STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

LINDA J. DAVIDSON LAPP, individually, and on behalf of and as natural guardian of FAITH LAPP, a minor,	)	
Petitioner,	)	
vs.	)	Case No. 03-0294N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
ORLANDO REGIONAL HEALTHCARE SYSTEM, INC.,	)	
Intervenor.	)	

FINAL ORDER

Pursuant to notice, the Division of Administrative Hearings, by Administrative Law Judge William J. Kendrick, held a hearing in the above-styled case on February 16, 2004, by video teleconference, with sites in Orlando and Tallahassee, Florida.

APPEARANCES

For Petitioner: Linda J. Davidson Lapp, pro se
9918 Bear Lake Road
Apopka, Florida 32703

For Respondent: Lynn Walker Wright, Esquire
Lynn Walker Wright, P.A.
2716 Rew Circle, Suite 102
Ocoee, Florida 34761

For Intervenor: Larry J. Townsend, Esquire
Mateer & Harbert, P.A.
225 East Robinson Street, Suite 600
Post Office Box 2854
Orlando, Florida 32802-2854

STATEMENT OF THE ISSUES

Whether Faith Lapp, a minor, qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan.

PRELIMINARY STATEMENT

On January 27, 2003, Linda J. Davidson Lapp, individually, and on behalf of and as natural guardian of Faith Lapp (Faith), 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 January 28, 2003, and on May 6, 2003, NICA filed a Motion for Summary Final Order, predicated on the opinion of its experts that Faith had neither a substantial mental nor motor impairment, and that her neurologic abnormalities were likely acquired in utero, rather than from oxygen deprivation or mechanical injury occurring during labor, delivery or

resuscitation. In the meantime, Orlando Regional Healthcare Systems, Inc., requested and was accorded leave to intervene.

On November 14, 2003, an Order was entered denying NICA's Motion for Summary Final Order, and a hearing was scheduled for February 16, 2004, to resolve whether the claim was compensable. At hearing, Linda J. Davidson Lapp testified on her own behalf, and Petitioner's Exhibit 1 was received into evidence. Also received into evidence were Joint Exhibits 1-4, Respondent's Exhibits 1 and 2, and Intervenor's Exhibits 1 and 2. No other witnesses were called, and no further exhibits were offered.

The transcript of the hearing was filed March 8, 2004, and the parties were accorded 10 days from that date to file proposed orders. Respondent and Intervenor elected to file such proposals, and they have been duly considered.

FINDINGS OF FACT

Preliminary findings

1. Linda J. Davidson Lapp is the natural mother and guardian of Faith Lapp, a minor. Faith was born a live infant on January 27, 1998, at Arnold Palmer Hospital for Children & Women (Arnold Palmer Hospital), a division of Orlando Regional Healthcare System, Inc., a hospital located in Orlando, Florida, and her birth weight exceeded 2,500 grams.

2. The physicians providing obstetrical services at Faith's birth were Penny A. Danna, M.D., and Steven Carlan,

M.D., who, at all times material hereto, were "participating physician[s]" in the Florida Birth-Related Neurological Injury Compensation Plan, as defined by Section 766.302(7), Florida Statutes.

Faith's birth

3. At or about 1:25 a.m., January 27, 1998, Mrs. Lapp (with an estimated date of delivery of January 22, 1998, and the fetus at 40+ weeks gestation) presented to Arnold Palmer Hospital, in labor. At the time, Mrs. Lapp's membranes were noted as intact, and vaginal examination revealed the cervix at 4 centimeters dilation, effacement complete, and the fetus at -1 station. Contractions were noted as mild, at a frequency of 2-3 minutes, with a duration of 40 seconds, and fetal monitoring revealed a reassuring fetal heart rate, with a baseline in the 130 beat per minute range.

4. From 1:25 a.m. until 5:00 a.m., when her membranes spontaneously ruptured, Mrs. Lapp's labor progress was steady, and fetal monitoring continued to reveal a reassuring fetal heart rate. Thereafter, to 7:05 a.m., when vaginal examination revealed Mrs. Lapp complete, monitoring continued to reveal a reassuring fetal heart rate, with a baseline in the 150 beat per minute range, and variable decelerations, with contractions, and a good return to baseline.

5. At 7:20 a.m., Mrs. Lapp was noted as pushing, with contractions, and variable decelerations continued without significant change until approximately 8:40 a.m., one hour prior to delivery, when fetal heart rate decelerations became persistent. Thereafter, at 9:25 a.m., the baby was noted to crown; at 9:34 a.m., the baby was noted as bradycardic with a fetal heart rate in the 70 beat per minute range; and at 9:36 a.m., the baby's head was noted as delivered, with the fetal heart rate continuing in the 70 beat per minute range.

