STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

REBEKAH LEAH SCARFONE, individually and as mother and natural guardian of MADISON MCCORKLE, III,	)	
Petitioner,	)	
vs.	)	Case No. 02-2021N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
STANLEY E. ROSEWATER, M.D. AND OB-GYN ASSOCIATES OF PINELLAS COUNTY, P.A.; MORTON PLANT MEASE HEALTHCARE, INC., d/b/a MORTON PLANT HOSPITAL; UNIVERSITY OF SOUTH FLORIDA BOARD OF TRUSTEES; and FLORIDA BOARD OF EDUCATION,	)	
Intervenors.	)	

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 August 5, 2003, in St. Petersburg, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

1. Whether Madison McCorkle, III, a minor, qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

2. Whether the notice provisions of the Plan were satisfied by the participating physician.

PRELIMINARY STATEMENT

On May 13, 2002, Rebekah Leah Scarfone, individually, and as mother and natural guardian of Madison McCorkle, III (Madison), a minor, filed a petition (claim) with the Division of Administrative Hearings (DOAH) for compensation under the Florida Birth-Related Neurological Injury Compensation Plan. Pertinent to this case, apart from contending that Madison suffered an injury compensable under the Plan, Petitioner also sought to avoid a claim of Plan immunity by averring that, and presumably requesting a finding that, the participating physician failed to comply with the notice provisions of the Plan.[1]

DOAH served the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the claim on

May 20, 2002, and on December 13, 2002, NICA served its response to the claim, and denied that Madison suffered a "birth-related neurological injury," as that term is defined by the Plan. In the interim, Stanley E. Rosewater, M.D.; OB-GYN Associates of Pinellas County, P.A.; Morton Plant Mease Healthcare, Inc., d/b/a Morton Plant Hospital; University of South Florida Board of Trustees; and Florida Board of Education, were accorded leave to intervene. Thereafter, at hearing, Community Health Centers of Pinellas, Inc., d/b/a Mother and Child Care of Clearwater, was also accorded leave to intervene.

Given the pleadings, and the parties' Pre-Hearing Stipulation, a hearing was held on August 5, 2003, to resolve whether Madison qualified for coverage under the Plan and whether the notice provisions of the Plan were satisfied by the participating physician.

At hearing, Petitioner's Exhibit 1 (the medical records filed with DOAH on May 13, 2002), Respondent's Exhibits 1-3, Intervenor Morton Plant Hospital's (Hospital's) Exhibits 1 and 2, and Intervenors' Stanley E. Rosewater, M.D., and OB-GYN Associates of Pinellas County, P.A. (Doctor's) Exhibits 1-3, were received into evidence. No witnesses were called, and no further exhibits were offered.

The hearing transcript was filed September 8, 2003, and the parties were accorded 10 days from that date to file proposed

orders. Intervenors and Respondent elected to file such proposals and they have been duly considered.

FINDINGS OF FACT

Preliminary Findings

1. Petitioner, Rebekah Leah Scarfone, now Rebekah Scarfone Jackson, is the mother and natural guardian of Madison McCorkle, III, a minor. Madison was born a live infant on June 2, 1999, at Morton Plant Hospital, a hospital located in Pinellas County, Florida, and his birth weight exceeded 2,500 grams.

2. The physician providing obstetrical services at Madison's birth was Stanley E. Rosewater, M.D., who, at all times material hereto, was a "participating physician" in the Florida Birth-Related Neurological Injury Compensation Plan.

Madison's Birth

3. At or about 1:15 a.m., June 2, 1999, Ms. Scarfone (with an estimated date of delivery of June 3, 1999, and the fetus at term) presented to Morton Plant Hospital, in labor. At the time, Ms. Scarfone's membranes were noted as intact, and vaginal examination revealed the cervix at three centimeters dilation, effacement at 90 percent, and the fetus at -1 station. Contractions were noted at a frequency of four minutes, with a duration of 70-80 seconds, and fetal monitoring revealed a reassuring fetal heart rate, with a baseline of 125-130 beats per minute.

4. From 1:15 a.m. until 3:48 p.m., when she was first evaluated by Dr. Rosewater, Ms. Scarfone's labor progress was slow, but steady, and fetal monitoring continued to reveal a reassuring fetal heart rate. At 3:48 p.m., Dr. Rosewater's vaginal examination revealed the cervix at nine centimeters, effacement at 100 percent, and the fetus at 0 station.

