respiratory effort. (CHO Chart, p. 26604, Exhibit C appended hereto; CHO Supp. Chart, pp. 407-413, Exhibit D appended hereto; Heidersbach Decl., Ex. G appended hereto, and Williams Decl., Exhibit F appended hereto.)

(2) Based on my education, training, knowledge and experience in pediatric brain death and the accepted medical standards set forth in the Guidelines, as well as my review of the records in this matter, on December 12, 2013, Dr. Heidersbach's examination confirmed that McMath fulfilled the criteria for brain death. There is no evidence that any diagnostic error occurred in the examination process. The patient's condition remained unchanged and the second examination and apnea test supported the conclusion that Ms. McMath fulfilled criteria for brain death. Dr. Heidersbach used the level of skill, knowledge and care in applying the accepted medical standards that other reputable pediatric critical care specialists would use in similar circumstances.

I. Given that two brain death examinations performed a day apart, in accordance with the Guidelines, revealed brain death, Dr. Heidersbach appropriately pronounced McMath clinically brain dead and deceased at 3:00 p.m. on December 12, 2013. Along with the

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brain death examination notes, Dr. Heidersbach completed a Physician Death Summary, wherein he documented McMath's medical course leading to brain death. (CHO Chart, p. 26604, Exhibit C appended hereto; CHO Supp. Chart, p. 407-410, Exhibit D appended hereto; and Williams Decl., Exhibit F appended hereto.) Based on my education, training, knowledge and experience in pediatric brain death, the application of the accepted medical standards set forth in the Guidelines, and review of records, no diagnostic error occurred in the determination of McMath's death at Children's Hospital Oakland on December 12, 2013.

J. On December 12, 2013, McMath was pronounced legally deceased under California's Uniform Determination of Death Act since she was clinically found to have suffered an irreversible cessation of all functions of the entire brain, including the brainstem, by two attending physicians during separate evaluations performed more than 12 hours apart, in accordance with the accepted medical standards set forth in the Guidelines.

K. McMath demonstrated occasional movements following the declaration of death. On December 13 and 14, 2013, it was noted that McMath was having brain-death associated spinal reflexes and occasional automatisms, including triple flexion of the lower extremities and brief clonic movements of unilateral upper extremities. Slight flexion at the ankle, knee and hip was elicited with touching her foot. McMath's neurological status remained unchanged. The neurologic examinations on December 13 and 14, 2013, remained consistent with brain death. (CHO Chart, pp. 208-211, 222-225, Exhibit C appended hereto.)

L. McMath continued to exhibit spinal reflexes. At the request of the family, on December 17, 2013, a third EEG was performed, lasting 31 minutes in duration. McMath was unresponsive to pinch, light touch and loud clapping. The EEG fulfilled the criteria for electrocerebral inactivity. The family was informed that the EEG remained consistent with brain death. (CHO Chart, pp. 43-44, and 161-163, Exhibit C appended hereto.)

M. On December 17, 2013, CHO arranged for a review of the EEG's and head CT scan with Dr. Jean Hayward, a pediatric neurologist at Kaiser Permanente Oakland. Dr. Hayward spoke with the family and Winkfield's attorney, Christopher Dolan, via a conference call to confirm the findings were consistent with irreversible brain injury and brain death. Dr.

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Hayward encouraged the family to conduct a prayer vigil and to meet with the PICU team to decide on a day and time to let McMath pass on. (CHO Chart, pp. 161-163, Exhibit C appended hereto; and Kaiser Permanente Oakland Chart, p. 5, Exhibit H appended hereto.)

N. In the afternoon on December 23, 2013, Dr. Fisher performed a brain death evaluation, in his capacity as the court's independent expert examiner, pursuant to the accepted medical standards set forth in the Guidelines. It was Dr. Fisher's determination that McMath met the neurologic examination criteria for brain death. Dr. Fisher determined that McMath's cerebral and brainstem reflexes were absent. She had no brainstem and no cerebral function. During apnea testing, there was no respiratory effort when taken off the ventilator for nine minutes. (Dr. Paul Fisher's 12/23/13 Brain Death Evaluation notes and Check List, Exhibit I appended hereto; and Reporter's Transcript, at pp. 8-31; 39:8 to 40:1; and 49:1-14, Exhibit L appended hereto.)

O. Dr. Fisher's brain death evaluation exceeded the minimum requirements to determine whether a child has suffered brain death. In addition to the required neurological examination and apnea testing, Dr. Fisher ordered a repeat EEG and a radionuclide cerebral blood flow study, both of which are recognized by the Guidelines as appropriate ancillary studies. Winkfield's attorney, Christopher Dolan, requested McMath undergo the radionuclide cerebral blood flow study. Dr. Fisher agreed it would be wise to perform the cerebral blood flow study on McMath because it is "beyond definitive" as a diagnostic tool of brain death and the test can help a family understand a brain death diagnosis. (See Dr. Paul Fisher's 12/23/13 Brain Death Evaluation notes and Check List, Exhibit I appended hereto; and Reporter's Transcript at pp. 27:3-22; 40:9-12; 41:3-21; 42:3-25; and 43:1-4, Exhibit L appended hereto.)

