STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

KAREN FARNUM and JAMES FARNUM, as parents and natural guardians of MORGAN FARNUM, a minor,	)	
Petitioners,	)	
vs.	)	Case No. 01-2288N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
MORTON PLANT HOSPITAL, INC.,	)	
Intervenor.	)	

FINAL ORDER

Pursuant to notice, the Division of Administrative Hearings, by Administrative Law Judge William J. Kendrick, held a final hearing in the above-styled case on November 14, 2002, in Tampa, Florida.

APPEARANCES

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For Intervenor: Margaret D. Matthews, Esquire
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STATEMENT OF THE ISSUE

At issue in this proceeding is whether Morgan Farnum, a minor, qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan.

PRELIMINARY STATEMENT

On June 6, 2001, Karen Farnum and James Farnum, as parents and natural guardians of Morgan Farnum (Morgan), a minor, filed a petition (claim) with the Division of Administrative Hearings (DOAH) for compensation under the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

DOAH served the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the claim on June 8, 2001. NICA reviewed the claim, and on August 20, 2001, gave notice that it had "determined that such claim is not a 'birth-related neurological injury' within the meaning of Section 766.302(2), Florida Statutes," and requested that "an order [be entered] setting a hearing in this cause on the issue of . . . compensability." Following a number of continuances, such a hearing was ultimately held on November 14, 2002.

At hearing, Karen Farnum testified on behalf of Petitioners, and Respondent's Exhibit 1 (the medical records

filed with DOAH on June 6, 2001), Exhibit 2 (copies of All Children's Hospital medical records filed with DOAH by Intervenor on October 30, 2002), Exhibit 3 (the deposition of Donald Willis, M.D., filed with DOAH on July 30, 2002), and Exhibit 4 (the deposition of Michael Duchowny, M.D., filed with DOAH on July 30, 2002), were received into evidence. No further witnesses were called and no further exhibits were offered.

The transcript of hearing was filed on December 6, 2002, and the parties were accorded 10 days from that date to file proposed final orders. Petitioners and Respondent elected to file such a proposal, and they have been duly-considered.

FINDINGS OF FACT

Preliminary findings

1. Petitioners, Karen Farnum and James Farnum, are the parents and natural guardians of Morgan Farnum. Morgan was born a live infant on July 30, 1996, at Morton Plant Hospital, a hospital located in Clearwater, Florida, and her birth weight exceeded 2,500 grams.

2. The physician providing obstetrical services at Morgan's birth was Patricia St. John, M.D., who, at all times material hereto, was a "participating physician" in the Florida Birth-Related Neurological Injury Compensation Plan, as defined by Section 766.302(7), Florida Statutes.

Morgan's birth

3. At or about 10:30 p.m., July 29, 1996, Mrs. Farnum (with an estimated date of delivery of July 20, 1996, and the fetus of 41 1/2 weeks gestation) experienced the onset of labor, and at 2:00 a.m., July 30, 1996, proceeded to Morton Plant Hospital, where she was admitted at 2:17 a.m. At the time, Mrs. Farnum reported her membranes had ruptured in route to the hospital (at 2:15 a.m.), and, following admission, meconium stained amniotic fluid was noted.

4. Mrs. Farnum rapidly progressed through labor, and Morgan was born at 2:42 a.m. Apgar scores were noted as 2, 5, and 7, at one, five, and ten minutes, respectively, and umbilical cord pH was reported as normal (7.4).

5. The Apgar scores assigned to Morgan are a numerical expression of the condition of a newborn infant, and reflect the sum points gained on assessment of heart rate, respiratory effort, muscle tone, reflex irritation, and skin color, with each category being assigned a score ranging from the lowest score of 0 through a maximum score of 2. As noted, at one minute, Morgan's Apgar score totaled 2, with heart rate being graded at 2, and respiratory effort, muscle tone, reflex irritation, and skin color being graded at 0. At five minutes, Morgan's Apgar scores totaled 5, with heart rate and respiratory effort being graded at 2 each, skin color being graded at 1, and

muscle tone and reflex irritation being graded at 0. At ten minutes, Morgan's Apgar score totaled 7, with heart rate and respiratory effort being graded at 2 each, and muscle tone, reflex irritation and skin color being graded at 1 each. Such scores are abnormal, and consistent with severe depression at birth.

