

As of 2020, Beam Legal has represented children and their families in twenty-five states to recover money damages for obstetrical and neonatal malpractice. Our record-breaking verdicts and settlements in Michigan, Illinois, Ohio, Pennsylvania and West Virginia make the headlines, but Beam Legal Team has won literally hundreds and hundreds of multi-million dollar confidential settlements that never get publicized.

I. Beam Legal Team Labor & Delivery Malpractice Case

Pitocin has often been called the “Opioid of Obstetrics”. All too often doctors and nurses overdose laboring mothers with Pitocin causing contractions that are too close, too frequent or too intense. When that happens babies can suffer loss of oxygen—hypoxic ischemic brain damage.

Here is an excerpt from a legal memorandum filed in one such case. The names of the parties have obviously been deleted, because it was a confidential record setting multi-million dollar settlement in a midwestern state capital.

Baby’s mom received regular and routine prenatal care and never developed any complications. Dr. Defendant even acknowledged that Baby’s mom’s prenatal care was normal and she expected to deliver a healthy baby on September 5, 2006. Sadly, due to Dr. Defendant’s lack of vigilance and supervision coupled with the failures of the residents and nursing staff at the Defendant Hospital, the baby was anything but healthy by the time he was born that day.

Baby’s mom came to the defendant hospital in the early morning hours of September 5, reporting cramping following spontaneous rupture of membranes. She was full term. Upon her arrival, she was admitted by Dr. Defendant, her prenatal obstetrician, although the doctor was not at the hospital at the time. At admission, a sterile vaginal exam (“SVE”) was performed revealing that Baby’s Mom’s cervix was 4 cm dilated, was 70% effaced, and her unborn baby was at the -2 station above the pelvic outlet. SVEs are done to determine progress in labor, and this exam revealed Baby’s Mom was in early, active labor with Baby.

Also at that time, Baby’s mom was connected to an electronic fetal heart monitor (“EFHM”) which monitors and records the unborn baby’s heart rate and the laboring mother’s contraction

activity. According to the nursing notes and EFHM, Baby's Mom was having regular contractions with a normal and reassuring heart rate throughout the early morning hours on September 5. In other words, at this point, all signs indicated mom's labor was proceeding normally.

Just before 7 a.m., Baby's mom's labor nurse called Dr. Defendant and informed her that Baby's mom was not progressing in labor despite the spontaneous rupture of membranes and regular contraction pattern. As a result, Dr. Defendant ordered that Pitocin be started to augment Baby's mom's labor and the drug was administered.

Pitocin is one of only 11 "High Alert" medications that are FDA approved in this country. See Kathleen Rice Simpson, RN, PhD, *Oxytocin as a High Alert Medication: Implications for Perinatal Patient Safety*, *American Journal of Maternal Child Nursing*, Vol. 34 (2009) (stating High Alert medications, like Pitocin, "are drugs that have a heightened risk of causing significant patient harm when they are used in error."). The literature provides "[a]lthough oxytocin [Pitocin] administration using pharmacologic principles can be therapeutic during labor, **inappropriate timing or excessive doses can have potentially negative effect on the mother and baby.**" Dr. Defendant, herself, knew this information:

Q: **Is, is oxytocin what is referred to as a high-alert medication?**

A: **Yes.**

Q: And do you know why it's called a high-alert medication?

A: Because **there is a high risk of potential harm involved in administering it.**

Q: **And does, does that include permanent central nervous system damage?**

A: **Yes.**

The FDA package insert for Pitocin/oxytocin explains, in great detail, the drug's potential devastating effects. This instruction for the medication provides "...**fetal deaths and permanent CNS or brain damage of the infant** due to various causes have been reported to be associated with the use of parenteral oxytocic drugs for induction of labor or for augmentation in the first and second stages of labor." The warnings go on to advise that "**[h]yperstimulation with strong (hypertonic) or prolonged (tetanic) contractions, or a resting tone of 15-20 mm H2O or more** between contractions can lead to a **tumultuous labor...uteroplacental hypoperfusion, and variable deceleration of the fetal heart, fetal hypoxia, hypercapnia, or death.**"

Similarly, the leading medical literature warns that the misuse of Pitocin will cause too many contractions – known as hyperstimulation or tachysystole – which depletes oxygen to the baby and results in hypoxic-ischemic brain damage. Additional research provides that increased or excessive uterine activity causes fetal acidemia and brain injury, according to Bakker, M.D., Elevated Uterine Activity Increased the Risk of Fetal Acidosis at Birth, *AJOG*, (April 2013). Moreover, the literature establishes that “**increased uterine contractions [are] an independent risk factor for asphyxia.**”^[1] These medical facts, as well, were not lost on Dr. Defendant who testified:

Q: What, what is the concern for the clinician, such as yourself, where there is tachysystole [excessive uterine activity]?

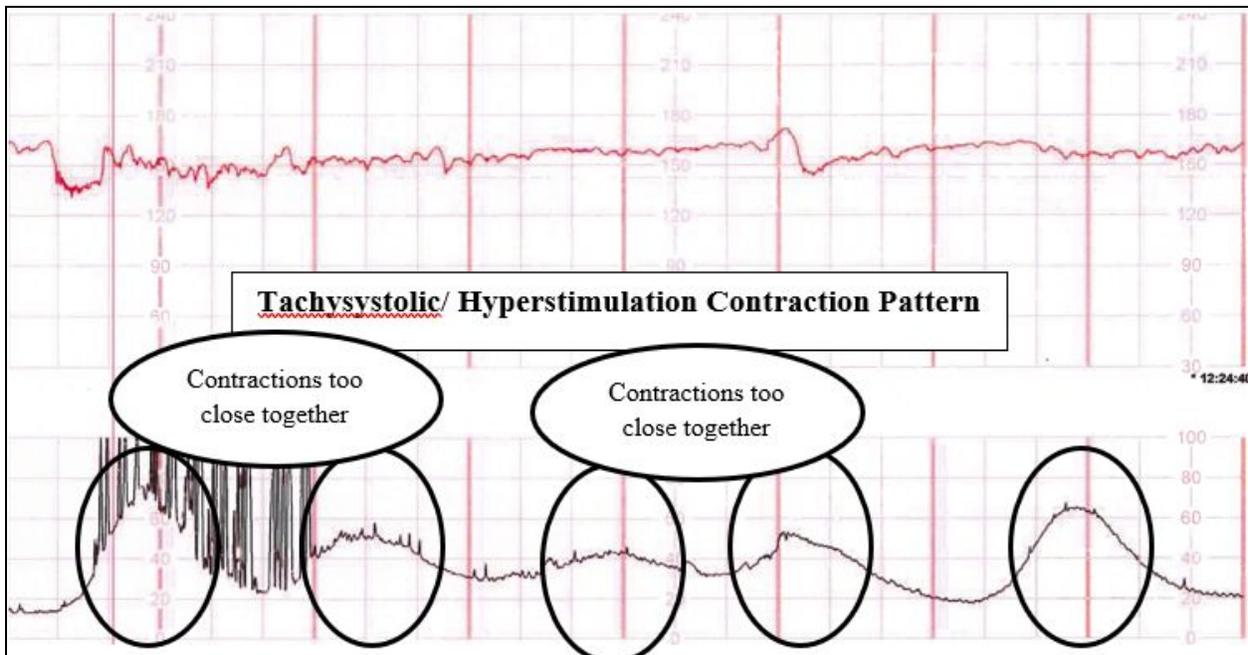
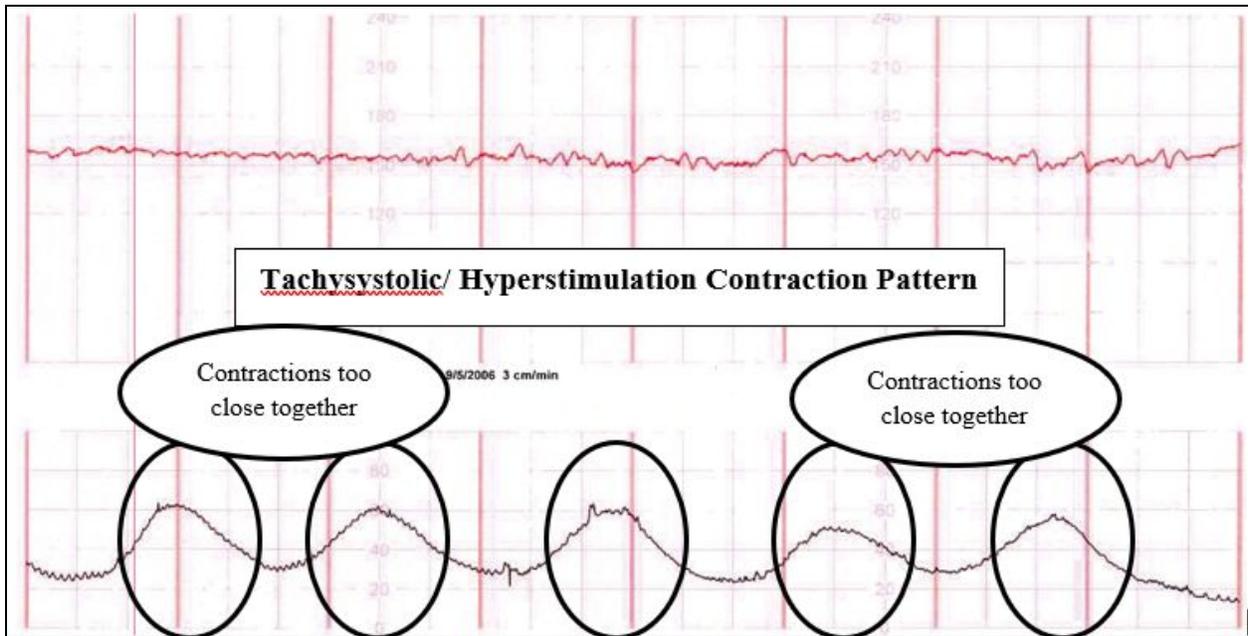
A: **You worry that the baby is not getting enough oxygenated blood through the placenta in the time periods when you’re not having contractions.**