(1) The radionuclide cerebral blood flow study performed on December 23, 2013, confirmed the clinical diagnosis of brain death. Dr. Fisher was present during the study. There was 40 minutes of imaging time, which exceeds the standard of care. The images demonstrate a complete absence of any blood flow to the brain. There is no intracerebral activity, only some activity in the scalp and the face. The cerebral blood flow study is diagnostic of McMath's brain death in that it conclusively demonstrates there is no blood flow going in McMath's brain. Dr. Fisher noted that McMath's CBF study has a "white-out in the part of the

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head where the brain is. Normally it would be dark black. In [McMath's] case it's completely white." (See CHO Chart, p. 17369, Exhibit C appended hereto; and Reporter's Transcript, pp. 24:5-9; 27:15 to 28:14; 28:19-29:12, Exhibit L appended hereto.)

(2) In addition, the EEG performed on December 23, 2013 fulfills the criteria for electrocerebral inactivity and brain death. He confirmed there was no brain activity. There was no change in the recording with clapping, pinching the left foot, pinching the left arm or shining a light in each eye. Dr. Fisher also compared the EEG with a prior EEG from December 11, 2013, and found there was no change. (See CHO Chart, pp. Exhibit C appended hereto; and Reporter's Transcript at 30:10 to 31:13, Exhibit L appended hereto)

P. Dr. Fisher prepared a 2-page report of his brain death examination and completed the "Check List for Documentation of Brain Death," found in Appendix 1 of the Guidelines. Dr. Fisher concluded that Ms. McMath has a known, irreversible brain injury and complete absence of cerebral function and brainstem function. (Dr. Paul Fisher's 12/23/13 Brain Death Evaluation notes and Check List, Exhibit I appended hereto.)

(1) Dr. Fisher found that Ms. McMath fulfilled the accepted medical standards for determining brain death by professional societies and the State of California. (Dr. Paul Fisher's 12/23/13 Brain Death Evaluation notes and Check List, Exhibit I appended hereto; and Reporter's Transcript, pp. 33:14 to 34:9, and 49:3-19, Exhibit L appended hereto.)

(2) Based on my experience and expertise in pediatric brain death and the accepted medical standards set forth in the Guidelines, as well as my review of the records in this matter, including the radionuclide cerebral blood flow study performed on December 23, 2013, Dr. Fisher's examination confirms that McMath fulfills the criteria for brain death. No diagnostic error was identified in the examination process. Dr. Fisher used the level of skill, knowledge and care in applying the accepted medical standards used by other reputable pediatric neurocritical care specialists in similar circumstances. Dr. Fisher appropriately determined that McMath continued to meet all diagnostic criteria for brain death, and that McMath was deceased under California law. To a reasonable degree of medical certainty, McMath satisfies the required accepted medical standards to determine brain death and meets the criteria for death under

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California law.

Q. On January 6, 2014, Ms. McMath was admitted to Saint Peter's University Hospital ("Saint Peter's") in New Brunswick, New Jersey, for placement of a tracheostomy and percutaneous endoscopic gastrostomy tube placement following brain death. The procedures were performed on January 8, 2014. McMath was hospitalized in the Pediatric Intensive Care Unit at Saint Peter's until August 25, 2014, because there was no rehabilitative facility willing to accept McMath. (Saint Peter's Chart, pp. 5, 483-484, and 495-498, Exhibit J appended hereto.)

(1) On McMath's admission to Saint Peter's University Hospital on January 6, 2014, McMath's clinical examination was consistent with brain death. McMath was non-responsive, had no cough or gag reflex, no pupillary response, and no spontaneous breathing. No formal brain death evaluation per the Guidelines was performed on McMath during her seven and a half month hospitalization at Saint Peter's. However, the daily neurological assessments performed by the PICU team at Saint Peter's were at all times consistent with lack of brain and brain stem function. The PICU team's diagnosis was that McMath was brain dead. The records document that McMath was at all times in a coma, had no brainstem reflexes, had no meaningful movement, lacked spontaneous respiration, and was fully dependent on artificial support. (Saint Peter's Chart, pp. 5, 483-484, 493-498, 500-501, 527, 532, 555-558, 560, 585, 608, 616-617, 712, 735, 754, 766, 778-781, 800, 821, and 823, Exhibit J appended hereto.)

(2) On August 25, 2014, McMath was discharged "home" to the custody of her mother. McMath's discharge diagnosis from Saint Peter's was brain death due to cardiopulmonary arrest and hypoxic ischemic encephalopathy. (Saint Peter's Chart, p. 5, Exhibit J appended hereto.)

(3) During McMath's hospitalization at Saint Peters, McMath continued to exhibit intermittent spinal reflexive responses, including movement in response to tactile stimulation. However, there was no evidence of cerebral or brain stem activity. (Saint Peter's Chart, pp. 527, 532, 556, 585, 593, 608, 616, and 712, Ex. J appended hereto.)

(4) Based on my experience and expertise in pediatric brain death and the accepted medical standards set forth in the Guidelines, as well as my review of the records in

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this matter, there is no medical evidence documented in the Saint Peter's chart that would cause a reputable expert in pediatric brain death to question McMath's death.

R. On September 26, 2014, McMath was subjected to several tests at University Hospital, in Newark, New Jersey, including brain imaging studies, a brainstem auditory evoked potentials, a somatosensory evoked potentials (upper extremities), a visual evoked potentials, and electroencephalography. (University Hospital Chart, appended at Exhibit K.)

(1) The tests performed on McMath at University Hospital on September are not accepted, validated ancillary studies and do not meet accepted diagnostic criteria for determining brain death (i.e., the Guidelines) and are not a substitute for the accepted medical standards. There is no substitute for the accepted medical standards as defined in the Guidelines. California's Uniform Determine of Death requires that brain death be evaluated under the accepted medical standards.