6. Following resuscitation, Morgan was transferred to the neonatal intensive care unit, where she remained until 1:10 p.m., when she was transferred to All Children's Hospital for further evaluation and monitoring. The circumstances of Morgan's birth and subsequent course at Morton Plant Hospital are summarized in the Neonatal Transfer Summary, as follows:

> HISTORY: Baby Girl Farnum was born on 7/30/1996 with an estimated gestational age of 41 weeks and a birth weight of 3670 grams . . . . There was spontaneous rupture of membranes at 27 minutes prior to delivery with some meconium stained amniotic fluid noted. Labor was noted to be rapid with some variables. The infant was suctioned by the obstetrician prior to delivery. There was a true kno[t] in the cord noted, as well as the cord around the neck X 2 and around the arm X 1. The infant was suctioned below the cord for a small amount of meconium fluid. She required positive pressure ventilation with a Fi02 of 100% X 1 minute to initiate respiratory effort. She then required whiffs of oxygen until approximately 5 minutes of age. Her Apgars were 2, 5 and 7 at 1, 5 and 10 minutes respectively. The infant was noted initially to be hypotonic. She was transferred to the Neonatal Intensive Care unit for further evaluation and management.

On admission to the intensive care unit her vital signs revealed a temperature of 97.2, pulse of 138, respiratory rate of 52 and blood pressure of 56/24. Her saturations were 80% in room air. She was placed in Fi02 of 100%, keeping saturations between 96 - 98%. Her physical exam was remarkable for hypotonicity. HEENT: pupils were constricted bilaterally, responding to light. Lungs: breath sounds were equal but coarse. Rhythm: normal heart sounds, no murmur was noted. Abdomen was soft. Impression at that time was term female infant, respiratory distress, perinatal depression and to rule out sepsis . . . .

PROBLEM #1 Respiratory: The infant was maintained in an oxyhood of 100%. Her blood gases revealed a progressive respiratory acidosis. Prior to intubation the pH was 7.09, PC02 was 74, P02 was 68, bicarb was 22, basex was -9.3. Following intubation the pH was 7.29, PC02 was 35, P02 was 186, bicarb was 17, basex was -8.4. Chest x-rays are consistent with some mild transient tachypnea. The x-rays following intubation are pending at this time.

PROBLEM #2 Metabolic Acidosis: The infant's initial blood gas following admission to the nursery with a Fi02 of 100% revealed a pH of 7.15, PC02 of 37, PO2 of 142, bicarb of 13.1 and basex of -50.1 (the core pH was reported 7.4). The infant has required 3 doses of sodium bicarb for correction of metabolic acidosis. The most recent bicarb is 17 with basex of -8.4. The electrolytes this morning revealed a bicarb of 16.

PROBLEM #3 Sepsis: Blood cultures were obtained and then the infant was placed on antibiotics. Admission white count was 26,300 with 60 polys, 3 bands, 31 lymphs, 6 monos with an I/T ratio 0.5. HCT was 42, platelet count was 224,000. The infant is currently on ampicillin and gentamicin.

PROBLEM #4 Metabolic Disorder: The infant's ALT is 601, AST is 1210. The blood ammonia level is 104. The questions of metabolic disease versus a viral infection versus perinatal depression as to the etiology for the derangements is in process right now.

PROBLEM #5 Hypotension: The infant was started on 5 mcg of dopamine. The infant's blood pressure is with a systolic of 56 with a diastolic of 38.

* * *

IMPRESSION: At this time is a term female infant.