Q: **Have you ever read that elevated uterine activity increases the risk of fetal acidosis at birth?**

A: **Yes.**

With full knowledge of the dangers of Pitocin, Dr. Defendant injected the drug into Baby’s mom over the next twelve hours of her labor, causing severe and persistent hyperstimulation/tachysystole until Baby was born with the exact acidemia/acidosis, hypoxia, and brain damage that all the literature warned about.

Shortly before 7 a.m., the Pitocin administration was started on Baby’s mom. Shortly thereafter, Dr. Defendant, making rounds, stopped into Baby’s Mom’s labor room. Id at 17. After this brief visit, Dr. Defendant was not at the bedside again until Baby’s head was crowning nearly twelve hours later; in fact, Dr. Defendant was not even in the Hospital during that time. Even though Dr. Defendant was not in the building, the Defendant Hospital’s nursing staff – specifically Nurse Defendant – continuously increased the dosage of Pitocin throughout the morning. As a consequence, Baby’s mom’s uterine activity continuously increased in frequency, strength, and duration but her labor still did not progress. As seen on the EFHM, Baby’s mom was experiencing tachysystole or hyperstimulation before and after 12 p.m. on the day of delivery.



If tachysystole develops when Pitocin is being administered, the standard of care for the doctors and nurses providing the drug is absolutely crystal clear à **TURN OFF THE PITOCIN!** The Pitocin package insert states “[t]he **oxytocin infusion should be discontinued immediately in the event of uterine hyperactivity** or fetal distress. Oxygen should be administered to the mother. **The mother and the fetus must be evaluated by the responsible**

physician.” Exhibit K (emphasis added). The applicable literature clearly states when there is oxytocin induced tachysystole to **(1) discontinue oxytocin**; (2) reposition the mother; (3) provide IV bolus and/or oxygen; **and (4) notify the provider**. Even the Defendant Hospital’s own policies and procedures set out exactly what Nurse Defendant and Dr. Defendant were required to do, providing “[n]otify healthcare provider **and discontinue/decrease IV oxytocin**...when there is evidence of: [a] non-reassuring fetal pattern or **contractions that are excessive in strength, frequency, and/or duration**.” Unfortunately, despite the presence of tachysystole as early as 10:00 a.m. on the 5th, Nurse Defendant, Dr. Defendant, nor any other care providers discontinued the Pitocin which was in complete contravention of the standard of care.

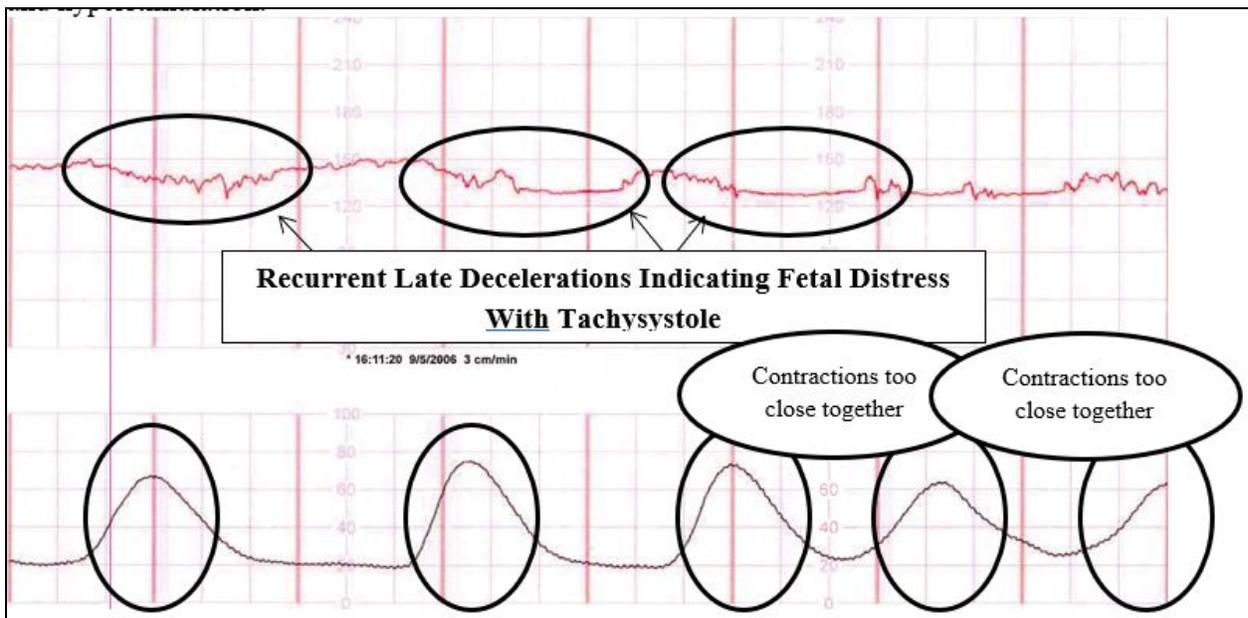
Plaintiff’s maternal fetal medicine expert, obstetrician expert, and nursing experts unanimously agree that Dr. Defendant, the labor nurses, and the other physicians involved in Baby’s mom’s and Baby’s care deviated from the standard of care by injudiciously managing the Pitocin. Specifically, Plaintiff’s obstetrical expert testified that shortly after the Pitocin was administered, **“tachysystole developed as a result of too much or injudicious use of Pitocin. For that reason, the Pitocin should have been stopped or discontinued as a result of this increased tachysystole.”** Similarly, expert labor and delivery nurse, Defendant, R.N. PhD, stated that the nurse deviated from the standard of care by failing to discontinue the Pitocin in the face of tachysystole after it was started.