S. Although McMath has been in Winkfield's custody since August 25, 2014, there is no evidence that McMath has been clinically evaluated by a physician in accord with the accepted medical standards in the Guidelines since December 23, 2013, when McMath was examined by Paul Fisher, M.D., at CHO. Without such an evaluation, there is no legal or medical basis to reconsider or disturb the medically sound and lawful pronouncement of McMath's death.

17. Based on my education, training, knowledge and experience in pediatric brain death, including the application of the accepted medical standards in the Guidelines, and having reviewed the medical records and imaging studies, as well as the Reporter's Transcripts of the testimony of Paul Fisher, M.D., and Robin Shanahan, M.D., at the hearing on December 24, 2013, it is my opinion that no diagnostic error occurred in the determination of brain death for Ms. McMath in December 2013. McMath's determination of brain death was made in accordance with the accepted medical standards. McMath fulfilled the accepted pediatric diagnostic criteria for brain death. Dr. Shanahan, Dr. Heidersbach and Dr. Fisher appropriately applied the accepted medical standards. McMath was appropriately pronounced deceased under California law in December 2013.

18. Based on my education, training, knowledge and experience in pediatric brain

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death, including the application of the accepted medical standards in Guidelines, and having reviewed the medical records and imaging studies, as well as the Reporter's Transcript of the testimony of Paul Fisher, M.D., and Robin Shanahan, M.D., at the hearing on December 24, 2013, it is my opinion, to a degree of medical certainty, that McMath is dead. McMath's death was established by a known cause of coma (anoxia during the 2 ½ hour period of cardiac arrest), and three brain death evaluations performed in accordance with the accepted Guidelines for the determination of brain death in infants and children. Testing included the required neurological examination and apnea tests, on each occasion. McMath demonstrated no brain or brain stem reflexes. She took no spontaneous breaths while off mechanical ventilator support during apnea testing. The physicians' clinical assessment of brain death was corroborated by several accepted ancillary studies, including four 'flat' or isoelectric EEGs and a radionuclide cerebral blood flow study performed under the accepted protocols. The radionuclide cerebral blood flow study performed on December 23, 2013, conclusively demonstrates that there is no blood flow going to McMath's brain which is consistent with brain death.

19. Based on my education, training, knowledge and experience in pediatric brain death, including the accepted medical standards in the Guidelines, as well as my review of the records in this matter, McMath continues to fulfill the accepted diagnostic criteria for brain death and meets the criteria for death under California's Uniform Determination of Death Act. My opinion is based on the following:

A. Brain death is a very conservative diagnosis. It is made by applying uniform medical criteria in a hospital setting by two qualified physicians, during independent examinations at least 12 hours apart. A determination of brain death is made when there is no doubt in the findings. In the case of McMath, the medical evidence of her brain death has clearly exceeded the minimum criteria to determine brain death based on the Guidelines and what is required by law and the medical profession. McMath was independently determined to be brain dead in accordance with the accepted medical standards by three physicians while McMath was a patient at CHO in December 2013. Several accepted ancillary studies (four EEG's and a cerebral blood flow study) were obtained to assist with confirmation of her death. Brain death is not

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reversible. The brain permanently ceases to function without blood flow. The cerebral blood flow study performed on December 23, 2013 is conclusive evidence of McMath's death. The blood flow study involves the injection of a radioactive isotope into the blood stream. By placing a radioactivity counter over the head, the amount of blood flow into the brain can be measured. A cerebral blood flow study demonstrating no blood flow is consistent with death. The cerebral blood flow study performed on December 23, 2013, confirmed that McMath had no intracranial blood flow.

B. There is no reliable medical evidence to support the allegation that McMath does not fulfill the accepted medical standards for brain death. The only accepted neurologic criteria for assessing McMath's brain function is a brain death evaluation performed in accordance with the accepted medical standards in the Guidelines. The accepted medical standards for determining pediatric brain death have not been applied to McMath since Dr. Fisher's evaluation on December 23, 2013. Although McMath has been in plaintiffs' custody since August 25, 2014, plaintiffs have not subjected McMath to a formal brain death evaluation in accordance with the Guidelines. In the absence of such an evaluation, there is no medical or legal basis to disturb the pronouncement of death made in accord with California's Uniform Determination of Death Act.

C. The medical records from St. Peter's University Hospital, in New Jersey, where McMath was a patient in the PICU from January 6, 2014 to August 25, 2014, are entirely consistent with the diagnosis made at CHO that McMath has no brain or brain stem activity. While a patient in the PICU at Saint Peter's McMath failed to initiate breaths on CPAP, demonstrating a lack of respiratory drive. She had no spontaneous movement. Her pupils remained fixed and non-reactive. She had no cough or gag reflex. There is nothing in McMath's medical records from Saint Peter's University Hospital that would cause a reputable expert in pediatric or adult brain death to question or reconsider the accepted brain death assessments of Dr. Robin Shanahan, Dr. Robert Heidersbach and Dr. Paul Fisher.