6. Delivery was complicated by a shoulder dystocia, and at 9:38 a.m., the labor and delivery record reveals the baby was not yet delivered, and the fetal heart rate was persisting in the 70 beat per minute range. Thereafter, at 9:40 a.m., Faith was delivered.

7. At delivery, Faith was severely depressed (without respiratory effort, reflex, or muscle tone; a color consistent with central cyanosis; and a heart rate under 60 beats per minute), and required resuscitation (ambu bagging with 100 percent oxygen, cardiac compression for 20 seconds, and intubation). Apgar scores were recorded as 1 and 6, at one and five minutes, respectively,[1] and cord pH was recorded at 7.28.

8. Following delivery, Faith was transported to the neonatal intensive care unit (NICU), where she remained until January 31, 1998, when she was discharged to her parent's care.

Faith's hospital course was summarized in her Clinical Resume (discharge summary), as follows:

> History . . . .
>
> Term newborn female, birth weight 4449 gm, born on 01/27/98 at APHCW. Mother is a 39-year-old gravida 2, para 1, 0 positive, maternal screens negative, uncomplicated gestation, 40+ weeks gestation, rupture of membranes 4 hr., 40 min. prior to delivery. Difficult extraction, vaginal delivery, epidural anesthesia, nuchal cord times one. During process of extraction, left fracture of the humerus. Baby cyanotic and apneic, heart rate 40-60, Ambu bagged with 100%, cardiac compressions given, intubated at one to 1-1/2 min. of life, with 3.5 cm ET tube, responded with 100% 02 by bagging, re-intubated due to air leak with 4.0 ET tube at 7-10 min. of age. Apgars 1 at one min., 6 at five min., cord pH 7.28, birth weight 4449 gm, temperature 98.8°, Accu-Chek 72, mean blood pressure low 30s. Hematocrit 49%.
>
> PHYSICAL EXAMINATION: Alert, molding of the head, bruising of the scalp. Pupils reactive to light. Nose and throat normal. Lungs coarse. No murmur. Abdomen soft. Liver 2 cm below right costal margin. Cord - 2 arteries, 1 vein. Female genitalia. Anus patent. Passing meconium. Spine normal. Left arm with swelling and tenderness at fracture site. Decreased tone and reflexes. Poor perfusion.
>
> IMPRESSION:
>
> 1. Post mature, 41 weeks female
> 2. Neonatal depression, post difficult delivery.
> 3. Aspiration.
> 4. Rule out sepsis.
> 5. Hypovolemia.
> 6. Left humerus fracture.

PROBLEM LIST:

Problem #1: Post mature, 41 weeks female.

Problem #2: Neonatal depression. Infant required 100%, pressures of 23/3 and an IMV of 30; pH 7.4, pCO2 22, PO2 393, base excess -8.1. Weaned and extubated to room air by day one. No apnea nor bradycardia. Monitor discontinued.

Problem #3: Rule out sepsis. Treated with ampicillin and gentamicin times 72 hr. Blood culture negative.

Problem #4: Fracture of the left humerus. Orthopaedic consult obtained, infant was splinted, now is positioned with left upper extremity pinned across chest and is comfortable. For follow-up with Dr. Topoleski.

Problem #5: Neurologic. A CT scan of the head shows some central subdural bleeding along tentorium and falx cerebri, small amount, slightly prominent extra-axial space left temporal region.[2]

Problem #6: Miscellaneous. Passed ABR hearing screening exam. Annual follow-up is recommended. Infant screening was done 01/28/97.

Problem #7: Fluids/electrolytes/nutrition. Feedings were begun on day 2, and advanced. Infant is tolerating ad lib feedings of maternal breast milk or Similac-20 with iron, and nippling well.

Physical examination, 01/31/98: Four days of age. Weight 4555 gm, head circumference 33.25 cm. Pink. Anterior fontanelle soft. No murmur. Lungs clear. Abdomen soft and full. Neurologic appropriate. Left arm positioned as noted above.

* * *

FINAL DIAGNOSIS:

1. Post term, 41 weeks female.
2. Neonatal depression.
3. Rule out sepsis.
4. Left fractured humerus.
5. Subdural bleeding.

9. Follow-up CT scan on March 25, 1998, showed resolution of the subdural hemorrhage. Specifically, the CT scan was read, as follows:

> The ventricles are normal in size and configuration. There is no midline shift. The attenuation characteristics of the brain are within normal limits for the patient's age and state of maturity. No extra-axial fluid collections are identified. The hemorrhagic changes described on the study of 01/30 have cleared.
>
> IMPRESSION:
>
> CT appearance of brain within normal limits.