5. Thereafter, commencing at or about 4:35 p.m., and continuing until 6:00 p.m., when the fetal heart rate was noted at 50-60 beats per minute and Ms. Scarfone was moved to the operating room for a stat forceps delivery, a pattern of deceleration in fetal heart rate developed.

6. Following admission to the operating room, at 6:13 p.m., the fetal heart rate was noted in the 160 beat per minute range, anesthesia was started at 6:15 p.m., forceps were applied by Dr. Rosewater at or about 6:25 p.m., and Madison was delivered at 6:29 p.m. According to the delivery notes, the cord was observed around the baby's shoulder during delivery, and reduced, and following delivery the baby was bulb suctioned on the perineum and taken to a warmer for resuscitation by the neonatology team.

7. At delivery, Madison was depressed (limp, without spontaneous respiration), and required positive pressure ventilation for about one minute before spontaneous respiration was achieved. Apgar scores were recorded as 2, 7, and 7, at one, five and ten minutes, respectively.[2]

8. Following delivery, Madison was transferred to the neonatal intensive care unit (NICU) and at or about 10:15 a.m., June 3, 1999, with evidence of seizure activity, he was transported to All Children's Hospital for further management. On discharge from All Children's Hospital on July 1, 1999, Madison's Neonatal Discharge Summary described his history as follows:

> Discharge Diagnoses:
>
> 1. Term Male Infant
> 2. Perinatal Depression
> 3. Hypoxic Ischemic Encephalopathy
> 4. Seizures
> 5. Right Optic nerve Hypoplasia and Left Macular Edema
> 6. Acute Tubular Necrosis
> 7. Evolving Encephalomalacia
> 8. Right Submandibular Fat Necrosis
>
> * * *
>
> HISTORY: Baby Boy Scarfone was born by a forceps delivery with a vertex presentation to a 20 year old G1P0 mother. Apgars were 2,7, and 7 and 1, 5, and 10 minutes respectively. Birth weight was 3210 gms and estimated gestational age was term. Maternal history was significant for: blood type A+, HBS Ag-, RPR nonreactive, and Group B strep negative. During labor there were deep variable decelerations. The mother took prenatal vitamins and received Pitocin. This was a forceps delivery and the cord was noted to be around the body. Delivery room resuscitation included whiffs of oxygen and positive pressure ventilation via mask. Care at the referring hospital included intubation and ventilation, peripheral IV fluids, umbilical arterial catheter placement, Dopamine, normal saline boluses x 3, and sodium bicarbonate

were given. Cranial ultrasound was performed.[3] Blood cultures were drawn and Ampicillin and Gentamicin initiated. The infant was noted to have 4 episodes of seizure activity and was started on Phenobarbital.

The infant was transferred to All Children's Hospital for perinatal depression and seizures.

RESPIRATORY: The infant was admitted on room air. The initial chest x-ray showed clear lung fields.

The infant developed stridor, with feedings, at 21 days of life. A Pulmonology consult was obtained. An OPMS study was recommended. No evidence of aspiration or suck, [s]wallow, incoordination was noted. The pulmonologist did not feel a bronchoscopy was needed at this time.

The infant had a sleep study performed with pH probe at 21 days of life. There were numerous central apneas and transient desaturations. There was no evidence of reflux. The infant was also studied in a car seat which showed intermittent central apnea, mixed apnea, and a few obstructive apneas and desaturations. The infant will be discharged home with an apnea monitor. He will also receive oxygen and when traveling will be placed in a car bed. He will have Pulmonology follow up 2 weeks after hospital discharge.

CARDIOVASCULAR: The infant had hypotension due to perinatal depression at newborn day of age and required treatment with volume expansion and Dopamine for 4 days.

* * *

INFECTION: Blood cultures were obtained at the referring hospital. The infant was started on Ampicillin and Gentamicin. Gentamicin was discontinued due to increased

> creatinine level. Ampicillin was continued for a total of 3 days.
>
> * * *
>
> CENTRAL NERVOUS SYSTEM: The infant was admitted with a diagnosis of seizures which were treated with Phenobarbital, Dilantin, and Ativan. The infant was evaluated by Neurology. A CT scan at 1 day of age for perinatal depression revealed bra[i]n edema in the left parietal/occipital region. A MRI, at 5 days, revealed probably left cerebellar intraparenchymal subacute hemorrhage, abnormal signal in the left hemisphere and basal ganglia probably representing infarction.
>
> The infant was evaluated by Ophthalmology on 6/4/99 for retinal (macular) edema and right optic nerve hypoplasia. [H]e will be followed by Ophthalmology.
>
> A repeat CT scan, at 19 days of life, revealed evolving encephalomalacia. A follow up EEG at 22 days of age was within normal limits.
>
> At the time of hospital discharge the infant is receiving Phenobarbital with the last level 14.4. He will be followed by Neurology and have a follow up Phenobarbital level in one week.
>
> Due to the history of perinatal depression the infant will require developmental follow up, occupational therapy, and physical therapy intervention. . . .