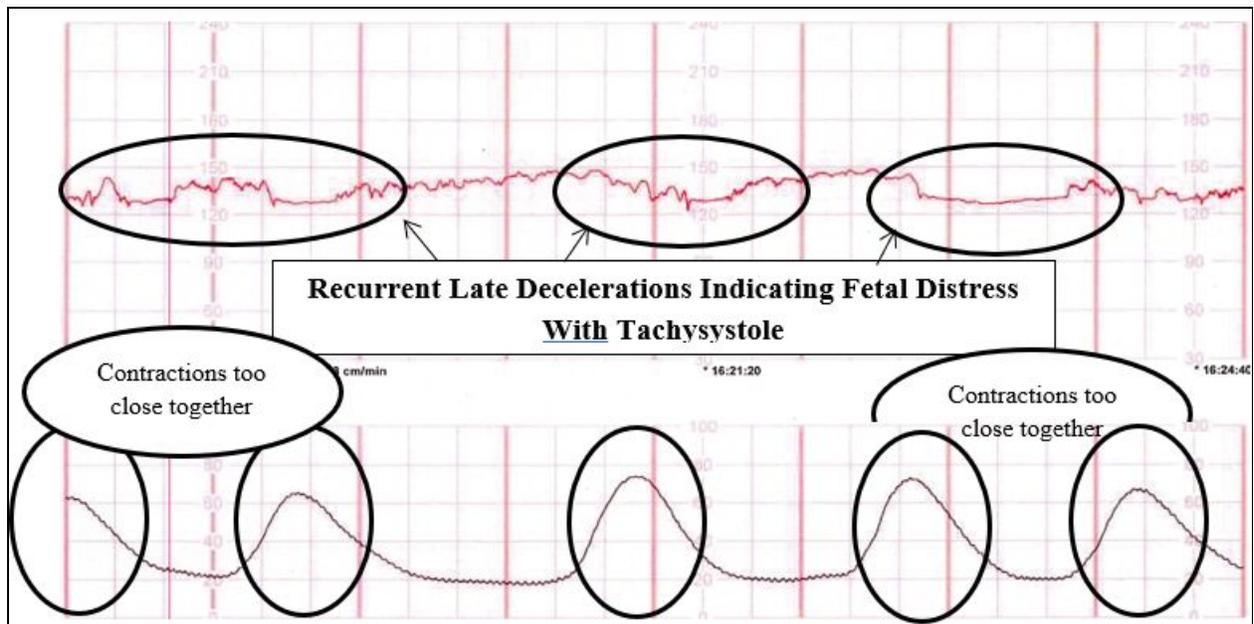
Moreover, even though Baby’s mom was being given an aggressive Pitocin regimen, she was not progressing in active labor. In 2006, if a patient failed to dilate for 2 or more hours, it was considered an arrest of labor and the patient should be taken for a Cesarean section. By approximately 13:30 on September 5, Baby’s mom’s labor had arrested and the standard of care required she be taken for a Cesarean section. Plaintiff’s maternal fetal medicine expert, opined “[b]ut Baby’s mom had really made no progress in the afternoon...early afternoon, 12:20, 1:30, she had made just minimal change. There was described by the nursing staff as not a lot of variability. She’d been ruptured for quite a while. **At that time discussion should have been you’re stuck here, we’re using Pitocin, not making progress, let’s proceed towards delivery.**” Dr. Defendant completely agreed, stating Baby’s mom “was examined more than two hours later at 13:31, she was still five centimeters. **A C-section should have been called at that point, so I fault her for that.**” If a C-section would have been done at this time, per the standard of care, for the arrested labor, Baby never would have undergone the remaining traumatic delivery and would be neurologically healthy today.

Soon after the arrest of labor should have been diagnosed, Nurse Defendant, undoubtedly concerned with the contraction pattern and fetal heart rate, finally contacted Dr.

Defendant who remained away from the Hospital. Nurse Defendant documented “Dr. Defendant notified of [vaginal exam], [fetal heart tones], contractions pattern, **questioned whether to increase Pitocin drip**, house officer reviewed strip and discussed with Dr. Defendant. **Orders to increase Pitocin to keep with regular pattern**. The house office was a resident, Defendant, who, like Dr. Defendant, deviated from reasonable practice by advising to increase Pitocin despite hours of tachysystole and a developing nonreassuring fetal heart rate. Also, despite Dr. Defendant’s “off-site” instruction, Nurse Defendant deviated from the standard of care by failing to advocate against continuing Pitocin and going up the chain of command if the physicians insisted on this dangerous and harmful plan of care. These reasonable actions were not taken and Baby was forced to continue through this traumatic labor, now beginning to suffer the effects of hypoxia and trauma.

Before 17:00, with Pitocin still titrating at a high dose and Dr. Defendant still away from the Hospital, Baby was demonstrating evidence of fetal distress from the persistent tachysystole and hyperstimulation. The expert testified that the above ominous findings were “all ways the baby tells you it’s not enjoying the environment it’s in. It will have decelerations, it will have minimal variability, it will have a rising baseline.”





By approximately 17:30, the experts unanimously agree that Baby must be delivered due to fetal distress to avoid hypoxic-ischemic injury to comply with the standard of care; the exact injury he eventually suffered. The Maternal Fetal Medicine Expert stated, “Decelerations, and we’ve made progress, but yet there’s frequent contractions, elevated uterine tone, it’s time to do a C-section. So I think around that 5:30, 5:40 mark, time to say let’s do a C-section... **But I think around 5:30 there was enough evidence to move towards cesarean, and standard of care would be to do that.**” Mirroring the Maternal Fetal Medicine expert’s opinion, the expert opined that by 17:30, the baby should have been delivered because he had developed “classic” markers of becoming hypoxic.

However, Dr. Defendant did not come to the Hospital, the nurse did not advocate for delivery, and no C-section was performed. Instead, Baby’s mom and Baby, Pitocin still infusing, continued to endure this traumatic labor. Due to the overdose of Pitocin, Baby’s mom reached complete at 10 cm dilation at approximately 18:02. Dr. Defendant was notified that Baby’s mom was complete at that time, however, she did not immediately come to the Hospital – in fact, **Dr. Defendant did not arrive until over 45 minutes later!** (Dr. Defendant arrived at 18:48.) Dr. Defendant’s explanation of the delay in her arrival, or lack thereof, was haunting:

Q: ...looking at this strip, when should you have been called to come in to see this patient?

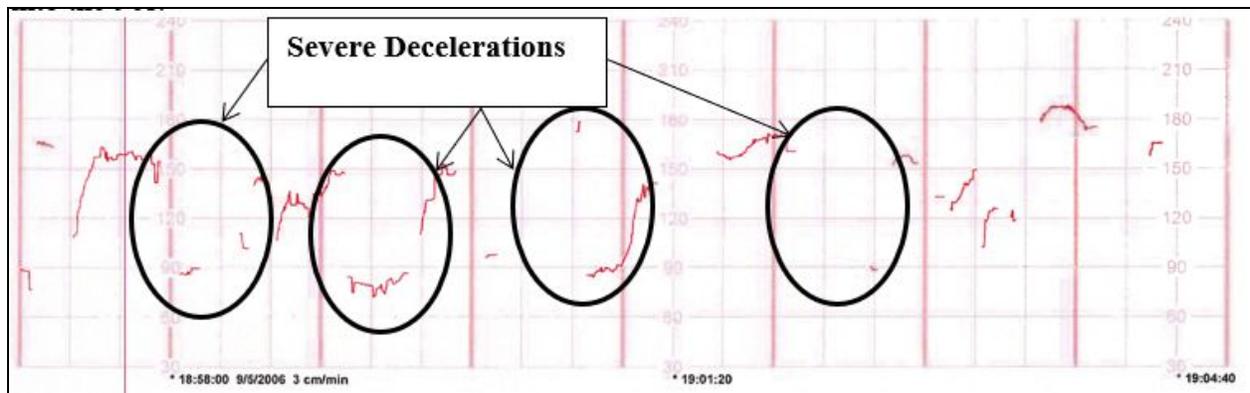
A: When she’s complete.

Q: When was she complete?

- A: She was complete – it says here it looks like 18:02.
Q: Okay. You would have wanted to be called by, by 18:02 to come in?
A: Yeah
Q: Do, do you – **what, what explanation do you have that if she's complete at 18:02 and the record says you're there at 18:48, any explanation for why it took you 46 – 45 minutes to get to the hospital?**
A: **No.**

As a result of Dr. Defendant's delay, Baby's mom was instructed not to deliver her baby while the healthcare team waited for the doctor to arrive. According to Dr. Defendant herself, the nursing staff – Nurse Defendant and the now present Charge Nurse – was instructing Baby's mom not to push, and “to try and delay a little bit until I could get there.” Since Dr. Defendant was not present, Nurse Defendant called in the charge nurse and the young resident to assist, but neither recommended a C-section, despite the obvious fetal distress evident on the EFHM.