Faith's subsequent development

10. Following discharge from Arnold Palmer Hospital, Faith was followed for a number of evolving irregularities. Pertinent to this case, insight into the complexity of her presentation can be gleaned from some observations by a few of Faith's physicians: Michael Pollack, M.D., a pediatric neurologist; Eric Trumble, M.D., a pediatric neurosurgeon; and Harry Flynn, Jr., M.D., an ophthalmologist.

11. Dr. Pollack initially evaluated Faith on March 30, 1998, and described his impressions, as follows:

> . . . Parents have observed that the patient does not follow although she appears to respond to light. She has been evaluated by Dr. Gold and Dr Richmond and apparently has retinal detachment . . . . A recent film of the patient's left arm apparently demonstrated that her humeral fracture is healing satisfactorily.
>
> * * *
>
> A recent CT scan of the head shows resolution of posterior fossa hemorrhage. In addition, the fluid collection over the left temporal region has largely disappeared but the left-sided subarachnoid space does remain larger than the right.
>
> Physical examination includes a weight of 14 pounds and a head circumference of 35.5 cm. The forehead appears underdeveloped and the head is small in relation to the face. Anterior fontanel is closed. There is ridging of coronal and sagittal sutures. Slight flattening of the right occiput is present and there is corresponding alopecia . . . .
>
> IMPRESSION:
>
> 1. Perinatal craniocerebral trauma and probable hypoxic ischemic encephalopathy.
> 2. Retinopathy by history.
> 3. Evolving microcephaly versus craniosynostosis: Primary microcephaly (failure of the head to grow because of poor brain growth) appears more likely than craniosynostosis . . . .

12. Dr. Pollack summarized his September 29, 1998, evaluation, as follows:

> Faith is an 8-month-old girl who was initially evaluated in my office 3/98 because of visual impairment and suspected seizures. Her diagnoses include perinatal

craniocerebral trauma and a possible hypoxic ischemic encephalopathy. In addition, she had a congenital retinopathy. Her diagnoses at Bascom Palmer Institute were: (1) congenital bilateral retinal detachment and (2) variation of persistent hyperplastic primary vitreous or persistent fetal vasculature bilaterally. Her MRI scan of the head showed an abnormality of the rostrum of the corpus callosum which was thought to fall in the spectrum of septo-optic dysplasia. Her condition, therefore, appears to be due to a combination of congenital anomalies and perinatal factors . . . .

In the past few months, the patient has undergone . . . [repair of metopic synostosis]. Although the shape of her head has improved, her head circumference has remained below the 5th percentile, supporting the view that primary microcephaly rather than craniosynostosis was responsible for the small head size in this patient. In addition, ptosis of the right upper lid developed postoperatively.

* * *

PHYSICAL EXAMINATION: Includes a length of 26.5 inches, weight 18-3/4 pounds, head circumference 38.5 cm. The head appears small in relation to the face. There is unilateral occipital flattening . . . .

IMPRESSION: Severe nonprogressive encephalopathy due to perinatal factors as outlined above and a congenital anomaly of the central nervous system. There is severe visual impairment which is due to a retinal anomaly . . . .

Her residual microcephaly suggests that deficient brain growth rather than craniosynostosis was responsible for her small head size . . . . Development is globally delayed. The combination of

> microcephaly, congenital CNS anomalies, visual impairment and global developmental delay in this patient suggests that she is likely to function in the trainable mentally handicapped range. Her motor attainment to date implies that she will walk independently.

13. Following September 29, 1998, Faith was seen by Dr. Pollack on July 21, 1999; April 3, 2000; and July 17, 2001, during which there was no apparent change in Dr. Pollack's impression. Thereafter, the record suggests that following Faith's last visit with Dr. Pollock, her neurology issues were followed in Miami; however, there is no evidence of record regarding those evaluations, if any.[3]

14. Following discharge from Arnold Palmer Hospital, Faith was also seen by Dr. Trumble and had serial workups for craniosynostosis. That diagnosis was rejected July 9, 1998, when "a head CT with 3-D reconstruction . . . revealed all sutures to be open with the exception of her metopic suture, which was supposed to be closed at this age." Faith did, however, have "metopic synostosis with a small palpable ridge," which was repaired on July 29, 1998. Faith apparently did well post-operatively, with the exception of right eye ptosis. Of note, an uncontrasted CT scan was reviewed by Dr. Trumble in March 1999, which he noted: "identifies normal morphology without evidence of increased CSF spaces or definite atrophy."