Discharge planning included follow-up with his pediatrician at Mother and Child Care (Dr. K. Adnan); Ophthalmology (Dr. J. Bruce Hess); Neurology (Pediatric Neurology Associates, P.A.); occupational therapy/physical therapy (Morton Plant Hospital -

Barrett Center, Outpatient Rehabilitative Services); and the Early Intervention Program.

Madison's Subsequent Development

9. Madison received a physical therapy evaluation at the Barrett Center on July 13, 1999, and an occupational therapy evaluation on August 10, 1999, to assess his need for rehabilitative services. Assessment on physical therapy evaluation was, as follows:

> Musculoskeletal Status
> Madison presents normal to mild high tone. Range of motion marked by tightness in hip and knee flexion; range of motion of feet within normal limits for his age, but Madison has a tendency to maintain feet dorsiflexed. Madison has increased flexion recoil of lower extremities during range of motion testing and when placed in various positions.

Recommendation was "[s]tart Physical Therapy services once a week; re-evaluation in six months." Assessment on occupational therapy evaluation was, as follows:

> Madison had normal tone in his upper extremities. He had the age appropriate grasp reflex. Passive and active range of motion of the upper extremities was within normal limits.

Under the circumstances, occupational therapy was not recommended, but follow-up screening in three months to monitor progress was suggested. Thereafter, by February 8, 2000, Madison was also receiving occupational therapy.

10. Madison had his first evaluation under the Early Intervention Program on August 2, 1999. The results of that evaluation were reported, as follows:

> Neurological Dubowitz is done with the patient in quiet alert state. Although he cries to aversive stimuli, he consoles readily with holding and a nipple. Movement and tone reveals symmetric arm and leg recoil. Flexion responses are initial in upper and lower extremities. There is some increase in tone in the lower extremities. Although head lags behind the body when brought from supine to sitting, in supported sitting he attempts to bring head upright from both anterior and posterior positions. In prone, he rolls head to the side and brings hand to shoulder level. No abnormal movements are noted. Reflexes indicate symmetric Moro response. Walking reflex is present. Palmar grasp is maintained. Suck is regular with good stripping. Neurobehavior includes conjugate eye movements, turning toward a rattle, and following a bright object horizontally and vertically.
>
> * * *
>
> Dubowitz Neonatal Neurological Examination is suspicious due to increased tone in the lower extremities.
>
> * * *
>
> EARLY INTERVENTION PROGRAM PLAN:
>
> * * *
>
> Recommend continuing with physical therapy on weekly basis.

11. Madison was re-evaluated under the Early Intervention Program on May 12, 2000. According to standardized testing,

Madison's cognitive skills were considered at risk for delay for his chronological age of 11 months 10 days; however, communication screening indicated his receptive and expressive language skills were age-appropriate. Neurological examination revealed that tone was mildly low, movements symmetrical. Recommendation was to follow-up in six months to monitor Madison's growth and development.

12. Madison's next evaluation under the Early Intervention Program was on November 10, 2000, at age 17 months 8 days. At the time, assessment was "[c]ognitive skills are delayed at a 13 month age level"; [m]otor skills are within normal limits at a 16 month age level"; and "[c]ommunication skills are in an at risk category with both receptive and expressive language at a 14 month level." Based on such evaluation, a homebound teacher was recommended one hour per week to work on cognitive and communication skills, and physical or occupational therapy were no longer deemed developmentally necessary. Nevertheless, according to the records of Pediatric Neurology Associates, discussed infra, physical and occupational therapy continued. Subsequently, in early 2001, Madison was also accorded speech therapy.

13. Madison's initial evaluation at Pediatric Neurology Associates, was on August 2, 1999. The results of that evaluation were noted, as follows:

This 2 month old was seen for a hospital follow-up for experiencing difficulties at birth. He has suffered perinatal depression and then neonatal seizures. There have been no seizures since hospitalization.

* * *

PHYSICAL EXAMINATION: The patient is a well-developed, well-nourished 2 month old white male. Head circumference is 38.5 centimeters, which is at the 50th percentile. There are no skin rashes noted. Anterior fontanel is soft and flat. Head and facies are symmetric without dysmorphic features. He does track objects. The pupils are equal, round, and respond to light, and constrict, bilaterally, to light. The conjunctivae are pink.