D. The testing performed on McMath at University Hospital on September 26, 2014, are not accepted, validated ancillary studies and do not meet the accepted diagnostic criteria for determining pediatric brain death. None of the results of the testing performed on McMath on

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September 26, 2014, would cause a reputable expert in pediatric or adult brain death to question or reconsider the accepted brain death assessments of Dr. Robin Shanahan, Dr. Robert Heidersbach and Dr. Paul Fisher, or disturb a pronouncement of death made in accord with California law. Again, the only accepted criteria for assessing McMath's brain function is brain death evaluation performed under the accepted medical standards in the Guidelines. There is no substitute for the accepted medical standards. The accepted medical standards for determining pediatric brain death have not been applied to McMath since Dr. Fisher's evaluation on December 23, 2013.

20. In conclusion, it is my opinion to a degree of medical certainty that McMath meets the criteria for death under California's Uniform Determination of Death Act. There is no possibility that McMath has recovered, or will someday recover, from death.

I declare under penalty of perjury under the laws of the State of California that all of the foregoing is true and correct, and as to those matters stated on my information and belief, I believe them to be true, and if called upon to testify to the matters herein I can competently testify thereto.

Executed on March 16, 2017, at St. Petersburg, Florida.

THOMAS A. NAKAGAWA, M.D., FAAP, FCCM

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Attorneys for Defendant FREDERICK S. ROSEN, M.D.

SUPERIOR COURT OF CALIFORNIA, COUNTY OF ALAMEDA

LATASHA NAILAH SPEARS WINKFIELD; MARVIN WINKFIELD; SANDRA CHATMAN; and JAHI McMATH, a minor, by and through her Guardian Ad Litem, LATASHA NAILAH SPEARS WINKFIELD,

Plaintiffs,

vs.

FREDERICK S. ROSEN, M.D.; UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND (formerly Children's Hospital & Research Center of Oakland); MILTON McMATH, a nominal defendant, and DOES 1 THROUGH 100,

Defendants.

/

No. RG15760730
ASSIGNED FOR ALL PURPOSES TO:
JUDGE STEPHEN PULIDO
DEPARTMENT 16

DECLARATION OF SANFORD SCHNEIDER, M.D., FAAN, FAAP

I, Sanford Schneider, M.D., FAAN, FAAP, declare:

1. I am a physician duly licensed to practice medicine in the State of California since 1966. My license number is G-11962. I specialize in the neurological treatment of children and young adults and have three active American specialty board certifications: Neurology with a special qualification in Child Neurology, Pediatrics, and Neurodevelopmental Disabilities. I was elected and maintain Fellowships in the American Academy of Neurology, the American Neurological Association, and the American Academy of Pediatrics. I am presently Clinical Professor of Pediatrics at the College of Medicine, University of California, Irvine. Previously, I have been a

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Professor of Neurology and Pediatrics and Head of the Section of Child Neurology at Loma Linda University School of Medicine and the School of Medicine of the University of Oklahoma. My pediatric neurology practice has consisted of a combination of patient evaluation and treatment, instructing medical students, residents, and fellows, and clinical research. My current curriculum vitae is appended hereto as Exhibit A.

2. I received my bachelor's degree from the University of Rochester [New York] in 1959 and, in 1963, I received my Doctor of Medicine from the New York University School of Medicine [New York]. Subsequently, I completed a one-year internship in pediatrics at the Duke University Medical Center [Durham, North Carolina], followed by a two-year residency in pediatrics at Babies Hospital, Columbia-Presbyterian Medical Center [New York]. Following the completion of my pediatric training, I served as a Captain in the United States Air Force. From 1968-1971, I completed a three-year fellowship in Pediatric Neurology and Neurology at the Neurological Institute at Columbia-Presbyterian Medical Center [New York].

3. I have specialized in practice of Pediatric Neurology for the past forty-eight years. Following the completion of my fellowship in Pediatric Neurology in 1971, I was recruited to Loma Linda University School of Medicine [Loma Linda, CA], where I was the Director of the Division of Child Neurology and a Professor of Neurology and Pediatrics from 1971 to 1993. In addition, from 1982 to 1991, I was the Chief and Chairman of the Department of Pediatrics at Riverside General Hospital/University Medical Center [Riverside, California]. I moved to Oklahoma in 1993. From 1993 to 1997, I was an endowed Professor of Neurology and the Chief of the Division of Child Neurology at the Children's Hospital of Oklahoma. After returning to California in 1997, I continued to see private practice patients as well as being Chief of the Pediatric Neurology Clinics at Arrowhead Regional Medical Center [Colton, CA]. In 2007, I began an association with Children's Hospital of Orange County [Orange, CA], where I see private pediatric patients and instruct and supervise child neurology fellows, residents and medical students. Since 2011, I have been a Clinical Professor of Pediatrics at the School of Medicine, University of California, Irvine. I currently have unrestricted medical staff privileges at Children's Hospital of Orange County and at Arrowhead Regional Medical Center.

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4. My research interests have included the determination of cerebral [brain] death in children and the universal standardization of the brain death diagnostic criteria for children and infants. I have published on these subjects in recognized peer review journals including *Pediatrics*, *Pediatric Neurology*, and the *Annals of Neurology*.

5. I am aware that the Legislature of the State of California has adopted the Uniform Determination of Death Act, which provides that an individual is dead if he or she has sustained an irreversible cessation of all functions of the entire brain, including the brain stem. I am aware that 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 must be independent confirmation by another physician. In California, as well as virtually all other states, the determination of death, including brain death, must be made in accordance with "accepted medical standards." Virtually all other states have adopted legislation similar to California's Uniform Determination of Death Act.

