

## USING THE FACT THAT A BABY IS COOLED TO PROVE CAUSATION IN AN HIE CASE

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My name is Jacob Diesselhorst. I am a partner and trial attorney with the law firm of Maples Nix & Diesselhorst in Edmond, Oklahoma. Our firm focuses our practice representing the victims of catastrophic personal injuries and wrongful death in all areas of personal injury law; however, our firm's primary practice area is medical negligence cases. For me in particular, I almost exclusively focus my practice on handling birth injury cases and leading our firm's birth injury case team. My birth injury practice is primarily focused on "HIE" - **hypoxic ischemic encephalopathy** – cases, representing the families of otherwise healthy newborn babies who suffered severe blood flow and oxygen deprivation to their brains during labor and delivery causing permanent hypoxic ischemic brain damage ("HIE Cases").

As many of you know from all sides of the spectrum, babies that suffer HIE during labor and delivery often end up with catastrophic neurological disabilities due to their brain damage. In fact, many of these children go on to develop severe forms of **cerebral palsy**, which is a motion disorder caused by damage to the areas of the brain that control motor function, balance and posture, etc. Most of our cases involve children with spastic quadriplegic cerebral palsy (CP), the most severe form of CP, which causes increased muscle tone or spasticity that affects a child's all four limbs, the trunk and face. Children with spastic quadriplegic CP usually cannot and never will walk and often have other severe neurological and developmental disabilities such as profound intellectual disability, seizures and problems with swallowing, continence, eating, vision, hearing, speech and communication. Many require PEG tubes for feeding and some even require tracheostomies for breathing and respiratory problems.

Because of the permanency and severity of babies who suffer HIE during labor and delivery, the damages in these types of cases can often be astronomical – with economic damages for future medical and life care needs and loss of earnings capacity often being multiple 8 figures, sometimes \$20 to \$30 even \$50 million or more. And that does not even take into consideration non-economic damages, which in states like Oklahoma, where there are no caps on non-economic damages, can also be multiple millions of dollars - depending on the jury.

As those of us who handle these types of civil cases know, medical malpractice cases, more specifically, birth injury obstetrical malpractice or negligence cases, are very complex, challenging, expensive and time-consuming cases to litigate as plaintiffs' attorneys. It is also important to remember, the burden of proof in birth injury cases involving babies who suffer HIE falls squarely on the shoulders of the plaintiff – on standard of care, causation and damages. Thus, these cases require the plaintiff's attorneys to hire numerous medical experts from multiple different medical specialties to prove their client's case - from top to bottom. This requires firms to retain experts in obstetrics, labor and delivery nursing, neonatology, pediatric neurology, pediatric neuroradiology, life care planning and an economist – and sometimes experts in placental pathology, genetics, orthopedic surgery, infectious disease, neuropsychology and vocational rehabilitation. In the same regard, defense firms who represent doctors and hospitals named in HIE cases also must usually retain numerous experts in these same fields of medicine, making these cases often turn into a “battle of the experts.”

Damages, in HIE cases, often speak loudly for themselves. Although fights can be fought on a particular brain damaged baby's life expectancy and nit-picking done of the plaintiffs' life care plan and/or economic loss reports, these areas are not typically where these cases are

won or lost. Instead, the battle is usually fought on **standard of care**, i.e., whether the health care providers (the obstetrician, doctor, midwife, labor and delivery nurse and/or the hospital) acted as a reasonably prudent health care provider should have acted under the same or similar circumstances. Additionally, in HIE cases there is usually a battle on **causation**, i.e., whether the baby's brain damage was directly caused as a result of the alleged negligence of the health care providers and/or would have prevented but for the alleged negligence. The issue of causation is often where HIE cases are most vigorously fought and typically won or lost by plaintiffs.

Today, I am not going to spend much time discussing standard of care in these cases. Instead, I am going to discuss "causation" – more specifically, how to use the fact that a specific baby met the inclusion criteria for and received therapeutic hypothermia or cooling treatment subsequent to delivery to help plaintiffs prove causation in an HIE case.

I will also spend some time today discussing ways that plaintiffs' law firms can utilize a hospital's policies or protocols on therapeutic hypothermia to their advantage. More specifically, I will discuss how the strict inclusion criteria required for a baby to qualify for cooling treatment can help prove causation for a plaintiff in an HIE case. This is especially effective when the baby is admitted to the NICU and receives cooling treatment at the same hospital where the labor and delivery, and the alleged negligence, occurred.