After Dr. Defendant finally arrived, Baby's mom was instructed to push. That ignorant and negligent instruction resulted in Baby becoming entrapped in a shoulder dystocia. A dystocia occurs when the newborn does not fit out of the pelvic outlet and becomes trapped against the pubic bone. This indicates a cephalopelvic disproportion (“CPD”) or misfit between baby and mom. During the dystocia, Baby's heartrate continued to deteriorate with decelerations down into the 90s.



Following the four-minute shoulder dystocia which was eventually relieved, further adding insult to hypoxic injury, Baby was finally delivered at 19:07. During the delivery, Baby was pulled out so forcefully by Dr. Defendant that the umbilical “cord immediately snapped on delivery.”

At birth, Baby was severely depressed and required resuscitation. Baby was born with a heart rate of less than 60, with only gasping respiratory efforts. He was pale, and limp. He required bulb suction, stimulation, and positive pressure ventilation in order to be resuscitated. In addition to the obvious signs that Baby had endured a traumatic birth delineated above, *supra*, there was ample evidence that he had suffered a hypoxic ischemic insult as well. At approximately one hour of life, arterial blood gases were taken which, even after resuscitation, demonstrated profound metabolic acidosis – a hallmark for intrapartum hypoxic injury – with a pH of 7.18 and a base excess of -16.1. Soon thereafter, Baby developed seizure activity which is also a classic marker birth related hypoxic ischemic brain injury. As a result, Baby was transferred to another hospital for a neurological evaluation.

At the hospital, the worst was confirmed: Baby had suffered a severe and devastating hypoxic ischemic insult during labor which caused his profound brain damage. In fact, leaving no doubt whatsoever as to the cause or timing of Baby's injury, the discharge summary at the hospital listed "Severe **Birth** Hypoxic Ischemic Encephalopathy" and "Subdural Cerebral Hemorrhage **Due To Birth Trauma Or Intrapartum Anoxia/Hypoxia**" as two of his many discharge diagnoses.

Moreover, it is clear that the Defendants' collective negligence in overdosing Baby's mom with Pitocin, failing to deliver due to an arrest of descent, and failing to deliver in the face of fetal distress was the cause of Baby's terrible brain damage. Plaintiff's expert pediatric neurologist testified that Baby was injured by a combination of prolonged hypoxia and trauma during his delivery which eventually caused brain damage. The expert will testify that if Baby had been delivered any time before 18:18, as was required by the standard of care per medical experts, Baby would not have suffered any brain injury. The following exchange took place at the deposition of the expert:

Q: ...Is there brain damage that is reversible if the child is delivered once fetal distress has started?

A: I don't like the term damages as it relates to the word reversible. But you could certainly have hypoxemia, you can even have ischemia, which means reduced blood flow and the brain cells are still able to cope. **But at some point when the ischemia and hypoxemia becomes sufficiently severe for a sufficiently long period of time, then the brain cells can no longer function. The machinery breaks down biochemically, it accumulates lactic acid in the cell and it becomes a**

crescendo phenomenon. The longer it goes on per unit of time, the greater amount of damage occurs.

Q: Before 1818, had Baby been delivered, it's your opinion that there would not have been irreversible damage?

A: Yes.

Q: After 1818 there would have been irreversible damage?

A: Probably after 1818. Certainly after 1826.

Tragically, although the standard of care required delivery by 13:30 and 17:30 according to the experts, Baby was not delivered until 19:07, which subjected him to the trauma, hypoxia, and ischemia that devastated his brain leaving him in the condition he is today. Fortunately, Beam Legal Team was able to win a multi-million dollar settlement.

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THE **R&S** REGION & STATE

PITTSBURGH POST-GAZETTE ■ THURSDAY, MAY 4, 2000

B SECTION

Boy awarded \$17.5 million in medical negligence

By Johnna A. Pro
Post-Gazette Staff Writer

After a five-week trial, a Washington County jury yesterday found that Washington Hospital and two doctors improperly treated a Canonsburg boy shortly after his birth and that their failure left him with permanent brain damage.

The jury awarded the boy, Ryan E. Taylor, 8, \$17.5 million in damages.

His mother, Lori Slider, 30, received \$375,000 in damages.

In awarding the money, the jury said that both the hospital and Pediatric Associates of Washington — composed of doctors Paul Wollinger and Edward Foley — were negligent in the care given to Ryan after his birth. The jury said the hospital should bear 70 percent of the responsibility and the pediatric practice, 30 percent.

Foley recently was named to the hospital's board.

The doctors could not be reached for comment.

The hospital, in a brief statement, said: "We are disappointed with the jury's verdict and are surprised by the amount of the award. The hospital is considering whether to appeal the decision."

The verdict is believed to be the largest ever awarded in Washington County, attorneys said.

With interest, the figure could total as much as \$36 million, said Bradley M. Bassi, of the Charleroi-based law firm, Bassi, McCune & Vreeland, who tried the case, along with Denver attorney Jack Beam, who specializes in hospital negligence cases, and a Detroit firm that specializes in civil cases.

"This is one of the ways our judicial system allows us to make people accountable," Bassi said.

He praised the jury for being willing to come down hard on a community hospital and local doctors. Their award, he said, sends a signal that it's OK for local juries to be tough.

The money will be used to care for Ryan, the family said.

Ryan, who functions at the level of a 3-year-old, has seizures and needs help with daily tasks.

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Boy awarded \$17.5 million in medical negligence case

LAWSUIT FROM PAGE B-1

such as dressing and brushing his teeth. He requires constant care.

Before Ryan was born Nov. 5, 1991, at the Washington Hospital, he was lacking in glucose.

After his birth and while he was in the hospital nursery, those caring for him noted on charts that he was not eating properly, and his mother expressed concern about it, Bassi said.

Because the infant didn't drink, he used up the nutrients in his body and his glucose level — considered to be severely low at 40 — dropped to zero three days after his birth. The baby went into a coma and stopped breathing for a time. It was not

until that happened that the baby was seen by a doctor, Bassi said.

He was transferred to Mercy Hospital in Uptown, where doctors were told the child had suffered a stroke.

"All that baby needed was a little cup of sugar water and he'd be fine," Bassi said. "The lack of glucose caused the neurons in his brain to die."

When doctors told Slider, then 21, that her son had suffered a stroke, she believed them.

But after three years, family members and her husband, Robert, persuaded Slider to call an attorney to get Ryan's medical records released.

She saw Beam's advertisement on television and reached him through an 800 number.

Ryan since has been diagnosed with cerebral palsy and epilepsy.

"I was devastated. I had no idea someone could do that to a child," Slider said at a news conference last night.

She thanked the jury.

Children's Hospital of Pittsburgh, where Ryan had been treated about six months after his birth, also had been named as a defendant in the lawsuit, the jury found it was not liable for any damages.

Staff writer Lynda Guydon Taylor contributed to this report.

Canonsburg woman seeks \$7.5 million in delayed damages in negligence suit

BY MARISSA N. SCARVEL
THE OBSERVER-REPORTER
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A Canonsburg woman and her young son, awarded more than \$18 million in a medical malpractice lawsuit a week ago, are seeking \$7.5 million in interest on the verdict.

Attorneys for Lori Slider and her son, Ryan Taylor, 8, filed the request for delayed damages Wednesday.

Under court regulations, a plaintiff can seek interest on damages awarded from a year after the lawsuit was filed through the date of the verdict.

In this case, attorneys are seeking interest from 1995 through May 3, the day a Washington County jury awarded Taylor, \$17.5 million and his mother \$575,000 after a five-week trial.

Washington Hospital, which was found 70 percent negligent for causing Taylor's permanent

brain damage, and pediatricians Edward Foley and Paul Wodlinger, who each were found to be 15 percent responsible, have 20 days to contest the request.

If they contest, a hearing will be held before Judge David L. Gilmore.