6. I am familiar with the "accepted medical standards" for determining brain death in children and infants. The clinical criteria for determining the irreversible cessation of all functions of the entire brain, including the brain stem, in children and infants were initially published by a multi-society Task Force in 1987. My work and research in pediatric brain injury and cerebral death led to my service on this multi-society Task Force. I am a co-author of the Task Force's report, titled American Academy of Pediatrics, Task Force on Brain Death in Children. Report of Special Task Force: Guidelines for Determination of Brain Death in Children, which was published in *Pediatrics* 1987;80(2):298-300, *Pediatr. Neurol.* 1987;3(4):242-243, and the *Annals of Neurology* 1987; 21:616-617. Several years ago, a second task force published an update to the 1987 pediatric brain death guidelines. The report that resulted from the committee's work, titled Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations, was published in 2011 in *Critical Care Medicine* 2011; 39:2139-2155; *Pediatrics* 2011;128:3 e720-e740; *Annals of Neurology* 2012;71:573-585; *and Clinical Pulmonary Medicine* 2012;19:119-126 [hereinafter "Guidelines]. A true and correct copy of the Guidelines is appended hereto at Exhibit B.

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7. The Guidelines represent the "accepted medical standards" for determining brain death in infants and children. The Guidelines are accepted nationwide, have been endorsed by the relevant medical societies, have been adopted by hospitals as the standard for determining pediatric brain death, and are utilized by attending pediatric critical care specialists and neurologists in determining whether a child is deceased due to brain death. From a legal, medical and societal perspective, it is uniformly accepted that a person, including a child, is dead when the neurologic diagnostic criteria of total and irreversible cessation of brain function in the Guidelines are fulfilled.

8. It is the medical and legal consensus that brain death is the criterion for death for that individual. Put simply, brain death is the irreversible loss of the integrative control of the brain to sustain biological control to sustain life. When brain death has occurred, the brain can no longer do what it is supposed to do. With destruction of the brain stem, the probability to ever regain function no longer exists. The brain and brain stem may still retain small pockets of surviving cells, but the organism itself is permanently dysfunctional. The neurologic criteria in the Guidelines is the clinical determination that a patient has sustained an irreversible (i.e., permanent) loss of neurologic function. A diagnosis of brain death made in accord with the Guidelines means that there is no medical possibility of recovery.

9. After brain death has occurred, with medical and respiratory support, the body [corpse] may remain intact. The circulatory and respiratory systems in a brain-dead individual are entirely dependent on the mechanical ventilator that supplies oxygen, and the medications that maintain the blood pressure and fluid balance. Hormones normally secreted by the brain [thyroid, adrenocorticoid, vasopressin] have to be externally supplied. The apparent signs of life [heartbeat, temperature, blood flow, hair and nail growth, spinal reflexive movements, chest rising and falling] are due to this technological support. To family members, these support systems may conceal the fact that death has occurred. However, once the external support is withdrawn, the heart will cease to beat and the corpse will sustain circulatory collapse. A beating heart and spinal reflexes in a brain-dead individual maintained on external support are not signs of life or the potential for recovery. Rather, the ventilator, medications and other interventions are preventing the natural decomposition of a corpse. Science has reached a point where corpses can be maintained on external

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support for prolonged periods. With the advent of transplant surgery, lay people can begin to understand that specific body organs can be viable after death and hearts, lungs, kidneys, even hands and faces can be utilized many hours after the donor's death. An infant's heart salvaged from a traumatic death can be flown cross country and many hours later re-implanted to replace a failing heart in another infant. A heart that continues to beat in a brain-dead individual on external support does not indicate that the person is alive. The fact that a brain-dead person's heart has not ceased to beat does not support the possibility of life, but simply that the corpse is being sustained by extraordinary external measures.

10. I have forty-eight years of experience in the evaluation and care of children with neurological disorders. As a specialist in the practice of Pediatric Neurology, I am responsible for diagnosing and treating children who have unstable, life-threatening and end-of-life conditions, including cardiopulmonary failure and brain trauma. I have significant professional experience in applying the accepted medical standards for determining brain death in children. During the course of my practice as a Pediatric Neurologist, I estimate that I have performed, or overseen, more than 300 examinations utilizing the accepted medical standards for determining brain death in children. My education, training and experience render me qualified to provide an expert opinion on whether a mistake was made in the diagnosis of Jahi McMath's brain death and whether the accepted medical standards were correctly applied to Jahi McMath [hereinafter "J. McMath"].

11. I have been retained by law firms of Hinshaw, Marsh, Still & Hinshaw, LLP, attorneys for defendant Frederick S. Rosen, M.D., and Galloway, Lucchese, Everson & Picchi, attorneys for defendant UCSF Benioff Children's Hospital Oakland, to review the medical records and other materials pertaining to J. McMath. Along with plaintiffs' First Amended Complaint, I have received and reviewed the following materials pertaining to J. McMath in connection with my review:

- A CD containing the imaging studies of the brain MRI (without contrast), MR angiogram (without contrast) and MRV (without contrast) performed at University Hospital (New Jersey) and the report of these imaging studies dated 9-26-14 (pp. 1-9)
- A CD containing 7 chest x-rays and 1 ultrasound produced by Saint Peter's University Hospital
- A CD containing the imaging studies performed at Children's Hospital Oakland including the chest x-rays on 12-10-13 and 12-11-13, the head CT on 12/11/13, and