The funduscopic examination demonstrates a positive red reflex. Tongue and palate are symmetric. There is upper respiratory congestion. Neck is supple without lymphadenopathy. Chest is clear to auscultation, bilaterally. Heart demonstrates regular rate and rhythm with normal S1 and S2. Spine is straight without masses, lesions, or dimples. Abdomen is soft and round without hepatosplenomegaly or tenderness. Full range of motion noted. There are no motor asymmetries identified. Tone is within normal limits. Deep tendon reflexes are +2. Response to plantar stimulation is withdrawal, bilaterally.

LABORATORIES: EEG, performed 06/04/99, is abnormal because of excessive sharp transients in the left posterior and central vertex region. EEG, performed 06/22/99, is normal. CT of the brain, 06/21/99, demonstrates peripheral foci of abnormal low density within the left parietal occipital region. High left parietal convexity and possibly more anteriorly within the left parietal lobe, as above. These regions likely represent evolving and encephalomalacia, possibly secondary to infarction, infection, or other

> brain insult. MRI of the brain, 06/07/99, demonstrates probably left cerebellar intraparenchymal early subacute hemorrhage. Abnormal signal in the left hemisphere, especially parietal occipital and in the basal ganglia (especially right thalamus) probably represents infarction. Phenobarbital level, 06/14/99, is 19.2 (15 to 40).
>
> IMPRESSION:
> 1. Hypoxic ischemic encephalopathy. Seizures, which are currently under control. Perinatal depression.
> 2. Right optic nerve hypoplasia.
>
> PLAN:
> 1. Will obtain Dr. Hess' ophthalmologic report.[4]
> 2. Will begin weaning Phenobarbital . . . .

14. Madison was also seen at Pediatric Neurology Associates (or Children's Medical Services Clinic) on November 12, 1999, February 8, 2000, November 27, 2001, and June 26, 2002. Initially, Ms. Scarfone reported no evidence of seizure activity, abnormal movements, or altered consciousness; however, on November 27, 2001, she reported a paroxysmal episode ("a spasm or seizure") had occurred, about two weeks previous. A CT of the brain on November 30, 2001, demonstrated:

> 1. Small focal area of decreased attenuation in the high left parietal area peripherally. This probably represents a small area of encephalomalacia.
> 2. No definite additional areas of abnormal attenuation are identified. Specifically, the fairly prominent area of low attenuation seen in the left posterior parietal area on the previous

> study of 06/21/99 is no longer seen. No new abnormalities are appreciated.

15. Subsequently, on June 26, 2002, Ms. Scarfone reported paroxysmal episodes, at one episode per month for the previous four to five months. At the time, the "Plan" included "[f]ollow-up in C[hildren's] M[edical] S[ervices] within the next two to four months," "[i]n the meantime, obtain a CT of the brain, noncontrast and repeat the EEG," and "[i]f episodes should continue, may consider an empirical trial of anticonvulsant therapy."

16. On October 3, 2002, Madison had a prolonged seizure. At the time, the head CT scan was negative; however, EEG of October 4, 2002, was abnormal, and Madison was placed on maintenance Dilantin, which, given allergic reaction, was changed to Depakene and then to Keppra. Madison's follow-up visit at Pediatric Neurology Associates on December 18, 2002, was reported, as follows:

> This 3 year old returns for a follow-up for history of hospitalization for seizure exacerbation.
>
> His mother reports his seizures usually start with waking up out of his sleep with coughing and then vomiting. He will stare and then go into tonic-clonic activity. The last event was one to two weeks ago.
>
> DEVELOPMENT: He is in multimodal therapies at school for a history of developmental delay.

PAST MEDICAL HISTORY: He has a history of anoxic encephalopathy and seizures.

PHYSICAL EXAMINATION: The patient is a 3 year old, male weighing 43 pounds (19.5 kilograms). Height 39-3/4 inches. Blood pressure is 86/44. Heart rate is 108. There are no skin rashes noted.

* * *

The extraocular movements are full and intact without nystagmus noted. The pupils are equal, round, and respond to light, and constrict bilaterally to light. Convergence is positive. Conjunctivae are pink. The funduscopic exam demonstrates discs of normal color and sharp margins with no hemorrhage or exudates. He is slightly impulsive during the exam. The neck is supple without lymphadenopathy. The heart demonstrates regular rate and rhythm with normal S1 and S2.

Full range of motion. Tone is slightly low. Reflexes are +2. Gait is without ataxia.