I will also briefly discuss some strategies that our firm utilizes and implements at trial to use the deposition testimony and opinions of the defendants' own medical experts regarding the fact that a baby qualified for and received therapeutic hypothermia treatment to help prove causation in an HIE case.

Finally, I will briefly discuss an example that I have seen in my practice of the incredible and astonishing benefits that therapeutic hypothermia can provide for some babies, who met the inclusion criteria for cooling therapy (in other words – were born with low APGAR scores, neonatal encephalopathy and acidosis – low pH and low base deficit), received therapeutic hypothermia treatment for HIE but then went on to have miraculously positive outcomes, with little to no residual neurological deficits or disabilities.

### **1. Using the fact that a baby received cooling treatment to prove causation**

As noted, HIE cases are very complex and challenging medical cases to prosecute, and therefore, can be difficult cases to prove medical causation to a jury at trial. The medical issues involved in an HIE case can be very complicated, confusing and, sometimes, incomprehensible to a jury. Skilled and experienced defense attorneys are also very good at “muddying up” and confounding the medicine as much as possible, making the jury feel incapable of understanding the issues in the case and thus unable to render a verdict in favor of the minor child plaintiff.

So, as plaintiff’s attorneys handling HIE cases, it is imperative that we be extremely knowledgeable and up to date about the medicine in these cases, fully understanding subjects like fetal heart monitoring strip interpretation, maternal and neonatal laboratory result analyses and brain neuro-imaging studies, findings and results, to name a few. It is also our job as plaintiffs’ attorneys in these cases to try to simplify complicated medical subject matters and concepts as much as possible in order to not only help the jury understand the issues in the case but, more importantly, to prove causation to the jury, i.e., that the baby’s brain damage was preventable had a cesarean section been called and performed sooner (or had a vaginal delivery never been attempted at all) which would have prevented the baby’s development of acidosis

and hypoxic ischemic brain damage from not getting enough oxygen during labor. However, in HIE cases where a baby meets the inclusion criteria for and receives therapeutic hypothermia treatment for suspected HIE, proving causation to the jury can be much less difficult and, in some cases, fairly easy and straightforward.

Briefly, therapeutic hypothermia or cooling is a treatment used to try and slow down or minimize the injury process in a baby's brain from the progression of HIE. Research shows that cooling therapy, if given within 6 hours of birth, can protect a baby's brain from further injury by decreasing blood flow to the injured areas of the brain, thus reducing swelling and potential for further brain damage after a hypoxic-ischemic insult has occurred. In order to qualify for this treatment, a baby must meet very strict inclusion criteria. **[SEE SLIDES 1 and 2]** In effect, these "inclusion criteria" practically mirror the ACOG clinical and physiologic "Neonatal Signs Consistent with an Acute Peripartum or Intrapartum Event" - identified in ACOG, Neonatal Encephalopathy and Neurologic Outcome, 2<sup>nd</sup> Edition (other than the requirement of neuroimaging evidence of acute hypoxic brain injury on MRI, which cannot be identified within the first six (6) hours of life).

In other words, if your firm has a potential HIE/birth injury case where:

(1) the baby was found to have low APGAR scores (less than 5) at 10 minutes of life and required positive pressure ventilation (PPV) at 10 minutes of life; and

(2) the baby has evidence of fetal acidosis (either metabolic or mixed metabolic/respiratory acidemia) from umbilical cord artery blood or a baby artery blood gas taken within one (1) hour of life, with a pH less than 7.0 and a Base Deficit > or = to -16; and

(3) the baby is found on neurological exam to be Sarnat Stage 2 or 3, meaning moderate to severe encephalopathy); and

(4) in turn, the baby thus meets a NICU's inclusion criteria for therapeutic hypothermia and receives the treatment – you likely have yourself a strong HIE case where causation is much easier to prove. The challenge however, still, is finding the right way to communicate these complex concepts of clinical, physiologic, laboratory and radiological evidence to the jury.

In our birth injury cases, we utilize demonstrative exhibits, used along with our testifying experts (and sometimes treating physicians and/or even the defendants' own medical experts), to educate, teach and help the jury understand the complex medical concepts that are vital to proving causation in an HIE case. As you know, one of the essential criteria for cooling is evidence of **asphyxia** at the time of birth, which requires a finding of **fetal acidosis** from blood drawn from the umbilical cord artery and/or from an artery of the baby within 60 minutes (1 hour) of birth.