15. On April 20, 1998, Faith's ophthalmologic problems were evaluated by Dr. Flynn, professor of ophthalmology at Bascom Palmer Eye Institute, Miami, Florida. Dr. Flynn described his impressions as follows:

> . . . [Faith] was examined on 4/20/98 regarding her retinal detachments in both eyes. . . . [The patient] had a traumatic delivery that involved extensive facial, cranial and subconjunctival hemorrhages. The patient has brought with her multiple studies including X-rays, CT scans and other studies that have been reviewed and are present on the chart. The patient is being referred regarding the possibility of any surgical therapy for this patient with bilateral retinal detachments. The ocular examination showed no recordable visual acuity although there did appear to be a response to light in each eye. The pupillary reaction showed a 1+ response to direct light in each eye. The tension by palpation was normal in both eyes.
>
> The anterior segment examination showed a white plague-like structure on the back surface of the lens in both eyes. The vitreous cavity was clear with no visible hemorrhage in either eye. The posterior segment examination showed total retinal detachment with dragging of the retina toward the inferior temporal quadrant in both eyes. The retinal folds were drawn forward as well to fibrous tissue inserting on the back surface of the lens.
>
> IMPRESSION:
>
> 1. Congenital bilateral retinal detachment both eyes.
>
> 2. Variation of persistent hyperplastic primary vitreous or persistent fetal vasculature both eyes.

> RECOMMENDATION:
>
> I discussed my findings with the patient [sic] and husband. I indicated that the retinal detachments were inoperable. I indicated that the changes present in the back of the eye could not have taken place in 2 1/2 months in spite of the extent of the trauma at delivery.[4]

16. Apart from the impressions of Faith's treating physicians, some insight into Faith's development may also be gleaned from certain evaluations and testing by the Seminole County Public Schools; including a Report of Adoptive Behavior Testing, dated August 21, 2003. On that test, administered at age 5 years, 7 months, Faith's ability to care for herself and interact with others ("Broad Independence") was measured based on an average of four areas of adaptive functioning: motor skills, social interaction and communication skills, personal living skills, and community living skills. There, Faith's motor skills, which included gross and fine motor proficiency tasks involving mobility, fitness, coordination, eye-hand coordination, and precise movements were said to be comparable to an individual at age 3-1 (3 years, one month). However, the examiner noted the basis for such conclusion, as follows:

> When presented with age-level tasks, Faith's gross-motor skills are age-appropriate. Age-level tasks involving balance, coordination, strength, and endurance will be manageable for her.

> When presented with age-level tasks, Faith's fine-motor skills are very limited. Age-level tasks requiring eye-hand coordination using the small muscles of the fingers, hands, and arms will be extremely difficult for her. (Emphasis added.)

(Intervenor's Exhibit 4.)

17. Faith's motor skills were also evaluated by the Seminole Public County Schools, and noted in a Physical Therapy Assessment/Evaluation report, dated October 2, 2003, as follows:

> OBSERVATIONS: Faith was evaluated in a variety of educational settings. She was observed in the classroom, during an obstacle course in another classroom, on the playground and around the school campus. During the obstacle course observation, Faith was participating in tunnel creeping, rockerboard activities, basketball and balance beam walking. Throughout the evaluation, it appeared that Faith had difficulty with some motor tasks due to body and spatial awareness as well as with her speed and intensity of her movements. With this evaluator, Faith followed all directions and seemed eager to please.
>
> * * *
>
> FUNCTIONAL MOBILITY: Faith ambulates indepen[den]tly in all directions demonstrating a forward lurch, hiking type of gait pattern, head is bent forwards. She is able to walk in the halls, on ramps and on sand on the playground without falling. She is able to creep and knee walk independently. Rises from the floor using a half kneel pattern or through a backwards crab type of pattern. Lowers self to floor with control. Transfers in/out of all chairs independently but teacher reports she often trips over her own feet. Ascends the stairs using a reciprocal pattern without

> holding the rail, descends using step to step pattern holding the rail.
>
> GROSS MOTOR: Faith sits on the floor with good balance in a criss cross position or sidesit position. She low kneels but weight bears on her right side more than her left and high kneels with good balance. She squats to pick an item up off the floor. Is able to jump off the floor and jumps on the trampoline at least 5 times in a row. She is able to walk on the balance beam taking 3 steps independently and attempts to walk backwards on it. On the playground, she is able to climb all structures independently with supervision. Within the school environment, Faith is able to push/pull her exterior doors and turn knobs of all interior doors.
>
> FINE MOTOR/VISUAL MOTOR: . . . According to notes from OCPS records, Faith may exhibit some visual motor issues as well as the visual impairment already noted.