1. Perinatal depression
2. Respiratory distress (suspect transient tachypnea)
3. Hypotension
4. Rule Out Sepsis
5. Metabolic Acidosis
6. Rule Out Metabolic Disease

7. Morgan remained at All Children's Hospital until August 16, 1996, when she was discharged to her parent's care.

Morgan's course at All Children's was summarized in her Neonatal Discharge Summary, as follows:

DISCHARGE DIAGNOSIS:

1. Perinatal Depression
2. Respiratory Distress
3. HSV Infection; Ruled Out
4. Increased Liver Function Tests - Resolved
5. Acute Renal Failure Resolved
6. Metabolic Acidosis
7. Status Epilepticus
8. Pulmonary Hypertension
9. Tricuspid Regurgitation
10. Diffuse Encephalopathy

* * *

RESPIRATORY/APNEA: The infant was admitted on 60% oxygen, rate of 35, and pressures of 17/5. The initial chest x-ray, at Morton Plant Hospital, was consistent with mild TTN. The first x-ray, at All Children's, showed the lungs well aerated.

She was weaned from the ventilator to ET CPAP of 7 days of age and then weaned to room air at 8 days of age. The infant's clinical course was compatible with transient tachypnea of the newborn and respiratory depression secondary to CNS insult.

CARDIOVASCULAR: The infant had hypotension due to perinatal depression and metabolic acidosis on newborn day of life and required treatment with dobutamine and dopamine. These were weaned and attempted to be discontinued at 3 days of age but the patient required restart of the dopamine for renal perfusion and was discontinued at 7 days of life.

An echocardiogram was done on newborn day of life secondary to perinatal depression which showed normal anatomy and function but was significant for pulmonary hypertension and moderately severe tricuspid regurgitation. These clinically improved during the patient's hospital stay and no follow up is indicated at this time.

INFECTIONS: Blood cultures were obtained at the referring hospital. ET tube for bacteria and virus, gastric cultures, urine cultures, and eye for virus cultures along with serum HSV,IgG, IgM, and PCR were obtained on admission. The infant was started on ampicillin, gentamicin, and acyclovir. The gentamicin was changed to Claforan on day of life 1 secondary to poor renal function. All cultures were negative and the antibiotics were stopped after 3

days, however, due to the risk of HSV infection the Acyclovir was continued for 7 days until the PCRs were negative.

* * *

HEMATOLOGY: The infant had a low fibrinogen on newborn day of age. This was treated with one unit of cryoprecipitate. This was felt to be due to perinatal asphyxia and it returned to normal by one day of age.

RENAL: The baby developed oliguria on the first day of life. This was felt to be secondary to the perinatal depression. She was treated with dopamine, dobutamine, and fluid restriction. Urine output returned to normal by 3 days . . . .

METABOLIC: The infant had persistent metabolic acidosis at newborn day of age felt to be secondary of perinatal depression. This responded to treatment with sodium bicarbonate and intubation.

The infant later developed a transient alkalosis secondary to aggressive management of the acidosis. This resolved by 2 days of age.

* * *

CENTRAL NERVOUS SYSTEM: A CT scan done at newborn day of age for perinatal depression showed generalized low attenuation of supratentorial brain parenchymal, especially the white matter tracts, most pronounced frontally and a questionable association of edema as the ventricles were small but the basilar cisterns were widely patent. This was thought to be secondary to a previous ischemic event.

Follow up CT scan at 6 days of life revealed diffuse cerebral edema slightly improved, but suspicious for a hypoxic event. Follow up CT at 16 days of life revealed continued

diffuse severe low density brain with evidence of encephalomalacia or edema with good evidence of improvement not identified. This was thought to have a poor prognostic appearance and may result in severe cerebral deficiency.

The infant developed seizures on newborn day of life. An EEG showed continuous seizure activity in both the left and right hemispheres. Follow up EEG at 1 day of life showed background slowing which is suggestive of a diffuse encephalopathic process and also repetitive discharge which was significant for subclinical electrographic seizures. The seizures were secondary to perinatal depression and were finally controlled with phenobarbital and Dilantin. A 24 hour continuous video EEG was started on the first day of life which initially had multiple clinical and subclinical seizures indicating the patient was in status epilepticus which decreased in frequency toward the end of the monitoring, revealing mostly severely depressed background without evidence of authentic or subclinical seizure activity. The dilantin was weaned and discontinued at 9 days of life. The phenobarbital was weaned but the patient will continue phenobarbital at discharge.