**[SEE SLIDE 3]**

In our HIE cases, we use demonstrative exhibits like this one to teach the jury what “fetal acidosis” is, how it is caused during labor and how fetal acidosis is diagnosed. This allows the jury to follow along, reading the content on the demonstrative exhibit while the witness is discussing the concept and/or allows a juror to read ahead on the demonstrative at their own pace to educate themselves. We have found that it is much easier to keep the jury's attention and focus and to explain complex medical terminology during witness testimony by using demonstratives like this one. In addition, a jury seems to comprehend the information better by being able to read for themselves the short excerpts of information on the demonstrative, while the witness on the stand is also discussing the same subject matter. In fact, a juror may read the

information on the demonstrative several times while the testimony is ongoing and may see the same board used multiple times with several witnesses throughout the trial. **[SEE SLIDE 4]**

Here is another example of a demonstrative exhibit that our firm has used in HIE cases, in tandem with other tutorial boards like the one before. In this example, this demonstrative was used to teach the jury **what HIE is, how HIE is caused and diagnosed** and, most importantly to our discussion today, **what therapeutic hypothermia is, why it is used to treat babies with HIE and what the outcomes of cooling can be**. Again, the language we use on the demonstrative is as simple and straightforward as possible to make it easier for the jury to understand. More importantly though, the jury being able to read the information on the demonstrative while the witness is testifying, keeps their attention and focus and can help make complicated medical terminology not so complicated after all as the trial progresses.

## **2. Using a hospital's Cooling P&P and/or the medical records to prove causation**

Another proactive way to help prove causation in an HIE case where the baby received therapeutic hypothermia treatment is by utilizing either: (1) the defendant hospital's own policies/protocols on cooling: or (2) if the baby is transferred to a tertiary hospital for NICU care and treatment, using that hospital's medical records pertaining to the decision to cool the baby. Often times, a plaintiff's attorney can also buttress these strategies to prove causation with applicable medical literature, articles or relevant medical texts discussing therapeutic hypothermia treatment for babies with suspected acute HIE. **[SEE SLIDE 5]**

Here is an example of a demonstrative exhibit that our firm used in an HIE case where the baby, who was a term baby delivered vaginally by emergency forceps due to the presence of absent variability on the FMS after several hours of pushing with recurrent severe variable

decelerations and a long prolonged deceleration, who suffered severe HIE, both partial prolonged and acute profound in nature. This baby was delivered at a hospital in Tulsa, Oklahoma that has its own NICU; therefore, the baby was treated in-house at the hospital where we alleged the negligence had occurred.

As you can see on this demonstrative, we used the defendant hospital's own body cooling protocol and algorithm to walk the jury through the reasons the baby qualified for the treatment. We also always include a "pull out" box on these types of demonstratives where we continue to teach the jury the medical issues in the case in simple and straightforward terms. For example, here we educate the jury that the reason this baby was cooled was "because he met the inclusion criteria of its (the defendant hospital's) own policy...meaning he had suffered brain damage from not getting enough oxygen during labor and delivery." We also always put a simple question at the top of each board to establish what issue in the case it is designed to educate the jury on.

So, in this case, we were able to establish that the defendant Hospital's own neonatologists, using its own protocols, found that this baby's clinical, laboratory and physiologic condition and diagnoses qualified him for cooling treatment. Which, in turn, means that the defendant Hospital itself acknowledged that, shortly after the delivery, this baby had more likely than not suffered acute asphyxia and hypoxic ischemic brain damage during his labor and delivery. What's more, in the event that during litigation the defense elects to pursue an alternative causation defense (such as infection, genetics, etc.), well, then the defense experts offering those opinions are contradicting the informed decisions made by the hospital's own NICU doctors, using the hospital's own protocols, to treat this baby in real time after his delivery, based on the contemporaneous medical evidence available to them of HIE.

In cases where the delivery occurs at a hospital that does not have its own NICU and, thus, a baby born asphyxiated is transferred to another hospital with a NICU and higher level of care, we have found that using the NICU's medical records on therapeutic hypothermia is a very effective way of proving causation in our HIE cases. **[SEE SLIDE 6]**

Here is an example of a demonstrative exhibit that our firm used in another HIE case where we utilized the receiving hospital's NICU records to educate the jury on how and why "we know that (the baby) suffered brain injury from not getting enough oxygen during labor at (the defendant hospital)." As you can see, we used the receiving hospital's NICU's "Qualified Neuro Exam for Whole Body Hypothermia" record and the clinical information contained therein to help prove causation, i.e., that the baby must have suffered acute HIE at the defendant hospital before being transferred, since he met the inclusion criteria for therapeutic hypothermia at the NICU and, in fact, received the treatment. Again, we then utilize "pull out" boxes to focus on specific aspects of the record that support our theory of causation.