(Intervenor's Exhibit 4.)

Coverage under the Plan

18. Pertinent to this case, coverage is afforded by the Plan for infants who suffer a "birth-related neurological injury," defined as in "injury to the brain . . . 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." § 766.302(2), Fla. Stat. See also §§ 766.309 and 766.31, Fla. Stat.

19. In this case, Petitioner and Intervenor are of the view that Faith suffered a "birth-related neurological injury," as defined by the Plan. In contrast, NICA is of the view that Faith did not suffer a "birth-related neurological injury" since her neurologic impairments are, more likely than not, prenatal (developmental) in origin, and resulted from cerebral malformation, as opposed to brain injury caused by oxygen during labor, delivery, or resuscitation. Moreover, NICA is of the view that Faith is not permanently and substantially mentally and physically impaired.

The cause and timing, as well as the significance of Faith's impairment

20. To address the cause and timing of Faith's impairments, as well as their significance, the parties offered the records related to Faith's birth and subsequent development, portions of which have been addressed supra (Joint Exhibits 1-4, and Intervenor's Exhibit 2); a color photograph of Faith taken several hours after her birth (Petitioner's Exhibit 1); the deposition of Leon Charash, M.D., a physician board-certified in pediatrics, who practices pediatric neurology (Intervenor's Exhibit 1); the deposition of Donald Willis, M.D., a physician board-certified in obstetrics and gynecology, as well as maternal-fetal medicine (Respondent's Exhibit 1); and the deposition of Michael Duchowny, M.D., a physician board-

certified in pediatrics, neurology with special competence in child neurology, and clinical neurophysiology. (Respondent's Exhibit 2.)

21. Dr. Willis, whose deposition was offered on behalf of NICA, was of the opinion that the birth records failed to support a conclusion that Faith suffered a brain injury from oxygen deprivation during labor or delivery, but offered no opinion regarding the likelihood of brain injury from oxygen deprivation during the course of resuscitation or from trauma associated with Faith's delivery. Dr. Willis expressed the basis for his opinions, as follows:

> BY MS. WRIGHT:
>
> * * *
>
> Q. After reviewing the records in this case, do you have an opinion within a reasonable degree of medical probability as to whether or not Faith Lapp qualifies for compensation under the NICA criteria you just described?
>
> * * *
>
> A. Yes, it was my opinion that there did not appear to be a loss of oxygen that occurred during labor or delivery that would result in this child's injury.
>
> * * *
>
> Q. Doctor, would you tell us how it is that you reached such an opinion as that?
>
> A. Yes. I reviewed the fetal heart rate monitor strips, which do show fetal heart

rate decelerations during the latter few hours of labor. Although they're not persistent decelerations until about the last hour before delivery, and then the fetal heart rate tracing does show persistent variable decelerations . . . . The Apgar scores that the baby had were low, the Apgar score was one and six. Of course, the baby had -- there was a shoulder dystocia at birth resulting in a very difficult delivery. However, the umbilical cord blood gas was normal with a pH of 7.28. And the baby had a course in the hospital that did not suggest an ischemic event during labor or delivery. In other words, did not have seizures in the post-delivery period, no other organ failure like renal failure, hypotension, those types of things, and was discharged home on the fourth day. So looking at all of that, I felt there was not oxygen deprivation during labor or delivery.

Q. . . . What is the significance of the fetal heart rate monitoring strips?

A. Well, the fetal heart rate monitor strips are consistent with some degree of umbilical cord compression or variable decelerations prior to delivery, and all fetuses react differently to that. But certainly if the fetal heart rate decelerations persist and are significant, then it can lead to a baby that has lack of oxygen at birth.

* * *

Q. Dr. Willis, can you tell us the significance of the cord blood pH which you referenced earlier as being normal at 7.28?

A. Right. Well, if a baby is born with a lack of oxygen, then they will have lack of oxygen and acidosis, which the two go together. And if the baby has lack of oxygen acidosis, then the cord pH should be

low. If the umbilical cord blood pH is within normal limits, it would suggest that for whatever fetal heart rate decelerations or whatever Apgar scores that were present, that that wasn't a result of or did not cause or was not a result of lack of oxygen to the baby.

* * *

Q. Would you anticipate the pH to be abnormal if the deceleration that you saw on the fetal heart monitoring strips had continuously occurred?

A. Well, the fetal heart rate monitor strip shows you that in a way that the baby is being stressed, but it doesn't really tell you if the baby is in distress. So different babies tolerate different amounts of fetal heart rate deceleration. So the bottom line here was the umbilical cord pH being normal. I felt that I could not say that those fetal heart rate decelerations that were present in that hour prior to birth really resulted in lack of oxygen to the baby.