If they don't contest the request, it is automatically granted, said attorney Bradley M. Bassi, one of three attorneys representing the plaintiffs.

The interest would bring the total damages to \$25.6 million.

Bassi said the defendants would be able to avoid incurring the interest if they had made a settlement offer prior to trial or if the plaintiffs caused delays. He added that an offer was never made by any of the defendants and that it's his position the plaintiff never delayed the case.

A jury deliberated about five hours over two days before reaching a unanimous decision.

A fourth defendant, Children's Hospital of Pittsburgh, was found not negligent.

Slider filed suit in 1994, claiming Taylor was healthy when born Nov. 5, 1991, and suffered permanent brain damage because of improper medical care.

Experts testified that the child should have been monitored more carefully because he was susceptible to hypoglycemia.

According to medical records, Taylor was given a blood test after turning blue three days after his birth and had a blood sugar level of zero.

The attorney for Wodlinger and Foley did not return a phone call seeking comment.

Washington Hospital president and CEO Telford Thomas said through a hospital spokeswoman that hospital attorneys "are reviewing the case and will make the appropriate response" to the plaintiff's request.

II. *Beam Legal Team Labor Delivery & Neonatal Malpractice Case*

Hypoglycemia or low blood sugar can be a deadly cause of brain damage. Jack Beam teamed with Detroit attorney Geoffrey Fieger to win more than \$25 million dollars for negligent failure to diagnose and treat neonatal hypoglycemia. In that case the baby was at risk for hypoglycemia, but the pediatricians did not test Ryan's blood. Consequently, he suffered seizures and permanent brain damage. Sometimes the negligence of doctors and hospitals does not stop at delivery. What follows are documents filed in such a case, which resulted in a confidential multi-million dollar settlement on the eve of trial.

The Baby's mom presented to Defendant Hospital for the delivery of her once upon a time very healthy son. She was 36 weeks gestation and the vaginal exam showed 5.5/70/-3. This indicates that the baby was high in his mother's abdomen, because he was a big baby. The baby would be delivered 21 ½ hours later at 18:55 – with exhausted glucose and oxygen reserves, yet still weighing 9 ½ pounds. Although “healthy as a bear” before he was born, by delivery, the baby had ongoing hypoxic ischemic brain damage and nearly every single possible risk factor for neonatal hypoglycemia:

- Infant of a diabetic mother
- Late pre-term
- LGA (large for gestational age)

Labor & Delivery Negligence

The mother's prenatal care showed that her unborn baby was developing perfectly normal and healthy despite his mom's high-risk factors. Mom was both obese and a diabetic during the pregnancy, which increases the risk of (1) having a big baby and (2) that baby being hypoglycemic – meaning insufficient glucose in the bloodstream. In fact, the obstetrician testified (and eerily predicted the outcome in this case):

Q. Let's talk a little bit more about the risks of [maternal] gestational diabetes. What do you see as the primary risk?

A. Risk to?

Q. Okay. And what about fetal risk?

A. Fetal risk, they have a risk of **macrosomia** [big baby] and **hypoglycemia** after birth.

Mom presented to the Defendant Hospital on February 5, before 10 p.m., complaining of contractions. She was connected to electronic continuous fetal monitor (EFHM), which is a device that measures and records the baby's heart rate during labor to ensure fetal well-being.

All the monitoring during the night and morning hours of February 6th were normal and reassuring, indicating a neurologically intact baby.

The defendant obstetrician first came to see Mom and Baby in utero at about 09:00 on February 6. At this time, Mom was 5.5 cm dilated and 70% effaced but Baby was still high in the birth canal at the -3 station, which should have been an indication that he may be too big to fit. But, despite the known risk that he was a big baby and he was not descending down the birth canal, the defendant obstetrician negligently failed to order an ultrasound to get an estimated fetal weight (EFW). The plaintiff's expert obstetrician testified:

10 Q. But where you believe the standard of care was
11 deviated when came in on February 5. Ultimately your
12 violation of standard of care for Defendant Obstetrician is that when
13 the patient came in on February 5 she did not at any
14 point before delivery do the ultrasound to find out the
15 size of the baby.

16 A. Right, but I also have to say that in her own
17 notes she said we're going to start serial ultrasounds
18 at the 33 week visit. Why didn't she order one for the
19 following week? Then they would have had one at 34
20 weeks and followed up at 36 weeks, if she didn't go into
21 labor, and another one at 36/38 weeks. Certainly that's
22 what serial ultrasounds means.

23 My point is that they breached the
24 standard of care not initiating that when they had that
25 discussion. Then they breached the standard of care

- 1 again when they had their last chance to do the
- 2 ultrasound when she came in at labor. There are two
- 3 breaches there.

Thereafter, a total of twenty-six (26) hours went by where Baby was at the -3 station failing to progress down into the birth canal before the defendant obstetrician decided to chemically force Baby through the birth canal by ordering Pitocin at 11:14. Pitocin is one of *only twelve (12) High Alert medications* commonly used in this country: it is well known that “[e]rrors that involve IV oxytocin administration during labor are most commonly dose related and often involve a lack of timely recognition and appropriate treatment of tachysystole.” (Exhibit D, Simpson, K., et al., Oxytocin as a High-Alert Medication: Implications for Perinatal Patient Safety 34:1 *American Journal of Maternal Child Nursing* 8, 8-9 (2009).) According to the FDA mandated Pitocin package insert – the drug’s instructions – overdosing a patient can lead to what happened here.

OVERDOSAGE

Overdosage with oxytocin depends essentially on uterine hyperactivity whether or not due to hypersensitivity to this agent. Hyperstimulation with strong (hypertonic) or prolonged (tetanic) contractions, or a resting tone of 15 to 20 mm H₂O or more between contractions can lead to tumultuous labor, uterine rupture, cervical and vaginal lacerations, postpartum hemorrhage, utero-placental hypoperfusion, and variable deceleration of fetal heart, fetal hypoxia, hypercapnia, or death. Water intoxication with convulsions,

In other words, excessive Pitocin can and does cause excessive uterine activity, such as uterine tachysystole (too many contractions) or uterine hypertonus (elevated resting tone greater than 15-20 millimeters of mercury via IUPC), which, if allowed to persist, can result in “**fetal hypoxia**” and “[p]ermanent CNS or brain damage.” (Id. at 3.) This is precisely what occurred here.

When Pitocin is being administered for an induction, continuous and readable fetal monitoring is required not just by the standard of care, but also pursuant to the defendant Hospital’s own policy and procedures:

- j. Continuous electronic fetal monitoring will be maintained during oxytocin infusion. Fetal heart rate (FHR) and uterine contraction assessment will follow ACOG recommendations for patients *with risk factors*:
- k. If external monitors are not adequately recording FHR and/or contractions, and internal monitors cannot be placed, the oxytocin infusion should be discontinued and the provider notified.

