

IN THE SUPERIOR COURT OF THE STATE OF EXAMPLE (SYNTHETIC)

A.C., individually and as guardian of Baby Boy C., Plaintiff,
v.
RIVERBEND REGIONAL MEDICAL CENTER, et al., Defendants.

Case No. SYN-2026-000123

EXPERT REPORT OF A. EXAMPLE, M.D.

Neonatal-Perinatal Medicine

Every name, fact and opinion in this report is invented for a work sample. It is the input to the citation audit, not an audit product.

Qualifications (SYNTHETIC)

I completed pediatric residency and a fellowship in neonatal-perinatal medicine, and I am board certified in both. I direct a level IV neonatal intensive care unit and a regional neonatal transport service. My curriculum vitae is attached as Exhibit A (SYNTHETIC).

I have given testimony by deposition or at trial in the matters listed in Exhibit B (SYNTHETIC). My fee for review is stated in Exhibit C (SYNTHETIC).

I. Assignment and Qualifications

1. I am a physician board certified in neonatal-perinatal medicine (SYNTHETIC). Counsel for plaintiff asked me to review the records of Baby Boy C. and to state my opinions on the nature and timing of his brain injury. I have practiced neonatology for more than twenty years and have cared for many infants treated with therapeutic hypothermia.
2. My opinions are stated to a reasonable degree of medical probability. I reserve the right to supplement them if further records or testimony become available.

II. Materials Reviewed

3. I reviewed the maternal and neonatal records of Riverbend Regional Medical Center and St. Columba Children's Hospital produced as BBC000001 through BBC000039, together with the literature listed at the end of this report [1-30].

III. Summary of the Record

4. The mother had gestational diabetes class A2, treated with insulin from 27 weeks (BBC000001). She was admitted at 39 weeks 2 days for induction; the admission tracing was Category I (BBC000002).

5. By 13:00 the tracing showed recurrent late decelerations with minimal variability, and the provider was notified at 12:50 (BBC000003). A Category III tracing was documented at 14:12; the obstetrician was paged at 14:14 and again at 14:22 (BBC000004).

6. The decision for emergency cesarean delivery was documented at 14:31, and the record gives a decision-to-delivery interval of 39 minutes (BBC000004). A retrospective study reports that an interval over 30 minutes doubles the risk of moderate or severe encephalopathy [28]; guidance on intrapartum response is set out in [30].

7. The umbilical arterial pH was 6.87 with a base deficit of 18.4 mmol/L (BBC000034). A base deficit at or above 12 mmol/L marks the threshold at which moderate or severe newborn complications appear [4]. The operative report describes a retroplacental clot of about 15 percent of the maternal surface (BBC000005).

8. Placental pathology showed a retroplacental hematoma consistent with abruption, maternal vascular malperfusion, and no acute chorioamnionitis (BBC000006). Severe fetal placental vascular lesions are strongly correlated with neurologic impairment [15]; none of those fetal vascular lesions is described here.

9. The infant was limp and apneic at birth, was intubated at three minutes and received endotracheal epinephrine at four minutes (BBC000010). Apgar scores were 1, 3 and 5 (BBC000005). The combination of severe acidemia, a low five-minute Apgar and delivery-room intubation identifies infants at the highest risk of seizures within the first hour [5].

10. At 30 minutes of life the neonatologist documented moderate to severe encephalopathy (BBC000011), using the staging first described by Sarnat and Sarnat [1]. A numeric score of the kind described by Thompson carries strong predictive value at the higher range [2].

11. The infant arrived at the cooling center 3 hours 34 minutes after birth (BBC000013), and servo-controlled whole-body cooling began at 4 hours 30 minutes of life (BBC000016). Whole-body cooling started within six hours reduced death or disability in the NICHD trial [19]; head cooling showed no effect in infants with the most severe aEEG changes [20]; cooling improved neurologic outcomes among survivors in TOBY [21]; and a Cochrane review pooled eleven randomized trials [22]. Cooling started between 6 and 24 hours may have benefit, with uncertainty [26]. Longer or deeper cooling did not reduce NICU deaths [25].

12. Electrographic seizures were recorded from 02:40 on June 15 (BBC000017). Clinical seizures are associated with worse outcome independent of the severity of injury on MRI [18]. The early aEEG background predicted outcome in about nine of ten infants before cooling was in use [16], and failure ever to develop sleep-wake cycling predicts a poor outcome [17].

13. The day-5 MRI showed a basal ganglia and thalamus predominant injury with involvement of the posterior limb of the internal capsule (BBC000017). This is the imaging signature of an acute sentinel event [10] and the pattern with the most impaired motor and cognitive outcome [11]. MRI scoring discriminates good from poor outcome [12], and MRI with spectroscopy distinguishes the patterns of injury [13]. In my opinion the injury occurred within the final 60 minutes before delivery. As Cowan and

colleagues wrote, "events in the immediate perinatal period are most important in neonatal brain injury" [9].

14. The record documents a negative blood culture and no acute chorioamnionitis (BBC000037), and metabolic and genetic studies with no diagnostic abnormality (BBC000038). The literature recognizes that about 14.5 percent of cerebral palsy is associated with intrapartum hypoxia-ischemia [6], that birth asphyxia is the main cause of newborn encephalopathy in population studies [7], and that every infant with severe HIE in one population series died or developed neurological damage [8]. The ACOG task force sets out the considerations for relating encephalopathy to an intrapartum event [3].

15. Lactate fell from 14.2 to 1.4 mmol/L by June 19 (BBC000035), a course consistent with a single acute insult rather than a prolonged or recurrent one.

16. The six-month MRI shows established injury evolved from the acute day-5 findings (BBC000039). Therapeutic hypothermia reduces lesions in exactly these structures in cooled infants [14]; its benefit is greatest in less severely affected infants, and outcomes "were strongly influenced by the severity of neonatal encephalopathy" [23]. Cooled children had lower death rates at six to seven years [24].

17. At 7 months corrected age the treating neurologist diagnosed dyskinetic cerebral palsy and anticipated Gross Motor Function Classification System level IV to V (BBC000022).

IV. Opinions

18. Opinion 1. Baby Boy C. sustained an acute profound hypoxic-ischemic brain injury in the final hour before delivery. Opinion 2. His cerebral palsy is the result of that injury. Opinion 3. Earlier delivery would more likely than not have avoided or reduced the injury. Hypothermia, in the words of the HELIX investigators, "reduced death or disability by one third in every setting studied" [27], and it could not be expected to reverse an injury of this severity. General background is drawn from [29].

19. I hold these opinions to a reasonable degree of medical probability.

20. A. Example, M.D. (SYNTHETIC) | Dated: August 3, 2026 (SYNTHETIC)

Exhibits

Exhibit A. Curriculum vitae (SYNTHETIC, not attached to this sample).

Exhibit B. Testimony list, prior four years (SYNTHETIC, not attached).

Exhibit C. Fee schedule (SYNTHETIC, not attached).

Materials Considered

Source	Bates range
Riverbend Regional Medical Center, maternal records	BBC000001 to BBC000009
Riverbend Regional Medical Center, infant records	BBC000010 to BBC000015
St. Columba Children's Hospital, NICU and outpatient records	BBC000016 to BBC000033
Laboratory, imaging and pathology	BBC000034 to BBC000039
Published literature	References [1] to [30]

References

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