In this case, as you can see, the baby's neurologic exam easily met the NICU's hypothermia qualifying criteria as the baby was lethargic, had decreased activity, abnormal posture, abnormal primitive reflexes, constricted pupils and apnea which required mechanical ventilation. So, we draw the jury's attention to these clinical facts and then use an additional text box to answer the question we posed at the top of the demonstrative. In this case, it was that this term baby, who had suffered a prolonged fetal bradycardia of over 15 minutes before being delivered by emergency C-section (albeit too late) was found by the specialists in the NICU at the receiving hospital to have "numerous signs of acute hypoxic neurological injury" since he "met the NICU's qualifying criteria for therapeutic hypothermia treatment for HIE." Of note, this child also had

umbilical cord arterial blood gas results from the defendant hospital, which supported a diagnosis of metabolic acidosis and birth asphyxia at birth, with a pH of 6.78 and a base deficit of -20.6, and subsequently also had an MRI done which supported a diagnosis of acute HIE.

### **3. Using Defendant's Experts to help prove causation based on a baby being cooled.**

Without giving away all our secrets about how we aim to prove causation to juries in our firm's HIE cases, I will briefly discuss this topic and show examples of deposition testimony we have obtained from defendants' own medical experts to establish causation in cases where a baby with HIE met the inclusion criteria for and received therapeutic hypothermia treatment. Of course, in order to take this approach and continue to maintain credibility with the jury, the baby's medical records must clearly support this position. **[SEE SLIDES 8 and 9]**

The first example is from the deposition of a **defense pediatric neurology expert**. First of all, it is important to lay a foundation and establish the expert is qualified to discuss therapeutic hypothermia and, in turn, causation of the baby's brain injury. From there, as you can see, using leading questions, we were able to obtain very strong testimony that supported our position on causation from the defendants' own pediatric neurology expert. He even went so far as to agree with me that there was "no dispute" that the baby we were discussing in the case had "suffered a hypoxic ischemic insult to his brain prior to the time of his birth" and that the baby was "an appropriate candidate for neonatal hypothermia therapy based on his assessment of...(having) moderate to severe neonatal encephalopathy and based on the blood gas studies that were done."

**[SEE SLIDE 7]**

Finally, this defense expert gave our clients an absolute kill shot opinion, which directly contradicted the causation opinions of defendants' other experts – admitting that the fact the baby “met the inclusion criteria for total body cooling indicates that there was a high index of suspicion by the physicians taking care of him that he had, in fact, suffered intrapartum asphyxia.” In fact, he even went so far as to affirmatively state: “...**let me go on the record saying I agree that there was intrapartum asphyxia.**” Well, unfortunately for the defendants, their other causation experts did not agree and had testified that the baby DID NOT have intrapartum asphyxia but that, instead, all the baby’s hypoxic brain damage occurred before labor. These glaring contradictions forced me to quote the great Sir Walter Scott in one of our pretrial motions in this case: “*Oh, what a tangled web we weave, when first we practice to deceive!*”

**[SEE SLIDES 10, 11, 12, 13]**

The next example is from the deposition of a **defense OBGYN expert** in one of our cases. Although OBGYN experts may not be qualified to offer opinions or discuss issues of neonatology or pediatric neurology; as we know, many OBGYN experts (on both sides) often still offer opinions on causation of the baby’s brain injury based on review of the fetal monitoring strip, the records of the baby’s condition at birth and the records from the baby’s subsequent NICU course. With all due respect, in my practice, I have come across numerous OBGYN defense experts who take the liberty of offering often flimsy causation opinions that the baby did not suffer intrapartum HIE, but that something else must have caused the baby’s brain injury before the labor and delivery. So, the job of the plaintiff attorney is to poke holes (the more gaping the better) in the defense expert’s opinions. More so, the basis of those opinions and, most of all, pin the experts down on what facts & evidence he is relying on to offer his causation opinions.

In this example, as you can see, I established with this defense OBGYN expert (in fact he volunteered the information) that the reason the baby was transferred to a hospital with a NICU for a higher level of care was because the neonatologist at the defendant hospital had “a concern that he (the baby) may have had a hypoxic event around the time of labor, and that they felt he was a candidate for head cooling.”