Follow up EEG at 16 days of life was abnormal secondary to attenuation of the background voltage with also excessive activity of sharp transients, especially in the left frontal temporal region, but also seemed to occur in the right temporal region. This EEG was felt to be consistent with a diffuse encephalopathic process with an area of additional superimposed cerebral dysfunction, most predominantly in the left frontal temporal region, but also in the right temporal regions and these areas were felt to be potentially epileptogenic. This EEG, though, was improved from the previous tracing.

* * *

> PHYSICAL EXAM AT DISCHARGE: Significant for a term female infant with generalized hypotonia, especially in the upper extremities . . . . Patient is slow to Moro, has a weak grasp . . . .

8. On August 8, 2001, following the filing of the claim for compensability, Morgan was examined by Michael Duchowny, M.D., a physician board-certified in pediatrics, neurology with special competence in child neurology, and clinical neurophysiology. Dr. Duchowny reported the results of his evaluation, as follows:

> PHYSICAL EXAMINATION reveals Morgan to be wheelchair bound. Her weight is estimated at 35-pounds. The skin is warm and moist. Her hair is brown and of normal texture. Her head circumference measures 46.7 cm, which is well below standard percentiles for age. There is a backward sloping to her forehead. The fontanelles are closed. There are no dysmorphic features and no facial asymmetries. She has frequent tongue protrusions and drooling almost constantly. There is some gingival hypertrophy. The neck is supple without masses or thyromegaly. The cardiovascular examination is unremarkable. She has a clean indwelling G-tube in the left upper abdominal quadrant. There is no palpable organomegaly. The peripheral pulses are 2+ and symmetric.
>
> Morgan's NEUROLOGIC EXAMINATION is significant for a severe degree of neurologic impairment. Morgan does not make good eye contact. There are conjugate eye movements with left esotropia. She has both kyphosis and thoracolumbar scoliosis. This is mild. A brief fundoscopic examination is unremarkable. There is no persistent

central gaze fixation and she does not conjugately follow. Morgan does brighten in response to music. Her pupils are 3 mm and react briskly to direct and consensually presented light.

Motor examination reveals double hemiparesis, with flexion postures of the upper extremities and bilateral fisting of the thumbs, greater on the right side. She has marked spasticity of all extremities, but no fixed contractures. Her feet can be dorsiflexed just to neutrality. Morgan's spasticity is prominent in all four extremities. In vertical suspension she tends to maintain a plantar grade attitude, with slight scissoring. In the supine position she demonstrates bilateral tonic neck responses which are obligate. There is significant head lag on pull-to-sit maneuver. Hoffmann signs are positive bilaterally and she has bilateral Babinski signs. The deep tendon reflexes are 3+ in the upper extremities and 4+ in the lowers, with bilateral crossed adductor responses and Babinski signs. There is withdrawal of all extremities to touch. Morgan has frequent tongue thrusting and an overactive gag response. She did not speak in words at anytime during the evaluation and it was not clear that she understood simple commands.

In SUMMARY, Morgan's neurologic examination is significant for a severe degree of mental and motor impairment. She is functioning at approximately age 2 to 3 months which puts her in the profoundly retarded range. She additionally demonstrates evidences of spastic tetraparesis, cortical inattentiveness and has a history of seizures, with startle myoclonus. Morgan additionally demonstrates microcephaly.

Coverage under the Plan

9. Pertinent to this case, coverage is afforded by the Plan for infants who suffer a "birth-related neurological injury," defined as an "injury to the brain . . . caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired." Section 766.302(2), Florida Statutes. See also Section 766.309(1)(a), Florida Statutes.

10. Here, it is undisputed that Morgan suffered a injury to the brain, which rendered her permanently and substantially mentally and physically impaired. Consequently, with regard to the issue of compensability, what remains to resolve is whether the proof supports the conclusion that, more likely than not, Morgan's brain injury was "caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period," as required for coverage under the Plan.