* * *

IMPRESSION:
1. Seizure reoccurrence.

PLAN:
1. Continue with Keppra . . . .

3. Follow-up will be in the CMS Clinic with Dr. Casadonte . . .

17. Dr. Casadonte reported the results of his follow-up of April 18, 2003, as follows:

Madison McCorkel [sic] presents to the CMS clinic. He's a child with seizures secondary to anoxic encephalopathy experienced at birth. He's on Keppra . . . . Mom reports he's had only one event in two months. The events are stereotypically where he awakens from his

> sleep. He coughs and stares. They last several minutes and then he's sleepy afterwards.
>
> He is three years 10 months . . . .
> He's alert.
> Pupils are equal and reactive.
> His face is symmetric.
> He moves his extremities equally.
> He attends Fuguitt Elementary through the FDLRS program.
> The plan is to continue Keppra . . . .

18. Notably, Madison's medical records fail to support a conclusion that he is substantially mentally or physically impaired, much less permanently impaired, and none of his treating physicians has expressed such an opinion. It is also worthy of note that, while Respondent presented the testimony of Dr. Michael Duchowny, discussed infra, to address the issues, neither Petitioner nor Intervenors, although they had the burden to prove Madison suffered a birth-related neurological injury, offered any expert testimony to establish that Madison's current deficits resulted from a brain injury caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation, or that Madison was permanently and substantially mentally and physically impaired.

19. Dr. Duchowny, a physician board certified in pediatrics, neurology with special competence in child neurology, and clinical neurophysiology, examined Madison, at NICA's

request, on September 11, 2002, and reported the results of his evaluation, as follows:

> Madison's NEUROLOGIC EXAMINATION reveals him to be overactive, inattentive, and impulsive. He maintains poor eye contact and it is difficult to keep him on track for the evaluation. He is quite defensive and, for example, fends off attempts to have his fundi looked at in detail. There are marked imitative gestures and repetitive movements. He tends to wave goodbye throughout the evaluation in a semi-repetitive fashion. The speech sounds are poorly articulated for lingual, labial, and guttural consonance and it is very difficult to understand his speech output. He tends to speak in one or two words. He could identify some body parts but not others and was not able to articulate colors in any specific fashion. It was difficult to keep his attention span on track. The cranial nerve examination reveals full visual fields to direct confrontation testing. He blinks to threat in both directions and reacts to sound in all planes. The pupils are 3mm and briskly reactive to direct and consensually presented light. I could not get a full fundoscopic evaluation. The tongue and palate move well. The uvula is midline. Motor examination reveals symmetric strength and bulk. His tone is slightly diminished throughout and his movements are uncoordinated. He postures his outstretched hands in a very marked fashion and there is marked decomposition of rapid alternating movement sequences. He has distal career from movements as well. There is no focal weakness or atrophy. The deep tendon reflexes are 1+ bilaterally. His gait and station are stable. There is pesplanus bilaterally. He did not fall while walking. The spine is straight without dysraphism. There is withdrawal of all extremities to provocation. Neurovascular examination discloses no cervical, cranial or ocular bruits, and there are no temperature or pulse asymmetries.

> IN SUMMARY, Madison's neurologic examination is significant for developmental delays in multiple areas. He is clearly delayed in terms of his expressive and receptive language skills, and has a speech articulation defect. He also has a short attention span, high activity level, and an impulsive behavioral style. Marked dyspraxia is also noted. Apart from these developmental findings, there are no focal or lateralizing features to suggest structural brain damage and I believe that Madison most likely has a pervasive developmental disorder and is at risk for falling within the autistic spectrum in the future. . . .
>
> I have not as yet had an opportunity to review Madison's medical records and will issue a final report once the review process is complete.

Following review of the medical records, Dr. Duchowny concluded:

> A review of the medical records suggests that the pregnancy with Madison was complicated by a probable vira[l] infection, as evidenced by the placental pathology, ophthalmology findings, elevated liver function tests, and neuro-imaging findings. The findings on Madison's neurologic examination are most consistent with the developmental syndrome of pervasive developmental disorder, and I strongly suspect that Madison will ultimately be diagnosed with childhood autism. Given these findings, I do not believe that Madison suffers from a substantial motor or mental impairment, or that h[is] problems were acquired in the course of labor, deliver, or the immediate post partum period.