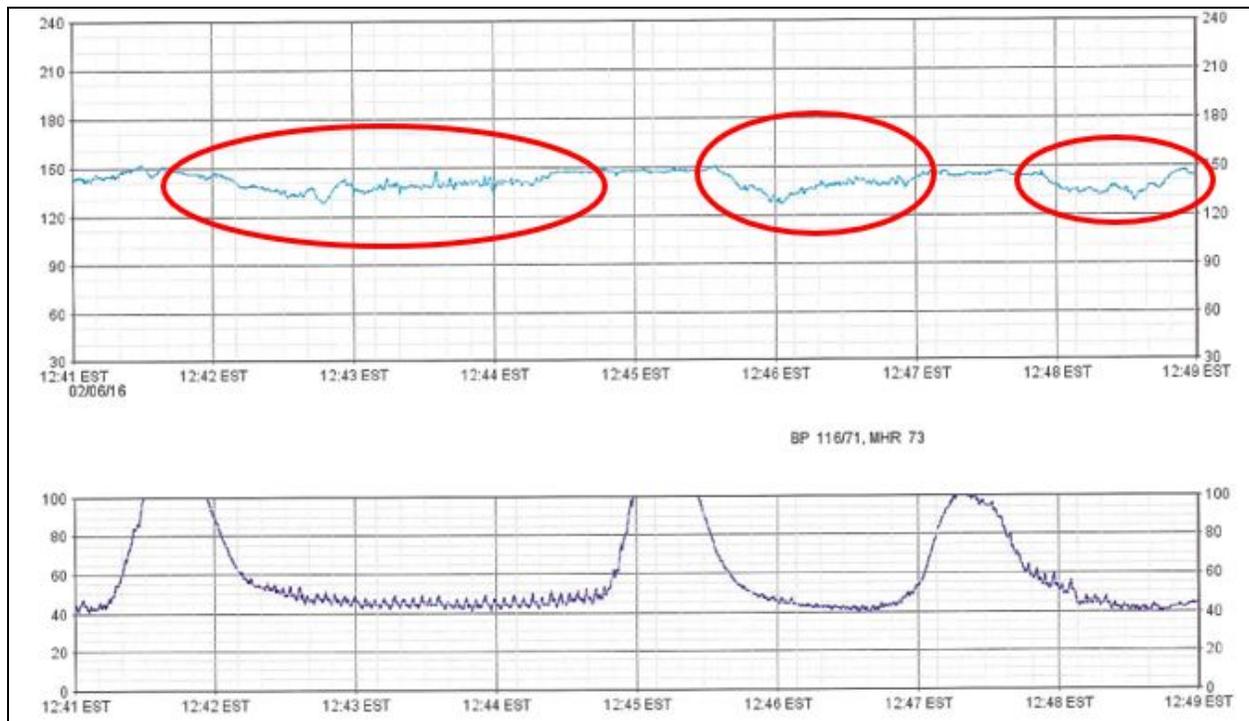
In other words, if the doctor or nurse cannot decipher the maternal contraction pattern and/or the fetal heart rate, Pitocin must be stopped. In this case, there is no indication the Pitocin was ever shut off. Here, the defendant obstetrician and the nurses never bothered to employ the technology of an IUPC (intrauterine pressure catheter) to easily and objectively “decipher” maternal contractions, in contravention of the defendant hospital’s own policies and the standard of care.

Not long after the Pitocin was started, late heart rate decelerations were seen on the fetal monitor strip. It is “Obstetrics 101” that late decelerations mean the baby is suffering from a lack of oxygen *in utero*. (Murray, Antepartal and Intrapartal Fetal Monitoring, p. 107 (stating all late decelerations “represent a fetal hypoxic response.”). Plaintiffs’ labor/delivery and newborn nurse expert testified that as early as 12:33 on 2/6/16, just one hour after it was started, the Pitocin should have been stopped.

Q. So are you saying, in this time frame of 12:33 to 12:41, the standard of care required the nurse to discontinue the Pitocin?

A. Yes.

Confirming Plaintiff Nurse Expert’s testimony and opinion, the EFHM was exhibiting repetitive late decelerations at 12:42, 12:46 and 12:48 from the increased contraction activity.



Thereafter until the delivery, with only a few exceptions, the EFHM is either exhibiting decelerations or **the fetal heart rate is not being continuously traced**, which is contrary to the standard of care and even Defendant Hospital's own written policy (See Exhibit F, supra).

An IUPC is *not required* when oxytocics are administered for induction or augmentation of labor. However, transducer belts may not fit around obese women who need close surveillance of the FHR and UA during induction. Therefore, **insertion of an IUPC and/or SE may be required to meet the standard of practice, e.g. the FHR should be *closely monitored* when oxytocin is infusing. The IUPC should be used when it necessary to better document contraction frequency, duration, intensity, and resting tone.**

In fact, the defendant hospital's nurses themselves document that they were unable to determine FHR decelerations due to their inability to adequately trace the uterine contractions.

T52:	2/6/2016 06:45 EST (FHR Deceleration: Other: unable to determine early vs late due to lack of monitoring of contraction pattern
T53:	2/6/2016 08:15 EST (FHR Deceleration: Other: decel present unable to determine type due to not able to trace contractions

The Defendant Hospital nurses tried to spin their failure to **continuously monitor** by stating that they were palpating the uterine contractions by hand. This is no substitute for a readable EFHM.

Q. Do you accept that nurses can palpate the strength and duration of contractions even if they're not showing up on the Toco?

A. That's very unusual. In any case, it's not accepted for Pitocin administration. You must have a continuous tracing. Also, this woman was morbidly obese. It's very difficult to palpate through all that adipose tissue to actually feel the contraction occurring and how long it lasts. So that is entirely not acceptable.

The nurse, around this time, says that she's doing contraction assessment by palpation. Again, that is not appropriate or accepted by any standard, by ACOG, AWHONN, and their own policy.

As stated by Plaintiff Nurse Expert, the Defendant Hospital's own policy and procedure states an IUPC should have been placed under these circumstances!

IUPC	<ul style="list-style-type: none"> • Ruptured membranes • Cervical dilation at least 1-2 cm 	<ul style="list-style-type: none"> • Accurate recording of contraction duration and intensity • Assessment of adequacy of contractions • Distinguishing early decelerations from late decelerations • Amnioinfusion 	<ul style="list-style-type: none"> • Vaginal bleeding of undetermined origin
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(Fetal Assessment P&P.)

After the Pitocin was administered and increased throughout the afternoon on February 6, Baby still would not come down the birth canal (showing Baby remained at the -2/-3 station at 16:54 when Mom was 7 cm dilated, 100% effaced). The reason Baby was not coming down is simple: he was too big to fit safely. Cephalopelvic disproportion (“CPD”) is when the baby’s head and body are too big to safely deliver vaginally through the maternal pelvis. Cunningham, et. al, Williams Obstetrics, 23rd Ed., McGraw-Hill, (2010). **If CPD is discovered, either by ultrasound or slow progress in labor, then a cesarean delivery is required under the standard of care.** Here, neither the defendant obstetrician nor the nurses did a U/S, nor did they recognize the protracted labor pattern, depriving Baby of the opportunity to be safely born.

As a result of the hospital staff’s repeated negligence, Mother and Baby continued to be overdosed with Pitocin causing worsening hypoxia to the baby during labor, with no relief in sight. By 16:30 on 2/6, given the continued non-reassuring fetal heart rate tracing with decelerations, the inability to continuously monitor the contractions and the slow progress of Baby through the birth canal, the OB experts opine that Baby should have been delivered by C-Section under the standard of care. Plaintiffs’ OB expert testified:

12 Q. So, was there something on the strip that
13 indicated this was emergent, she had to have this right
14 away, that decision to incision time?
15 A. Yes. If you look at the strips they are
16 horrendous. This is a very ominous strip. It was
17 getting worse and worse as the hours went by. The baby
18 was showing definite signs of hypoxia, worsening
19 hypoxia.

Plaintiff Nurse Expert agrees that the baby should have been delivered earlier and that by 16:30, the nursing staff should have been advocating for delivery by C-Section:

Q. Just so we’re clear, it’s your opinion that the nurse had an obligation, under the standard of care, to advocate for a C-section delivery by 14:30?

A. We’re at 16:30.

Q. I'm sorry. 16:30?

A. Somewhere around there, yes.

Q. And if the doctor doesn't agree with you?

A. Well, then I'd use my chain of command.

If Defendant Obstetrician and the nurses had complied with the standard of care and gotten Baby born by C-section at or before 16:30, all of Baby's neurological damage and injuries could and should have been prevented. Again, Plaintiff Obstetrician Expert testified:

- 2 Q. Do you believe that the C section been performed
- 3 by 16:30 that Baby would have had no neurologic
- 4 injury from an HIE?
- 5 A. I believe so.

Moreover, Plaintiff expert Pediatric Neurologist, further testified that Baby's permanent and irreversible brain damage did not start occurring until around 18:33. He stated:

Q By what time should -- by what time -- if Baby had been delivered earlier by C-section, would he have avoided the brain injury?

A I think if you had delivered him by 1833, we would not be here.

Q And what time was Baby born?

A 1855.