The cause and timing of Morgan's brain injury

11. To address the cause and timing of Morgan's brain injury, the parties offered the medical records relating to Mrs. Farnum's antepartum course, as well as those associated with Morgan's birth and subsequent development. Additionally,

Mrs. Farnum testified on her own behalf, and Respondent offered the deposition testimony of Dr. Donald Willis, a physician board-certified in obstetrics and gynecology, as well as maternal-fetal medicine, and the deposition testimony of Dr. Michael Duchowny, whose qualifications were previously discussed.

12. As for the timing of Morgan's brain injury, it was Dr. Willis' opinion, based on his review of the medical records, that Morgan's brain injury occurred prior to the onset of labor. In so concluding, Dr. Willis noted that the time between the onset of labor and Morgan's delivery was brief; that following admission to the hospital, the fetal monitor strips did not reveal any significant abnormalities; the umbilical cord pH (a pH of 7.4, with a base excess of -4) was well within normal limits; and the CT scan, at approximately 15 hours of birth, already revealed evidence of hypoxic changes (damage). Consequently, Dr. Willis resolved that the most likely explanation for Morgan's depression at birth was a injury that predated the onset of labor.[1]

13. Also speaking to the timing of Morgan's brain injury was Dr. Duchowny who, based on his review of the medical records was likewise of the opinion that the injury Morgan suffered was attributable to events which occurred prior to labor. In reaching such conclusion, Dr. Duchowny noted that, based on his

review of the CT scan done on July 30, 1996, at 5:30 p.m., the amount of edema evident would take a minimum of 24 hours, and as long as 48 hours, to develop. As for the cause of Morgan's injury, Dr. Duchowny noted the possibility of infection (since Mrs. Farnum was febrile on admission to the hospital), as well as the possibility of hypoxia (as a result of the tight nucal cord, and true knot), but did not express an opinion, within reasonable medical probability, as to the likely cause of Morgan's injury.

14. In contrast to the proof offered by Respondent regarding the timing of Morgan's injury, Petitioners and Intervenor offered no expert testimony regarding the timing of Morgan's injury or its cause. Consequently, given that the opinions of Doctors Willis and Duchowny are logical and consistent with the other proof, it must be resolved that Morgan's injury occurred prior to the onset of labor. See, e.g., Thomas v. Salvation Army, 562 So. 2d 746, 749 (Fla. 1st DCA 1990)("In evaluating medical evidence, a judge of compensation claims may not reject uncontroverted medical testimony without a reasonable explanation ."). Moreover, given the lack of medical evidence as to causation, it must be resolved that the proof failed to demonstrate that Morgan's brain injury was caused by oxygen deprivation or mechanical injury, as required for coverage under the Plan. See, e.g.,

Thomas v. Salvation Army, supra, at page 749 ("It is an established rule that a workers' compensation claimant must prove the existence of a causal connection between the employment and injury for which benefits are sought, and the existence of causation must be based upon reasonable medical probability.")

CONCLUSIONS OF LAW

15. The Division of Administrative Hearings has jurisdiction over the parties to, and the subject matter of, these proceedings. Section 766.301, et seq., Florida Statutes.

16. The Florida Birth-Related Neurological Injury Compensation Plan was established by the Legislature "for the purpose of providing compensation, irrespective of fault, for birth-related neurological injury claims" relating to births occurring on or after January 1, 1989. Section 766.303(1), Florida Statutes.

17. The injured "infant, her or his personal representative, parents, dependents, and next of kin," may seek compensation under the Plan by filing a claim for compensation with the Division of Administrative Hearings. Sections 766.302(3), 766.303(2), 766.305(1), and 766.313, Florida Statutes. The Florida Birth-Related Neurological Injury Compensation Association, which administers the Plan, has "45 days from the date of service of a complete claim . . . in which

to file a response to the petition and to submit relevant written information relating to the issue of whether the injury is a birth-related neurological injury." Section 766.305(3), Florida Statutes.