Stated otherwise, while Dr. Duchowny acknowledged that Madison's birth was stressful, and resulted in a number of problems that had to be managed post-delivery, he was of the opinion that the

deficits Madison currently exhibits are "developmentally based, meaning that they have to do with abnormalities during the formation of the brain as opposed to consequences of hypoxia, ischemia or trauma." (Respondent's Exhibit 3, at page 30.) As for Dr. Duchowny's opinion that Madison does not suffer from a substantial motor or mental impairment, it is worthy of note that, although they had the opportunity to do so during the course of his deposition, the parties did not challenge or otherwise question his opinion.

20. Finally, pertinent to a current assessment of Madison's neurologic presentation is the deposition testimony of Ms. Scarfone, taken July 21, 2003. (Hospital Exhibit 2.) At the time, Ms. Scarfone offered the following observations:

> Q Is Madison currently enrolled in any school or educational program?
>
> A Yes.
>
> Q Where?
>
> A Fuguitt elementary in the FDLRS Program.
>
> Q What is the FDLRS Program?
>
> A It's for kids that have developmental problems, autistic children, for kids that are developmentally delayed.
>
> Q Is that a year-round program?
>
> A Yes. He was in pre-K, and he's going to be in pre-K again.

Q Has he been diagnosed as suffering from autism?

A No.

Q What kind of developmental delays does he have?

A Speech. He's four. They say that he's at age three. So I guess that would be developmental altogether.

Q What other developmental delays does he have other than speech?

A He's not like other kids. I mean, he's behind. I don't know what - what it would be called. I mean, he's four years old, and he acts as if he's three. I mean, healthwise, I mean, his vision is bad in his left eye, and he has seizures.

Q Describe the seizures for me.

A Before he was not placed on the medicine, he would wake up from a nap, and he would have convulsions. Since he's been placed on the medicine, he will just wake up with the gagging effect, and he'll just stare off. And he'll last maybe like a minute or two, and then he'll - it will go away, and he'll just want to go to sleep.

Q How often does he have these seizures?

A Since he's been on the medicine, he usually has maybe one to every three months.

Q Does he have any problem with swallowing?

A No.

Q Does he have any motor problems?

A Motor skills?

Q Yes, ma'am.

A I was told that he did, yes.

Q By whom were you told?

A I don't recall. Plenty of people have told me, but it was a certain program that I used to take him to. I was told by his occupational therapist that he had, and I don't remember what it was called.

Q Is he currently enrolled in any programs designed to assist him with any motor problems?

A No.

Q What kind of motor problems has he had in the past?

A He was delayed when he was young. He, like, wasn't sitting up when he should. They had to - I had to take him to therapy to set him up because his - when he was born, his legs were bowed up. I had to take him to therapy to stretch his legs. He was late sitting up and crawling, walking, stuff like that.

Q Does he currently have any motor deficits?

A No.

Q He is able to walk, run, jump?

A Yes.

Q Skip?

A Yes.

Q As far as you're concerned, whatever motor problems he's had in the past with his legs have resolved?

A Yes.

Q Does he have any motor problems with his hands or arms?

A No.

* * *

Q Fuguitt Elementary is a public school?

A Yes.

Q And he's going to be repeating the pre-K program?

A Yes.

Q Is he in school today?

A No. He starts back when school starts back.

Q Has he been off for the summer?

A Yes.

Q What has he been doing?

A Stays home with me.

Q And his brother?

A Yes.

A And his two stepsisters?

A Yes. . . .

Q Okay, Has he had any sort of therapy this summer?

A Yes, he takes speech therapy in FDLRS.

Q So even though school is not ongoing, that particular program provides some sort of summer therapy?

A Oh, I'm sorry, no, not for the summer. No, he hasn't done anything in that.

Q He hasn't had any kind of therapy since school let out in May?

A No.

Q Other than that which he receives at school, is he receiving any sort of therapy?

A No.

* * *

Q Has anyone suggested to you now that he is in school, that he needs anything in addition to that which the school is providing?

A No. I did sign - well, I did sign a paper for his school for vision. They wanted to see if he qualifies for vision class or vision therapy.

Q You said it's the one eye that's bad, the left -

A The left eye.

* * *

Q . . . Other than the problem with his left eye and the problems he has with respect to speech, are there any other objective problems that you, as his mother, have observed?

A He's very active, very hyper.

Q Has he been treated for that hyperactivity?

A No.

Coverage Under the Plan

21. 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."[5] Section 766.302(2).[6] See also Section 766.309.