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the radionuclide cerebral blood flow study on 12-23-13
- A CD containing the 4 EEG recordings performed at Children's Hospital Oakland on 12-11-13, 12-12-13, 12-17-13 and 12-23-13
- Records of Children's Hospital Oakland
- Records of Saint Peter's University Hospital (pp. 1-12702)
- Records of Kaiser Permanente Hayward (pp.1-94)
- Records of Kaiser Permanente Oakland (pp. 1-7)
- Records produced by Med Life Pharmacy (pp. 1-36)
- Records produced by Preferred Home Health Care (pp. 1-350)
- Records produced by Thi Nguyen, M.D. (pp. 1-368)
- Records of Alieta Eck, M.D. (pp. 1-151)
- Records of Bayada Home Health Care (pp. 1-4655)
- Records of University Hospital (pp. 1-5)
- A CD containing video recordings numbered 1 to 34 produced by plaintiffs
- A CD containing video recordings numbered 1 to 17 produced by plaintiffs
- Photographs produced by plaintiffs numbered 1-288
- Paul Byrne declaration date 12-20-13
- Updated declaration of D. Alan Shewmon dated 12-10-14
- Calixto Machado declaration dated 10-5-14, and curriculum vitae
- Calixto Machado letter to Philip De Fina dated 9-29-14
- Letter from Alieta Eck, M.D., dated 4-10-16
- Philip De Fina declaration dated 10-2-14
- The EEG report provided by Elena Labkovsky
- Ivan Mikolaenko declaration dated 10-7-14
- Charles Prestiacomo declaration dated 10-8-14
- Latasha Winkfield declaration filed 12-20-13
- Paul Fisher's curriculum vitae
- Paul Fisher letter dated 12/23/13 and brain death exam notes and checklist dated 12/23/13, prepared by Paul Fisher
- Reporter's Transcript of Proceedings on 12-24-13
- Amended Order filed 1-2-14
- Order filed 10-1-2014
- Writ of Error Corum Nobis filed on 10-3-2014
- D. Alan Shewmon declaration dated 10-3-2014 and curriculum vitae
- Philip De Fina declaration and curriculum vitae
- Calixto Machado declaration and curriculum vitae
- Charles Pretigiacomo declaration and curriculum vitae
- Elena B. Labkovsky declaration and curriculum vitae
- EEG report prepared by Elena Labrovsky
- Court order Appointing Paul Fisher filed on 10-6-14, including Dr. Fisher's CV, and Dr. Fisher's letter dated 10-6-14, which includes Dr. Fisher's examination and consultation finding of Jahi McMath on December 23, 2013, and a copy of the Guidelines
- Declaration of Sharon Williams, M.D. filed December 20, 2013, and attachment
- Declaration of Robin Shanahan, M.D., filed December 20, 2013
- Declaration of Robert Heidersbach, M.D., filed December 20, 2013
- Declaration of Paul Byrne, M.D., filed December 30, 2013
- Declaration of Christopher Dolan, filed December 30, 2013
- Opposition to Ex Parte Application filed by Children's Hospital on December 30, 2013
- Declaration of Dr. Ann Petru filed January 3, 2014
- Declaration of Dr. Heidi Flori filed January 3, 2014
- Declaration of Dr. Sidney Gospe, Jr., filed January 3, 2014

12. I have also read the Reporter's Transcripts of the December 23, 2013 and December

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24, 2013, hearings involving Ms. Winkfield's opposition to the hospital's withdrawal of J. McMath mechanical ventilator following the pronouncement of death on December 12, 2013. The Reporter's Transcripts are important to my understanding of J. McMath's medical condition, whether or not the accepted medical standards were applied in accord with the Guidelines, and whether or not a mistake was made in J. McMath's diagnosis. My opinions in this case are based in significant part on the Reporter's Transcripts. Two physicians testified at the December 24, 2013 hearing, Robin Shanahan, M.D., and Paul Fisher, M.D., regarding the specifics of their brain death examinations, performed at Children's Hospital Oakland on December 11, 2013 and December 23, 2013, respectively. The two physicians' testimony expounds on the physicians' documentation of their brain death examinations set forth in the medical records. Since J. McMath has not undergone a brain death examination since December 2013, Dr. Fisher and Dr. Shanahan's testimony is important evidence of J. McMath's medical condition.

13. Based on my education, training, knowledge and experience in pediatric brain death, including the application of the accepted medical standards in Guidelines, and having reviewed the medical records and imaging studies, as well as the Reporter's Transcripts and the testimony of Paul Fisher, M.D., and Robin Shanahan, M.D., at the hearing on December 24, 2013, it is my opinion that there were no errors made in the determination of J. McMath's brain death in December 2013 at Children's Hospital Oakland. J. McMath fulfills the accepted pediatric diagnostic criteria for brain death, and Dr. Robin Shanahan, Dr. Robert Heidersbach and Dr. Paul Fisher appropriately applied the accepted medical standards. Indeed, Dr. Fisher examination exceeded what is required to find brain death. J. McMath was appropriately pronounced deceased under California law.