But, the standard of care was breached when Defendant Obstetrician and the nurses persisted with Pitocin forcing Baby down the birth canal to deliver vaginally. Finally, by 18:25 on 2/6, Mom reached completely dilated at 10 cm and Baby was bludgeoned down the birth canal

to the +2 station. During the birth, Baby's shoulder got stuck because he was so big which should have been no surprise to Defendant Obstetrician, had she been paying attention during labor, even assuming her failure to do an ultrasound for fetal weight. After getting stuck, Baby's head "turtle" signed where it retracted back in the vagina because he was too big to deliver. No matter, Defendant Obstetrician continued with the Pitocin and forced Baby to deliver vaginally, which mercifully occurred at 18:55 on 2/6/16.

Neonatal Negligence

At birth, Baby was severely depressed and required resuscitation. His Apgar scores were low – 4 and 1 minute and 7 at 5 minutes – requiring resuscitation for the first several minutes of his life. Cord blood gases, a test to measure how hypoxic a baby is at birth, were collected but never tested by the Defendant Hospital. As a result of this missing/destroyed evidence, no one can know just how hypoxic Baby was at birth, but radiology that would be performed after Baby crashed and was transferred to the children's hospital confirms that he was born with hypoxia and ischemia coupled with hypoglycemia resulting in devastating brain damage.

Tragically for Baby, the negligence committed on him by this defendant was only just beginning. The baby boy – in addition to being born hypoxic with ongoing brain damage – had every risk factor for neonatal hypoglycemia. Defendant Hospital's hypoglycemia protocol (listing late preterm, infant of a diabetic mother, and large baby as risk factors for hypoglycemia). Worse than having the risk factors, Baby indeed had and was immediately diagnosed with hypoglycemia by the defendant pediatrician. But, neither Defendant Pediatrician nor any nurse for the first 36 hours of Baby's life treated him by simply giving him IV glucose (sugar water in an IV).

Everyone, except the defendant hospital's pediatrician, knows hypoglycemia can and does cause brain damage and exacerbates brain damage from hypoxia-ischemia. In 2014, even the second edition of ACOG and the AAP "pro defendant"[2] publication regarding causes of Cerebral Palsy and brain damage acknowledged:

Hypoglycemia

Hypoglycemia can adversely affect the neonatal brain...In later childhood, neonatal hypoglycemia has been associated with a triad of cortical visual deficits, occipital localization-related epilepsy, and developmental delay.

Data from rodent models suggest that brain injury associated with hypoglycemia is more severe when hypoxia-ischemia and seizures also are present...This suggests that hypoglycemia and hypoxia-ischemia may act synergistically to cause neonatal brain injury.

(The Neonatal Encephalopathy and Neurologic Outcome, 2nd Ed (2014), p. 119.)

The very basic management guidelines for a physician caring for a neonate with hypoglycemia outline the exact care and treatment that Baby should have received upon his birth.

As soon as it is evident that the infant is sick, **glucose-containing solutions should be given intravenously**. It is important to also remain alert to the infant who has been identified as high risk for feeding intolerance or hypoglycemia, as these infants may also need an IV glucose infusion while feedings are being administered.

(The STABLE Program, Guidelines for Neonatal Healthcare Providers (2013))

The defendant pediatrician was not well educated. Tragically, she was the only doctor who treated Baby before he was finally transferred on day of life 2:

Q. **Have you learned in your training, education, and experience that a baby can suffer permanent central nervous system injury from hypoglycemia even if they're asymptomatic?**

A. **No.**

Q. **Have you ever learned in your training, education, and experience that untreated hypoglycemia can cause permanent brain damage in a baby?**

A. **No, sir.**

THE WITNESS: There's no literature to support that it causes brain damage.

BY MR. PATTERSON:

Q. All right. ... **Defendant Pediatrician, is it your testimony that you are aware of no literature that states hypoglycemia in a newborn can cause permanent brain injury to that baby?**

A. **Correct.**

This testimony is truly dumbfounding. In fact, **even the DEFENDANT’S pediatrician experts testified that it would be dangerous for a doctor to care for a newborn who does not know hypoglycemia causes brain damage.** The DEFENSE pediatrician expert testified:

Q: So you would agree with me that as a basic premise that **if a pediatrician did not know that low blood sugar could cause brain damage in a baby, that would be a dangerous thing for the pediatrician not to know, right?**

A: In some clinical circumstances, **yes, that would be dangerous**, not all.

Q: Did you see where Defendant Pediatrician said she did not know that hypoglycemia could cause brain damage in a baby?

A: I did see that.

Similarly, the other DEFENSE pediatrician expert testified:

Q: And just to my point, ***if the doctor did not know that hypoglycemia can cause brain damage, that would be a dangerous thing for the doctor not to know, right?***

A: ***If the doctor truly did not grasp that concept, then I agree with you.***

Q: And you were getting ahead of me, but you saw where Defendant Pediatrician testified that in her training, education, and experience, she never learned that untreated hypoglycemia can cause brain damage. You saw that testimony of [the Defendant’s pediatrician], did you not?

A: I cringed as I read that testimony...

Despite not knowing the consequences of neonatal hypoglycemia, the defendant pediatrician certainly knew that Baby Boy was (a) at risk for hypoglycemia (b) had hypoglycemia and (c) needed to be monitored and treated for hypoglycemia in accordance with the Hospital’s policy and procedure. Defendant Pediatrician testified:

Q. Did you ever learn that

A. Premature --

Q. -- a baby who is preterm or late preterm is more likely to have hypoglycemia than a term baby?

A. Yes, sir.

Q. Did you ever learn that a baby who is large for gestational age is more likely to have hypoglycemia than is an average for gestational age baby?

A. Yes, sir.

Q. You said "no"?

A. I said "yes, sir."

Q. Have you ever learned that an infant of a diabetic mother is more likely to have hypoglycemia as a newborn than an infant of a non-diabetic mother?

A. Yes

Q. Have you ever learned that a baby who was stressed during labor and delivery is more likely to have hypoglycemia than a baby who was unstressed during labor and delivery?

A. Yes.

Q. Have you ever learned that a baby who has suffered hypoxia during labor and delivery is more likely to suffer from hypoglycemia as a neonate than a baby without hypoxia?

A. Yes.

After Baby's delivery, since he was depressed at birth and at risk for hypoglycemia, he had his blood glucose screened and was evaluated by Defendant Pediatrician. At 19:09, when Baby was only 14 minutes old, his blood glucose result of 27 proved he was hypoglycemic (stating glucose levels should be kept above 50). Defendant Pediatrician evaluated Baby before 20:12 on 2/6 and diagnosed him with hypoglycemia based upon his blood glucose screen in real time.

Diagnosis: <u>Pre-term neonate (36^{1/2} wks)</u> <u>Shoulder dystocia</u> <u>descendental diabetic mother</u> <u>LG A. Infant of</u>	
PRIMARY CARE PHYSICIAN FOLLOW-UP: <u>Infant consumed 20ml of donor breast milk. Check B.S. freq. use only per protocol.</u>	
TIME <u>20:12</u> DATE <u>2/6/</u> 	Admission Physician signature 

Defendant Pediatrician also testified:

Q: On your admission note, you document that Baby is hypoglycemic, correct?

A: Yes.

Q: And that was based upon a blood sugar draw that revealed [Baby] had a blood glucose of 27?

A: Yes, but he exhibited no other signs with it.

Q: So he was hypoglycemic without any symptoms, true?

A: He was asymptomatic.

Q: Because you found Baby had asymptomatic hypoglycemia, you ordered the nurses to check his blood sugar frequently per protocol, right?

A: Correct.

Q: All right...you had instructed [the nurses] to manage Baby's hypoglycemia and blood sugars and feedings per this policy [Hospital hypoglycemia policy], correct?

A: Yes.