22. Here, given the proof, it must be resolved that Madison suffers neither a substantial mental impairment nor a substantial physical impairment, much less a permanent and substantial mental and physical impairment required for coverage under the Plan. Moreover, given Dr. Duchowny's observations, and the paucity of proof to the contrary, it cannot be resolved, as suggested by Intervenors, that the cause of Madison's deficits resulted from a brain injury caused by oxygen deprivation or mechanical injury that occurred during labor, delivery, or resuscitation, as opposed to a developmental abnormality, that preceded the onset of labor. See Wausau Insurance Company v. Tillman, 765 So. 2d 123, 124 (Fla. 1st DCA 2000)("Because the medical conditions which the claimant alleged had resulted from the workplace incident were not readily observable, he was obliged to present expert medical evidence establishing that causal connection."); 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.")

The Notice Provisions of the Plan

23. Pertinent to this case, at the time of Madison's birth, Section 766.316, Florida Statutes (1998), prescribed the notice requirement, as follows:

> Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient when the patient has an emergency medical condition as defined in s. [395.002(9)(b)][7] or when notice is not practicable.

24. Here, there being no proof to support a contrary conclusion, Dr. Rosewater presumably did not provide Ms. Scarfone notice. See 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.") However, at the time, he was not required to do so.

25. Notably, Section 766.316, Florida Statutes (1998), describes those circumstances under which notice need not be given, as follows:

> . . . Notice need not be given to a patient when the patient has an emergency medical condition as defined in [s. 395.002(9)(b)] or when notice is not practicable.

Pertinent to this case, Section 395.002(9)(b), defines "emergency medical condition" to mean:

> (b) With respect to a pregnant woman:
>
> * * *
>
> 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Here, on presentation to Morton Plant Hospital, there was clear evidence of the onset and persistence of uterine contractions. Consequently, Dr. Rosewater was not required to provide Ms. Scarfone with notice.

CONCLUSIONS OF LAW

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

27. 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).

28. 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. 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).

29. 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). 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, 766.309, and 766.31.

30. 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). 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).

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

> injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at

> least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery 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.

32. As the claimants, the burden rested on Petitioner or, as the proponent of the issue, the Intervenors to demonstrate that Madison suffered a "birth-related neurological injury." Section 766.309(1)(a). See also Balino v. Department of Health and Rehabilitative Services, supra, ("[T]he burden of proof, apart from statute, is on the party asserting the affirmative issue before an administrative tribunal.")

33. Here, the proof failed to support the conclusion, that more likely than not, Madison's neurologic impairments resulted from an "injury to the brain . . . caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation." Moreover, the proof demonstrated that Madison was neither substantially mentally impaired nor substantially physically impaired. Consequently, the record developed in this case failed to demonstrate that Madison suffered a "birth-related neurological injury," within the meaning of Section 766.302(2), and the claim is not compensable. Sections 766.302(2), 766.309(1), and 766.31(1). See also Florida Birth-Related

Neurological Injury Compensation Association v. Florida Division of Administrative Hearings, 686 So. 2d 1349 (Fla. 1997)(The Plan is written in the conjunctive and can only be interpreted to require both substantial mental and substantial physical impairment.); 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 constructed 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).

34. 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). Such an order constitutes final agency action subject to appellate court review. Section 766.311(1).

CONCLUSION

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

ORDERED that the claim for compensation filed by Rebekah Leah Scarfone, individually, and as mother and natural guardian of Madison McCorkle, III, a minor, is dismissed with prejudice.

DONE AND ORDERED this 24th day of October, 2003, in Tallahassee, Leon County, Florida.

S

WILLIAM J. KENDRICK
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of October, 2003.

ENDNOTES

[1]/ Petitioner also averred that Morton Plant Hospital and Mother and Child Care of Clearwater failed to comply with the notice provisions of the Plan; however, that claim was abandoned in the parties' Pre-Hearing Stipulation.

[2]/ The Apgar scores assigned to Madison 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 irritability, and 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, Madison's Apgar score totaled 2, with heart rate and reflex irritability being graded at 1 each, and respiratory effort, muscle tone, and color being graded at 0. At five and ten minutes, Madison's Apgar score totaled 7, with heart rate and respiratory effort being graded at 2 each, and muscle tone, reflex irritability, and color being graded at 1 each.

[3]/ The ultrasound revealed no evidence of intracranial hemorrhage, but did reveal a 1.0 by 1.5 centimeter fluid collection in the left scalp consistent with edema or hematoma.