14. Based on my education, training, knowledge and experience in pediatric brain death, including the application of the accepted medical standards in Guidelines, and having reviewed the medical records, EEG and imaging studies from Children's Hospital Oakland, as well as the Reporter's Transcripts and the testimony of Paul Fisher, M.D., and Robin Shanahan, M.D., at the hearing on December 24, 2013, it is my opinion, to a reasonable degree of medical certainty, that J. McMath is dead. J. McMath's death was established by a known cause of coma [anoxia during the

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2 ½ hour code blue resuscitation], and three subsequent brain death evaluations performed by three different qualified physicians [Robin Shanahan, M.D., Robert Heidersbach, M.D., and Paul Fisher, M.D.], which included the required neurological examination and apnea tests on each occasion. J. McMath had no evidence of brain activity or brain stem reflexes. During apnea testing she took no spontaneous breaths while off the mechanical respirator for greater than nine minutes despite elevated arterial carbon dioxide levels. The clinical assessment of brain death was corroborated by several accepted ancillary studies, including four isoelectric or 'flat' EEGs and a radionuclide cerebral blood flow study. I have personally reviewed four EEG recordings and the radionuclide cerebral blood flow study, and I agree with the medical findings made at the time. The radionuclide cerebral blood study is diagnostic of J. McMath's brain death in that it conclusively demonstrates there is no blood flow going in J. McMath's brain. A brain ceases to function if it is deprived of blood flow for more than five minutes.

15. Based on my education, training, knowledge and experience in pediatric brain death, including the accepted medical standards in the Guidelines, as well as my review of the records in this matter, J. McMath continues to fulfill the accepted diagnostic criteria for brain death, i.e., coma, lack of brain stem reflexes, and the absence of spontaneous respiration.

a. Following J. McMath's discharge from Children's Hospital Oakland, on January 6, 2014, J. McMath was admitted to Saint Peter's University Hospital ["Saint Peter's"] in New Brunswick, New Jersey, for placement of a tracheostomy for mechanical ventilation and percutaneous endoscopic gastrostomy tube placement for nutrition following brain death. These procedures were performed on January 8, 2014. Since there was no rehabilitative facility that was willing to accept J. McMath, J. McMath was hospitalized in the pediatric intensive care unit at Saint Peter's until August 25, 2014. The chart reflects that on admission on January 6, 2014, J. McMath was examined at length by the Chief of Pediatric Critical Care, Siva P. Jonna, M.D. Dr. Jonna reported his clinical examination was consistent with brain death. J. McMath was non-responsive, had no cough or gag reflex, no pupillary responses, and no spontaneous breathing. On January 9, 2014, Dr. Jonna noted in the progress notes that he spoke with the mother, grandmother and father about J. McMath's brain death and loss of brain function. On January 10, 2014, Dr. Jonna reported

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that he explained to J. McMath's family that there was "no hope of brain recovery." Although no formal brain death evaluation per the Guidelines was ever performed on J. McMath during her hospitalization at Saint Peter's, the daily neurological assessments performed by the PICU team were at all times consistent with lack of brain and brain stem function, and the diagnosis was that J. McMath was brain dead. The records document that J. McMath was at all times in a coma, had no brain stem reflexes, had no meaningful movement, lacked spontaneous respiration, and was fully dependent on external support. On August 25, 2014, J. McMath was discharged to Ms. Winkfield's apartment in New Jersey where J. McMath has received continuous 24-hour a day home nursing care. The discharge diagnosis from Saint Peter's was brain death due to cardiopulmonary arrest and hypoxic ischemic encephalopathy. A selection of records from Saint Peter's is appended hereto at Exhibit C.

b. On September 26, 2014, J. McMath was subjected to several tests at University Hospital, in Newark, New Jersey, including brain imaging studies, a brain stem auditory evoked potentials, a somatosensory evoked potentials (upper extremities), a visual evoked potentials, and electroencephelography. Although these tests are not the accepted diagnostic criteria for determining brain death, i.e., the Guidelines, the results are consistent with J. McMath's diagnosis of brain death made in December 2013. None of the test results would cause a reputable expert in pediatric or adult brain death to question or reconsider the accepted brain death assessments of Dr. Robin Shanahan, Dr. Robert Heidersbach and Dr. Paul Fisher performed in December 2013 at Children's Hospital Oakland. The reports for the tests performed on J. McMath at University Hospital on September 26, 2014 tests are appended hereto at Exhibit D.

16. I have reviewed all of the evidence submitted by the plaintiffs in this case. No reputable expert in pediatric or adult brain death would reasonably rely on plaintiffs' evidence to make a brain death assessment. The *only* accepted method of assessing brain death is a brain death evaluation performed in accord with the accepted criteria in the Guidelines.

17. J. McMath has not undergone a brain death evaluation since Dr. Fisher's evaluation on December 23, 2013. The Guidelines provide that the determination of brain death in children is a clinical diagnosis based on the absence of neurologic function with a known irreversible cause of

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coma. The brain death assessment must be made independently by two physicians who are familiar with the patient's history and completed the neurologic examinations in accord with the Guidelines. The brain death examination consists of (1) identifying the cause and presence of irreversible coma, i.e., complete loss of consciousness, vocalization, volitional activity, and lack of response to painful stimuli, (2) normalizing physiologic parameters prior to the clinical examination, (3) a physical examination that demonstrates the absence of brain stem reflexes, and (4) apnea testing demonstrating the absence of respiratory control system reflexes in the brain stem. The clinical examinations should be carried out by experienced clinicians who are familiar with children, and have specific training in neurocritical care, such as pediatric neurologists and pediatric intensivists.

a. Prior to the clinical examination, the examining physician must confirm the patient is eligible for a brain death examination, i.e., the prerequisites for initiating a brain death evaluation. Hypotension, hypothermia, metabolic disturbances, and medications, which can interfere with neurologic examination and apnea testing, must be identified and corrected before proceeding with the brain death evaluation.