Q. In other words, you would have anticipated the pH score to be abnormal if the infant had been severely affected by the deceleration?

A. That is correct.

* * *

Q. And the significance of the Apgar scores?

A. Well, the Apgar score at one minute tells you how much resuscitation is going to be required for the newborn, and the one was simply one point for fetal heart rate. The baby at birth had no spontaneous respiration, it was pale and it was not moving, and the only points that the baby got -- therefore, was depressed at that

time, and the Apgar score was one. The one-minute Apgar score is not a very good indicator of long-term neurologic development though. The five- and the 10 minute Apgar scores are better indicators for that. The Apgar score at five minutes was listed at six. That's still low.

We consider Apgar score to be low if it is under seven. So a six is just under the cut-off. If the baby had an Apgar score of seven at five minutes, then it would have been considered a normal score . . . .

* * *

BY MS. LAPP:

Q. [D]o you normally . . . [limit yourself as you did in this case]?

A. Normally -- normally, in most cases, I don't limit myself as much as I am with your case.

Q. You found that my case was --

A. I found it a little bit confusing. If I saw the fetal heart rate tracing that I saw here and the Apgar scores that I saw and if the cord pH was abnormal, or I didn't see a cord pH, then I would have assumed that there would have been hypoxia to this baby at birth. But the fact that the cord pH was so normal, I really have to stop and question that. So then with that -- and this happens in other cases.

So with that then, I have to look and see what else. And from doing this for several years and practicing in my subspecialty, I know that babies that have hypoxic injury to the brain at time of birth or during labor frequently have seizures during the first hour or two after birth and many of the other things that we've talked about. So, for instance, if your baby would have had a

seizure disorder an hour or two hours after birth and would have been hypotensive, I might have in that circumstance decided that I would have simply ignored the cord pH result because it wouldn't have fit everything that I see.

Q. Could it be possible that . . . [it was] human error . . . ?

A. That is why I look at many different things. Again, if I would have seen other things that would have been consistent with hypoxic injury to the brain at birth, then I would have said I am going to discard this cord pH because it just doesn't fit the rest of the picture. And so that is the reason I kind of limited myself to labor and delivery, because the baby is depressed after birth, and I really can't explain that.

* * *

Q. . . . When would she have had these seizures?

A. It would have been after birth, relatively in a short period after birth. I guess what I'm trying to say is from a maternal fetal standpoint, the medicine that I practice, if I see a poor fetal heart rate tracing and a baby with low Apgars and then seizures two hours after birth and then a CT scan done at five or six days of life which shows a cystic structure -- shows maybe brain edema consistent with hypoxic injury, then that all becomes a very, very clear picture for me.

In this case, unfortunately, the picture just was not so clear. Because of that, I wanted to limit myself to labor and delivery because I could not make such a clear picture of what happened after that.

(Respondent's Exhibit 1.)

22. Dr. Duchowny, whose deposition was also offered on behalf of NICA, was of the opinion, based on his review of the records and his neurologic evaluation of Faith on March 12, 2003, that Faith's impairments, more likely than not, resulted from cerebral malformation, as opposed to brain injury caused by oxygen deprivation during labor, delivery, or resuscitation, and that, regardless of the cause, Faith was not permanently and substantially mentally and physically impaired. Dr. Duchowny expressed the basis for his opinions, as follows:

> BY MS. WRIGHT:
>
> * * *
>
> Q. Could you tell me, after reviewing the records concerning the records of both Linda Lapp and also Faith Lapp, your review of all the records you've just named and your examination of Faith Lapp, if you have reached an opinion which is in the reasonable degree of medical probability as to whether or not Faith Lapp sustained permanent mental and physical impairment as a result of her labor and delivery?
>
> A. Yes. I believe that Faith does not have a substantial mental or motor impairment and that her neurologic disabilities were acquired in utero and not the result of a birth related neurological injury that occurred during labor, delivery or resuscitation in the immediate post delivery period.
>
> Q. Could you tell me what you base that opinion on, Doctor?

A. That opinion is based on the medical records which indicated that Faith's labor and delivery were complicated by a fractured left humerus, but that her cord blood pH was normal; her Apgar scores of 1 and 6 were reasonably good; that she did not have findings in the post natal period which are consistent with either mechanical injury or severe hypoxia; and that her evaluations, including my examination, all suggested that the types of neurologic disabilities that she has resulted from developmental abnormalities which occurred during the time that the brain was forming in interuterine life.

Q. Doctor, in examining Faith's records, would you comment on the blood cord results?

A. Well, her cord pH of the blood gas was 7.28, which is essentially normal. There is no indication of any hypoxia at that point in time when the blood gases were drawn from the cord.