[4]/ Madison was followed by Dr. Hess, a pediatric ophthalmologist for suspected hypoplasia of the right optic nerve; evolving atrophy of the left optic nerve, which evolved following evidence of macula retinae edema; and strabismus (a deviation of the eye which the patient cannot overcome). Ultimately, Madison demonstrated good vision in the right eye, with good fixation and following abilities; however, his left eye evidenced very poor vision, with optic nerve atrophy, and reduced fixation and following. Consequently, on February 15, 2000, at 8 months of age, Madison underwent eye muscle surgery (strabismus surgery) to realign his eyes. Such surgery was successful. As for the cause of Madison's macula retinae edema, and resultant optic atrophy, Dr. Hess was of the opinion that it was most likely associated with the left cerebellar hemorrhage noted on the MRI scan at five days of age. (Doctor's Exhibit 3, pages 17 and 18.) Dr. Hess did not, however, have any opinion as to "whether . . . [Madison's] visual impairments were related to in any way the circumstances surrounding his birth," or otherwise express an opinion as to the timing of the hemorrhage he felt was the cause of Madison's optic atrophy. (Doctor's Exhibit 3, page 14.)

[5]/ Permanent and substantial are not defined by the Plan, however, the American Heritage Dictionary of the English Language, New College Edition (1979), defines "permanent" as:

> . . . 1. Fixed and changeless; lasting or meant to last indefinitely. 2. Not expected to change in status, condition, or place . . .

It further defines "substantial" as:

> . . . 1. Of, pertaining to, or having substance; material. 2. Not imaginary; true; real. 3. Solidly built, strong. 4. Ample, sustaining . . . 5. Considerable in importance, value, degree, amount, or extent . . . --sub-stan'tial-ly adv.

When, as here, the Legislature has not defined the words used in a phrase, they should usually be given their plain and ordinary meaning. Southeastern Fisheries Association, Inc. v. Department of Natural Resources, 453 So. 2d 1351 (Fla. 1984.) Where, however, the phrase contains a key word like "substantially," the phrase is plainly susceptible to more than one meaning. Under such circumstances, consideration must be accorded not only the

literal or usual meaning of the word, but also to its meaning and effect in the context of the objectives and purposes of the statute's enactment. See Florida State Racing Commission v. McLaughlin, 102 So. 2d 574 (Fla. 1958.) Indeed, "[i]t is a fundamental rule of statutory construction that legislative intent is the polestar by which the court must be guided [in construing enactments of the legislative]." State v. Webb, 398 So. 2d 820, 834 (Fla. 1981).

Turning to the provisions of the Plan, certain insights may be gleaned regarding the meaning the Legislature intended to ascribe to the word "substantially," and more particularly its use in the phrase "permanently and substantially mentally and physically impaired." First, the Legislature has expressed its intent in Section 766.301(2), Florida Statutes, as follows:

> It is the intent of the Legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodian care and rehabilitation. This plan shall apply only to birth-related neurological injuries. (Emphasis added)

"Catastrophic," an adjective of the noun "catastrophe," is defined by The American Heritage Dictionary of the English Language, New College Edition (1979), as "a great and sudden calamity; disaster." (Emphasis added.)

It is further worthy of note that physicians commonly use terms such as "mild," "moderate," and "severe" to describe the scope of an infant's mental and physical injury.

Finally, as observed by the court in Humana of Florida, Inc. v. McKaughn, 652 So. 2d 852, 858 (Fla. 2d DCA 1995), the Florida Birth-Related Neurological Injury Compensation Plan, like the Worker's Compensation Act, is a "limited statutory substitute for common law rights and liabilities." Accordingly, "because 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 . . . [and] a legal representative of an infant should be free to pursue common law remedies for damages resulting in an injury not encompassed within the express provisions of the Plan." Humana of Florida, Inc. v. McKaughn, supra, at page 859. Accord, Carlile v. Game and Fresh Water Fish Commission, 354 So. 2d 362 (Fla. 1977)(A

statute designed to change the common law rule must speak in clear, unequivocal terms, for the presumption is that no change in the common law was intended unless the statute is explicit in this regard.)

Given the Legislature's intent to restrict no-fault coverage under the Plan to "a limited class of catastrophic injuries," as well as the common practice among physicians to use terms such as "mild," "moderate," or "severe" to describe the degree of an infant's injuries, it is concluded that the word "substantially," as used in the phrase "permanently and substantially mentally and physically impaired," denotes a "catastrophic" mental and physical injury, as opposed to one that might be described as "mild" or "moderate."

[6]/ All citations are to Florida Statutes (2002) unless otherwise indicated.

[7]/ Redesignated as Section 395.002(9)(b), from Section 395.002(8)(b), to conform to amendments by Chapter 98-89, Section 23, Laws of Florida, and Chapter 98-171, Section 37, Laws of Florida. See Section 766.316, Florida Statutes (1998), note 2.

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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.