18. If NICA determines that the injury alleged in a claim is a compensable birth-related neurological injury, it may award compensation to the claimant, provided that the award is approved by the administrative law judge to whom the claim has been assigned. Section 766.305(6), Florida Statutes. If, on the other hand, NICA disputes the claim, as it has in the instant case, the dispute must be resolved by the assigned administrative law judge in accordance with the provisions of Chapter 120, Florida Statutes. Sections 766.304, 766.307, 766.309, and 766.31, Florida Statutes.

19. In discharging this responsibility, the administrative law judge must make the following determination based upon the available evidence:

> (a) Whether the injury claimed is a birth-related neurological injury. If the claimant has demonstrated, to the satisfaction of the administrative law judge, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically impaired, a rebuttable presumption shall arise that the injury is a birth-related neurological injury as defined in s. 766.303(2).

> (b) Whether obstetrical services were delivered by a participating physician in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital; or by a certified nurse midwife in a teaching hospital supervised by a participating physician in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital.

Section 766.309(1), Florida Statutes. An award may be sustained only if the administrative law judge concludes that the "infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at birth." Section 766.31(1), Florida Statutes.

20. Pertinent to this case, "birth-related neurological injury" is defined by Section 766.302(2), Florida Statutes, to mean:

> . . . injury to the brain or spinal cord of a live infant weighing at least 2,500 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

21. As the claimants, the burden rested on Petitioners to demonstrate entitlement to compensation. Section 766.309(1)(a), Florida Statutes. See also Balino v. Department of Health and

Rehabilitative Services, 348 So. 2d 349, 350 (Fla. 1st DCA 1977), ("[T]he burden of proof, apart from statute, is on the party asserting the affirmative issue before an administrative tribunal").

22. Here, since the proof demonstrated, more likely than not, that Morgan's neurologic impairment resulted from an injury to the brain that predated the onset of labor, and failed to demonstrate that Morgan's brain injury was caused by oxygen deprivation or mechanical injury, it must be resolved that Morgan was not shown to have suffered a "birth-related injury," within the meaning of Section 766.302(2), Florida Statutes, and the claim is not compensable. See also Humana of Florida, Inc. v. McKaughan, 652 So. 2d 852, 859 (Fla. 5th DCA 1995)("[B]ecause the Plan . . . is a statutory substitute for common law rights and liabilities, it should be strictly construed to include only those subjects clearly embraced within its terms."), approved, Florida Birth-Related Neurological Injury Compensation Association v. McKaughan, 668 So. 2d 974, 979 (Fla. 1996).

23. Where, as here, the administrative law judge determines that ". . . the injury alleged is not a birth-related neurological injury . . . he [is required to] enter an order [to such effect] and . . . cause a copy of such order to be sent immediately to the parties by registered or certified mail." Section 766.309(2), Florida Statutes. Such an order constitutes

final agency action subject to appellate court review. Section 766.311(1), Florida Statutes.

CONCLUSION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

ORDERED that the petition for compensation filed by Karen Farnum and James Farnum, as parents and natural guardians of Morgan Farnum, a minor, is hereby denied with prejudice.

DONE AND ORDERED this 10th day of January, 2003, in Tallahassee, Leon County, Florida.

_____
WILLIAM J. KENDRICK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 10th day of January, 2003.

ENDNOTE

1/ Dr. Willis expressed no opinion as to the likely cause of Morgan's brain injury.

COPIES FURNISHED:
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NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this final order is entitled to judicial review pursuant to Sections 120.68 and 766.311, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original of a notice of appeal with the Agency Clerk of the Division of Administrative Hearings and a copy, accompanied by filing fees prescribed by law, with the appropriate District Court of Appeal. See Section 766.311, Florida Statutes, and Florida Birth-Related Neurological Injury Compensation Association v. Carreras, 598 So. 2d 299 (Fla. 1st DCA 1992). The notice of appeal must be filed within 30 days of rendition of the order to be reviewed.