With this same OBGYN expert, we were also able to reveal that he had not even reviewed the baby’s NICU records and was “not aware of...any of the details of his treatment” at the NICU. Yet, he was still willing to offer causation opinions in the case that the baby’s brain injury predated the labor and delivery. So then, using the NICU records that this expert had admittedly never reviewed before his deposition, we were able to further establish that the neonatologists in the NICU noted that the baby had suffered “an acute asphyxial event.” We also established that the baby met the hospital’s criteria for cooling and then went through the NICU records with him (for the first time) to confirm the baby’s qualifying clinical and neurological findings.

**[SEE SLIDES 14, 15 and 16]**

My third example is from the deposition of a **pediatric neuroradiologist expert** retained by the defense in one of our HIE cases. I struggle to refer to him as a “defense expert” though because his testimony was so helpful and supportive of plaintiff’s theory of causation and harmful to defendants’ alternative causation defense. Although pediatric neuroradiologists do not provide hands on clinical care to asphyxiated babies and are not involved in the diagnosis and/or decision-making whether to provide cooling treatment to a baby with suspected HIE, many are still knowledgeable about therapeutic hypothermia due to its relevance to their review, interpretation, analysis and findings of later MRI imaging of the neonatal brain. In addition,

neuroradiologists are also knowledgeable about the potential of more favorable outcomes for some asphyxiated babies who receive cooling therapy, both clinically and radiologically.

In the case I am using for this example, this “defense” neuroradiologist expert testified that the baby met the criteria for therapeutic hypothermia “most probably...due to hypoxic ischemic injury.” So, he basically agreed with the opinions of plaintiff’s pediatric neuroradiologist expert on the cause of the baby’s brain injury and only differed as to the “timing of the injury” – stating that the radiology imaging, in and of itself alone, could not confirm the timing of the injury and, thus, the timing was “unknown.” Well, this allowed me to then establish with him, in offering the opinion that the timing of the injury was “unknown,” that he was only relying on the radiologic evidence and was not relying (and in fact was ignoring) all the clinical evidence in the case in order to offer that “opinion” to the jury. In fact, when questioned about the actual clinical evidence in the case, i.e., the fact the baby was not breathing when he was born, had to be intubated, was diagnosed with profound metabolic acidosis and was transferred to a higher level of care NICU where he qualified for and received cooling therapy, the defense neuroradiology expert admitted he was not relying on any of those facts to offer his opinion on timing. Not only that, this defense expert was “the gift that kept on giving,” when he testified, in response to my question about the baby’s clinical findings at the time of birth, “that all of those things you described are the result of oxygen deprivation to the fetus.” [SEE SLIDES 17 and 18]

The last example is from the deposition of a, with all due respect, “well-traveled” **defense neonatology expert** who, in this case (like most cases he testifies in), was offering the opinion the baby suffered the hypoxic ischemic injuries to his brain several days before the labor and delivery. This is despite the fact the baby had absent fetal heart rate variability on the fetal

monitoring strip for around 20 minutes, after having sustained several hours of severe variable decelerations and a 10-minute prolonged deceleration, before the emergency forceps delivery finally occurred (which was performed by a resident with the attending physician “observing”). This defense neonatologist was also willing to offer this causation opinion even though this baby was born with APGAR scores of 0,0, 2 at 1, 5 and 10 minutes respectively; had profound metabolic acidosis on his initial arterial blood gas results after birth (no cord gases) and despite the fact he met the defendant hospital’s own criteria for and received cooling treatment there.

As you can also see from his testimony, we were able to establish that this neonatology expert had not been provided the defendant hospital’s protocol on therapeutic hypothermia as part of his materials to review in the case and therefore had never seen or reviewed it before reaching his opinions on causation and presenting for deposition. So, he got to have a really good look at it during his deposition, where we proceeded to establish that the baby: “met both the physiologic and neurologic criteria for therapeutic hypothermia based on the defendant hospital’s own policies and procedures.” From there, we also went over in detail with this expert, using both the defendant’s own cooling policy and the baby’s medical records from the defendant hospital’s NICU, to establish several key points which supported plaintiff’s theory of causation that the baby had suffered acute hypoxic ischemic brain damage during labor and delivery. Namely, the defendants’ neonatology expert had to concede that the baby:

- 1) had a blood gas pH 7.0 to 7.15 or a base deficit of -10 to -15.9;
- 2) had an acute perinatal event, with severe fetal heart rate abnormalities;
- 3) had a need for ventilation initiated at birth and continued to 10 minutes of life; and
- 4) was found to be Sarnat stage 3 - i.e., had severe neonatal encephalopathy.