Q. Would you comment--you said earlier that her Apgar was relatively normal at 1 and 6. What did you mean by that?

A. An Apgar score of 1 at one minute is not an unusual finding in normal deliveries. It reflects obstetrical medication; and I think the important Apgar score is at five minutes, which for Faith was 6. While not being perfect, it certainly is a decent Apgar score and inconsistent with asphyxia.

* * *

Q. Well, you indicated after that, if I heard you correctly, that you didn't see any post delivery signs of hypoxia.

A. That's correct. Faith did require some ventilatory support for the first day, but she never developed systemic signs of hypoxia, which might produce abnormalities

of her heart, liver, kidney, lungs, or cardiovascular system.

* * *

Q. You indicate further that there was no evidence of mechanical injury. Could you tell us for the record what you mean by "mechanical injury?"

A. Well, there was no evidence of mechanical injury to the central nervous system, meaning there was no trauma to the brain or spinal cord. Faith did have a left Erb's palsy, which indicates dysfunction in the brachial plexus. I believe this was mechanically induced, but it was outside the central nervous system.

* * *

Q. Let's now turn to your opinion that Faith does not suffer from a substantial and permanent mental or physical impairment. Could you comment on the reasons why you believe that to be your opinion?

A. Yes. At the time that I evaluated Faith last March, she was five years old. She did have a short attention span, and she was an overactive child, but she was able to talk. Albeit with a speech delay, she was able to talk. In fact, could speak in short phrases. She seemed to be socially appropriate. And with some effort, one could actually complete the examination because there would be some interaction between Faith and myself. She wouldn't cooperate for all testing but much of the testing did in fact get done.

* * *

BY MR. THOMPSON:

* * *

Q. . . . [Y]ou . . . [agree] that you believe there are neurologic abnormalities. Correct?

A. Yes.

Q. When you say that they were acquired in utero, you think that those were something that developed prior to the birthing process?

A. Yes.

Q. Is that what you mean?

A. Yes.

Q. Do you have a name for whatever that process was that caused that?

A. I believe it is cerebral malformation.

Q. And is that a chromosomal problem?

A. Not usually.

Q. What's usually the cause of that?

A. Unknown interuterine acquired factors.

Q. You have stated that you agree that there were mechanical injuries to this child during the labor and delivery process, correct?

A. Yes.

Q. You said one evidence of that was the fractured humerus. Correct?

A. Yes.

Q. She had some abnormalities on CT scan, I believe, some sort of--I can look for it, but you may remember what it was. I've got it right here. "A central subdural bleeding along the tentorium and faux cerebrum of a small amount." Do you recall that CT scan of the head that was taken shortly after her birth?

A. Yes.

Q. Would you agree that that was the result of a mechanical injury to her head?

A. Yes.

* * *

Q. Would you agree that the pH of 7.28 in the cord blood may not represent what her true level of acidosis was?

A. No, I wouldn't agree with that statement.

Q. Could that be a lab error?

* * *

A. Well, anything is possible; but given the Apgar score and given her ultimate clinical findings, I regard that cord blood pH as being accurate.

Q. What do you account for her being cyanotic?

A. She already had brain dysfunction in utero. So, if you take a newborn, whose brain is not normal, and you provide stress, their response is often abnormal.

Q. . . . Would you agree that Faith's laboratory work after her birth did show evidence of problems with her liver?

A. No.

Q. Are you familiar with what her LDH was?

A. Yes. It was elevated, but the rest of her liver functions were normal.

Q. Was her AST normal?

A. I would have to check. I don't believe it was significantly elevated.

Q. Was her ALT abnormal?

A. Again, there were mild elevations that I don't think were significant, as I recall.

Q. I may have asked you this. I apologize if I have. You do agree that her hydrocephaly is a result of secondary atrophy, as opposed to some other reason?

A. No, I don't agree with that.

Q. But you disagree with Dr. Trumbull [sic] when he said that in his report of July 9th, 1998?[5]

A. Well, you would have to ask Dr. Trumbull [sic] what he meant by that. But my understanding is that there were findings, there were abnormalities, but they would not be classified as atrophy. It would really be failure to develop, which is different.

Q. How can you distinguish between atrophy and failure to develop?

A. Well, atrophy implies at one point all the brain structures were normal, and then something happened to damage those structures.

Developmental problems imply that they never developed correctly in the first place so they never assumed normal proportions.

> The findings that Faith had on her MRI are more consistent with developmental abnormalities to her brain, so I would not classify them as atrophy.

(Respondent's Exhibit 2.)