As a brief aside, Defendant Pediatrician attempts to explain away her egregious negligence in not administering IV glucose to Baby because he was "asymptomatic," but such an excuse is completely irrelevant. For instance, the Hospital's own policy specifically dictates how to properly manage an "asymptomatic" newborn who has or is at risk for hypoglycemia. See Exhibit O. Moreover, the expert pediatrician testified about the importance of screening for and treating hypoglycemia **before** symptoms are present:

In the case of hypoglycemia, the goal is to not wait until symptoms. **Because if you wait until symptoms, the baby may have already experienced irreversible brain damage.** That's why screening is in place. So to say that -- I would say, if I'm understanding your question, **that for a pediatrician to not -- to have their -- their -- their approach to be to sit back and wait until there's symptoms, that would be below the standard of care.**

Moreover, once again, the defendant's pediatrician expert agrees, similarly testifying:

Q: Do you agree that it is inappropriate to wait to treat a baby with hypoglycemia until the baby develops symptoms because **if you wait until there are symptoms, the baby may have already experienced irreversible brain damage?**

A: **I can agree to that.**

Obviously and disastrously for Baby, Defendant Pediatrician and the defendant hospital neonatal nurses lacked even the most fundamental and basic scientific knowledge that hypoglycemia can cause permanent and irreversible brain damage. As a result, Baby's dangerously low glucose levels were never – NEVER – treated with IV glucose as was required under the standard of care. The following is a chart of baby's glucose levels for the first thirty (30) hours of his life:

TIME (NEO 7-8)	GLUCOSE
2/6, 19:09 (14 min of life)	27
2/6, 21:03 (2h, 8min)	20
2/6, 22:09 (3h, 14min)	26
2/6, 23:02 (4h, 7min)	37
2/7, 00:59 (6h, 4min)	31
2/7, 01:20 (6h, 25min)	43
2/7, 03:55 (9hrs)	58
2/7, 06:08 (11h, 13min)	79
2/7, 09:08 (14h, 13min)	40
2/7, 11:55 (17h)	32
2/7, 12:25 (17h, 30min)	45
2/7, 14:00 (19h, 5min)	39
2/7, 18:13 (23h, 18min)	39
2/7, 20:40 (25h, 45min)	46
2/7, 20:44 (25h, 49min)	52
2/7, 23:30 (28h, 35min)	56
2/7, 23:35 (28h, 40min)	54
2/8, 02:00 (31h, 5min)	47

Although Defendant Pediatrician and the nursing staff lacked anywhere near a sufficient understanding of hypoglycemia, all they needed to do to treat Baby in accordance with the standard of care was read and execute their own damn policy! Again (there is a theme here), according to the DEFENSE experts, the Hospital algorithm/policy regarding hypoglycemia was consistent with the standard of care.

Q: Okay. And is the hospital guideline consistent with what would be required of a physician to render appropriate care ... in your opinion?

A: In my opinion, yes.

Q: So would you agree that the hospital policy is consistent with the standard of care for managing neonatal hypoglycemia?

A: Yes.

Pursuant to the defendant hospital's very own policy and procedure, "How To" algorithm for treating hypoglycemia, Defendant Pediatrician and the neonatal nurses violated the standard of care. After birth, Baby's first glucose level was 27. Since that was hypoglycemic, Baby was fed and then re-screened about two hours later, at 21:03. Despite Baby Boy eating after the first glucose test, the second glucose screen was critical and worse, measured at 20.^[3] At that time, based upon the general medical consensus, the hospital policy, and the standard of care, Baby needed and should have been given IV glucose. Expert pediatrician testified:

Q: What's the...basis for the opinion that [Defendant Pediatrician] violated the standard of care at 21:06 [on 2/6]?

A: Because that's the time when the second blood glucose had been done, and it was even lower than the first and the baby had been fed. And now you have – and we haven't even talked about this practice, but when you put that together with the baby's risk factors, the baby should have gotten IV glucose then.

Again, the defense experts even agree:

Q: **If Baby's blood glucose was really 20 at 21:03 following 20 cc's of feeding, the shoulder dystocia, the labor, and given his risk factors, if his true blood glucose was 20 at 21:03, then you would agree with me it was below the standard of care not to give that baby IV glucose, true?**

A: **True.**

Another defense expert agreed:

Q: And going back to my question, it is your opinion that the blood serum test for Baby's glucose level should have been done at or about 9:03 p.m. when the nurses got the result of 20?

A: Yes.

Q: And that was not done until 1:20 a.m., true?

A: Yes, 1:20 a.m. [so four hours too late under the standard of care].

Q: And do you agree that if the blood serum draw was done at 9:03 p.m. and came back at or about 20, like the point of care testing at the same time, that the standard of care would have required that Baby be given IV glucose to treat hypoglycemia?

A: Yes, if you have a lab serum test that says that number, you've confirmed you've made the diagnosis and that would be the appropriate treatment.

Q: When was Baby given IV glucose?

A: I'm not aware that he was until the time of, that the transfer team came.

So, the Plaintiff experts, defense experts, and hospital policy all agree that IV glucose should have been given to Baby Boy at 21:03 under the standard of care, but that was never done. Then, for the next 30 hours, Baby Boy was never given glucose until he finally crashed, suffering apnea, mottling and seizures requiring he be transferred to the children's hospital.[4] Transfer was likely the only reason Baby is still alive.

Causation and Damages

At the children's Hospital, Baby Boy's brain imaging revealed he had severe bilateral intraventricular hemorrhages and hypoxic ischemic brain damage from a combination of hypoxia-ischemia and hypoglycemia. In fact, the MRI report of his brain specifically stated **“[c]onsideration for hypoglycemia as the inciting etiology in the setting of gestational diabetes, seizures and preferential posterior involvement.”** World renowned neuroradiologist, out of Stanford, testified that Baby's brain damage on imaging is the classic picture reported in the literature of a child who suffered a severe hypoxic ischemic insult combined with hypoglycemic injury to his brain. The pediatric neurologist opined and testified “As you know, HIE, hypoxic ischemic encephalopathy, potentiates hypoglycemia, and the two work synergistically to produce damage which happened in this case.” Therefore, all of Baby Boy's severe brain damage was caused by a lack of oxygen and lack of sugar to his brain which

could have – and would have – been prevented if he was delivered by C-section and given IV glucose, as both were required under the standard of care.

Currently, Baby Boy is just over three (3) years old. He carries the diagnosis of cerebral palsy, epilepsy, global developmental delay, cortical visual impairment, microcephaly, plagiocephaly. He currently utilizes bilateral ankle/foot orthotics, a right-hand splint and a splint for the 3rd finger on his right hand. Moreover, Baby receives Botox injections for increased spasticity and was recently referred by his pediatric neurologist to a psychologist for management of self-injurious behaviors. He also receives weekly physical and occupational therapies, monthly vision therapy and has in-home devices that assist with Baby Boy's efforts at mobility such as a gait trainer and a therapeutic tricycle. As of yet, Baby Boy is unable to walk independently.

As a result of his deficits, Baby Boy struggles greatly and needs assistance with all activities of daily living. He is non-verbal and unable to walk, run, jump or otherwise act like a typical 3-year-old. Baby Boy is now and forever dependent on assistance from others for all the most basic human needs. His Father will never be able to teach him how to ride a bicycle. His Mother will never get to cheer him on from the bleachers under Friday night lights. His older sister will never be able to throw around a baseball in the back yard and will forever bear the burden of "the protector" or the sisterly guilt of living her own life other than as a caretaker.

Plaintiff's physiatrist will testify that Baby Boy will require 24-hour assistance and supervision for the rest of his life and that in the future, he will not be employable. The following plans/reports are attached hereto and show that the economic damages are **\$23,820,947 to \$55,769,435** (future value)/ \$2,233,326-\$4,916,487 (present value).

[1] See Breda Hayes, M.D., A Case-Control Study of Hypoxic Ischemic Encephalopathy In Newborn Infants At Greater Than 36 Weeks Gestation, AJOG, (2013) attached hereto as Exhibit M (emphasis added).

[2] One of the great mysteries of modern American medicine is why obstetricians who do not treat babies took it upon themselves to determine etiology of neonatal neurologic injuries.

[3] What is more confirmatory of hypoglycemia than a laboratory test? Consider a patient with no outward signs of bleeding, but the hematocrit and hemoglobin (H&H) levels showed the patient was bleeding out internally. Would the healthcare team treat the patient pursuant to the H&H blood test, or continue to do nothing because their eyes did not see any blood? The point is, how can Defendant Pediatrician, or anyone for that matter, say that Baby was asymptomatic when there are laboratory tests confirming that Baby's glucose levels were dangerously low and consistent with hypoglycemia?

[4] There was continued negligence in failing to administer IV glucose for two days after delivery, but those are not summarized here.