#### **4. An example in my practice of miraculously positive outcome from cooling.**

The final subject I want to briefly touch on is an example from my own practice of a case where timely therapeutic hypothermia treatment clearly had a miraculously positive effect on a baby's ultimate neurological outcome. This compelling case shows just how important and valuable timely therapeutic hypothermia treatment for babies suspected to have acute HIE can be in improving outcomes and saving some babies from the often catastrophic neurological sequelae of severe intrapartum HIE.

This case in particular will always stand out to me. It was from 2015 and involved a 39-week gestation mother who was induced into labor and whose baby was later delivered via emergency C-section, far too late, due to non-reassuring fetal heart rate status, which included variable, late and some prolonged decelerations and minimal to absent variability. The baby was delivered with floppy tone, minimal respirations but a heart rate greater than 100. She still required continued respiratory support with signs of respiratory distress, including grunting and retractions in the nursery at the delivering hospital. Initial blood work was done including an arterial blood gas at 1-hour life which showed a low pH of 7.04 and a base deficit of -23.1. At this point, OU Children's Medical Center in Oklahoma City was contacted due to the baby's "significant acidosis" and the decision was made to transfer her there by Neoflight for therapeutic hypothermia treatment. The discharge/transfer diagnoses from the transferring hospital noted "metabolic acidosis" and "hypoxic injury."

Upon admission to the OUMC NICU, the baby met the inclusion criteria for cooling and underwent a 72-hour course. During her NICU admission, the baby was diagnosed with coagulopathy and thrombocytopenia, requiring multiple blood transfusions; hyperbilirubinemia;

required dopamine for perfusion issues and had an abnormal EEG. Moreover, an MRI was performed at around day of life 14 which showed an acute infarct in the left corona radiata & basal ganglia, restricted diffusion extending along the corticospinal tract & moderate areas of encephalomalacia in the bilateral parietal lobes with extension into the subcortical white matter.

After a 3-week admission in the NICU, the baby was discharged home with a diagnosis of hypoxic ischemic encephalopathy (mild to moderate) with instructions to establish care with a pediatric neurologist and obtain a follow MRI in a few months. The records also reflect the family was informed about the potential for neuro-developmental problems for their baby, including mental deficiencies and cerebral palsy.

At 12-weeks of age, the baby was seen for an initial visit with a pediatric neurologist at OU Children's Physicians Neurology Clinic. The history included "HIE at birth treated with cool cap and perinatal stroke." The history went on to note that the baby was born "via emergency C-section due to decreased fetal heart tones (with) the rate...down to 10 in utero... (with the) c-section (performed) 2 hours later." However, the neurological exam of the baby on this date painted a much different and unexpected picture. The baby was noted to be awake and alert, with normal pupils and eye movements and normal facial movement. Her motor function noted she could move all extremities symmetrically with full active range of motion, equal strength and normal tone. She also had no abnormal movements and good head control in a sitting position.

By 1 year of age, incredibly, the baby had a completely normal neurological exam with normal fine and gross motor skills, normal development, normal language, normal growth, normal strength and gait and, most notably, normal tone, with no signs of cerebral palsy or any movement disorders.

At 18 months of age, after our firm filed the case to preserve the 2-year statute of limitations of the parents at the family's request, our firm thankfully rejected the case, advising the family that their baby had made miraculous recovery from the hypoxia she suffered during labor and delivery and that, therefore, we did not believe they had a viable case worth pursuing.

Like I do with all my clients, even the ones whose cases we do not pursue, I have stayed in touch with the family and kept up with them on Facebook. The baby is not a baby anymore, she is now 6-years old. **[SEE SLIDE 18]** She is a very gifted singer who loves George Strait. She loves to go fishing with her daddy and has caught some really big catfish. She loves to go to the rodeo with her parents and has even tried out go-cart racing and the pig races. She has recently started school and is one of the smartest and most outgoing kids in her class. I am proud and honored to report that his child is a healthy and happy soon to be 7-year-old girl. Her outcome, an outright miracle, is the ultimate success story to tell regarding the incredible benefits that timely therapeutic hypothermia can provide a baby born with hypoxic brain injury.

I always tell potential clients that our evaluation of these cases is like a teeter-totter. On one side, you have a baby with a very good outcome which means you have a bad lawsuit. On the other side, you have a baby with a very bad outcome which means you probably have a good lawsuit. I also always tell my clients that I would much prefer they stay on the side of a good baby/bad lawsuit and not have to go forward with filing a case, because that means they have a healthy child. It also means medical miracles really do happen. Thank you for your time.

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