b. The physical examination consists of neurologic tests that document loss of all brain stem reflexes, including (1) mid-position or fully dilated pupils which do not respond to light; typically fixed in a mid-size or dilated position (4-9mm), (2) absence of movement of bulbar musculature including facial or oropharyngeal muscles, (3) absent gag, cough, sucking and rooting reflex, (4) absent corneal reflexes, and (5) absent oculovestibular reflexes.

c. The two examinations must include apnea testing unless there is a medical contraindication or hemodynamic instability. A positive apnea test is an essential sign of definitive loss of brain function. The main objective of apnea testing is to prove the absence of respiratory control system reflexes in the brain stem when intense physiologic stimulation to breathe [elevated arterial carbon dioxide] occurs. Apnea testing requires documentation of arterial blood gases in a hospital setting.

d. There are only two accepted ancillary tests to assist with a determination of brain death: an electroencephalogram [EEG] and a radionuclide cerebral blood flow study. These two ancillary studies are not required to establish brain death. Nor are they a substitute for the

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required clinical evaluation. These ancillary tests must be performed in a hospital setting by technicians holding the requisite education, training and experience. EEG testing must be performed in accordance with the guidelines established by the American Electroencephalographic Society. Interpretation of the ancillary studies requires the expertise of appropriately trained and qualified individuals who understand the limitations of these studies to avoid any potential misinterpretation. Further, similar to the neurologic examination, hemodynamic and temperature parameters should be normalized before obtaining EEG or cerebral blood flow studies.

e. Brain MRI and MR angiography are not validated tests to assess brain death. The Guidelines state: "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." (Ex. B, p. e729.)

The above accepted medical standards for diagnosing pediatric brain death have not been applied to J. McMath since Dr. Paul Fisher's examination performed at Children's Hospital Oakland on December 23, 2013.

18. The records reflect that J. McMath has demonstrated spinal reflexes since her death on December 12, 2013. It is documented in the medical records from Children's Hospital Oakland and Saint Peter's University Hospital that J. McMath has frequent purposeless spinal reflexive movements with and without tactile stimulation to the body. Spinal reflexes may remain intact after brain death and are a known and common phenomenon in brain dead patients maintained on mechanical ventilation. J. McMath's attending physicians at Children's Hospital Oakland and Saint Peter's assessed J. McMath's movements as reflexive spinal movements by neurological exam and serial EEG studies. The attending physicians at Children's Hospital and Saint Peter's routinely checked J. McMath's brain stem reflexes and at all times found she has no brain activity and is dead. The medical records reflect that the physicians at both Children's Hospital Oakland and Saint Peter's explained to J. McMath's family that the movements are spinal reflexes and do not signify that J. McMath is alive. In addition, the somatosensory evoked potentials test, performed on J. McMath at University Hospital on September 26, 2014, appended at Exhibit D hereto, documents that J. McMath's spinal cord has some integrity up to the C5 cervical vertebrae, which explains the spinal

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reflexes, but there is loss of neurological brain pathway function above this level, which is consistent with brain death. It is a medical impossibility that J. McMath is moving in response to verbal commands. The brain stem auditory evoked potentials test performed at University Hospital on September 26, 2014, appended at Exhibit D hereto, demonstrates that as a result of J. McMath's brain death she has no auditory pathways; there were no evoked cerebral potentials to maximum aural stimulation. This test result establishes to a reasonable degree of medical certainty that J. McMath cannot respond to verbal commands because she has no cerebral mechanism to hear sound.

19. In conclusion, it is my opinion to a reasonable degree of medical certainty that J. McMath fulfills the criteria for death under California's Uniform Determination of Death Act. There is absolutely no medical possibility that J. McMath has recovered, or will someday recover, from death.

20. I understand that plaintiffs' allegation that J. McMath is not dead is based on the opinion of D. Alan Shewmon, M.D. The dissenting theory proposed by Dr. Shewmon is that death is not a neurological phenomena and death only occurs after total cessation of the systemic circulation. This theory is contrary to the accepted medical and legal standards that brain death is a legal criterion for death. Dr. Shewmon's opinion is a philosophical minority opinion that denies and conflicts with the accepted medical standards in the Guidelines as well as California law.

I declare under penalty of perjury under the laws of the State of California that all of the foregoing is true and correct, and as to those matters stated on my information and belief, I believe them to be true, and if called upon to testify to the matters herein I can competently testify thereto.

Executed on November 9, 2016, at Riverside California

By: ______________________________
SANFORD SCHNEIDER, M.D., FAAN, FAAP

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PROOF OF SERVICE
(C.C.P. §§ 1013a, 2015.5)

I, the undersigned, say:

I am now and at all times herein mentioned have been over the age of 18 years, a resident of the State of California and employed in Santa Clara County, California, and not a party to the within action or cause; my business address is 12901 Saratoga Avenue, Saratoga, California 95070.

I am readily familiar with this firm's business practice for collection and processing of correspondence for mailing with the U.S. Postal Service, mailing via Federal Express, hand delivery via messenger service, and transmission by facsimile machine. I served a copy of each of the documents listed below by placing said copies for processing as indicated herein.

CASE MANAGEMENT STATEMENT

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I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this Declaration was executed on March 23, 2017.

Renee Infantino

Court: Alameda County Superior Court
Action No: RG15760730
Case Name: *Spears/Winkfield, et al. v. Rosen, M.D., et al.*