23. Dr. Charash, whose deposition was offered by Intervenor, and whose testimony was supportive of Petitioner's claim, did not examine Faith, although he was accorded the opportunity to do so,[6] but based on the records, he was of the opinion that Faith suffered a "birth-related neurological injury."

24. With regard to brain injury, Dr. Charash was of the opinion that Faith's injury had two components, lack of oxygen and trauma (mechanical injury). As for oxygen deprivation being a likely course of brain injury, Dr. Charash noted Faith's one-minute Apgar score, which reflected severe depression; the need for resuscitation; an increased number of nucleated red cells; a low bicarb; a likely false pH, since Faith was given a bolus of sodium bicarb on delivery without adverse effect; and evidence of kidney malfunction, with transient abnormalities in her liver enzymes. As for trauma, Dr. Charash noted the subdural hemorrhage (cephalohematoma), observed on CT scan at 3 days of age, a likely result of trauma during delivery, as well as the severe bruising of the head documented following delivery. Finally, as further evidence of likely brain injury,

Dr. Charash noted that on delivery, Faith's head, at 33 1/4 centimeters, was normal, but within a matter of months failed to grow as one would expect, and that she is now microcephalic. Consequently, Dr. Charash concluded that Faith likely suffered brain injury during labor, delivery, and resuscitation caused by oxygen deprivation and mechanical injury. (Intervenor's Exhibit 1, page 18.)

25. As for the neurological consequences associated with such injury, Dr. Charash offered the following observations:

> EXAMINATION BY
> MR. TOWNSEND:
>
> * * *
>
> Q. Did . . . the lack of oxygen or the trauma affect her mentally in any way?
>
> A. Yes. I think it has left her with certain physical stigmata and certain intellectual stigmata. She has certain physical injuries based upon her birth difficulties and she's been left with behavioral and cognitive and learning difficulties; yes.
>
> Q. And that's clearly set forth in the records that you've reviewed, the cognitive and the physical problems?
>
> A. Yes. Let me deal with them one at a time, if I may.
>
> Q. All right, sir.
>
> A. The Orange County Public Schools have evaluated her and they find her functioning at percentiles which are far below age expectations. For example, there's a report

of the Highland Elementary School in kindergarten described on 8/21/03, it's one of many reports, but this brings us up to five years and seven months . . . . At this point in time she's five years and seven months old. Her ability for functional independence is that of a three-year old which puts her in the lower one tenth of one percent of the population, 0.1, which means that 99 people out of a hundred outscore her in that area. They give her a rating for motor skills. They think her motor skills are three years and one month at an age of five years and seven months, which, again, puts her in the profoundly retarded area in terms of her motor skills, precise movements, coordination, fitness, etc. They have another score of social interaction and communication. Again, she's equivalent in one area to a three year one month old, another area she can pass tests at two years and two months, she has great difficulty with tasks that approach four years and eight months. And so it goes. They basically conclude that in every area she averages out three years and no months. She's five years and seven months. This gives her a quotient of an aggregate of all other adaptive performance in the range of retardation . . . . There is a psychoeducational evaluation done at the Seminole County Public Schools. This is carried out when she's five years and seven months. . . . The conclusion here . . . is . . . that the child is performing in areas that range from the very low category in the WJ-111 cognitive battery. She's considered to be significantly deficient. She's in the second percentile in the Bracken, B-R-A-C-K-E-N, basic concept scale. She's in the fourth percentile in some other test. On the Stanford Binet, in her verbal ability she does better, she's at the 12th percentile, and that's not retarded.

. . . Now, her physical problems are of great significance here and, frankly, I

> think they relate to what I've mentioned before, her problems with balance, equilibrium, coordination, some of which may be tangentially a consequence of her visual impairments, but it is my opinion within a reasonable degree of medical certainty that her major physical problem aside from the structural change in her brain which makes it abnormally very, very small is her blindness or her severe visual impairments.

26. As noted, Dr. Charash was of the opinion that Faith's principal physical injury was her visual impairment, which rendered her substantially physically impaired, and that Faith's visual impairment resulted from bilateral retinal detachment that was caused by mechanical injury during delivery.[7] (Intervenor's Exhibit 1, pages 21-31.) Consequently, if credited, Dr. Charash's testimony would support the conclusion that Faith suffered bilateral retinal detachment caused by mechanical injury that rendered her substantially physically impaired, and that such impairment did not result from a brain injury. Notably, other physicians who have examined Faith, as well as the Seminole County School System, have concluded that Faith's gross and fine motor skills, except to the extent they may be diminished because of her visual impairment, are age appropriate. Consequently, given the record, there is no competent proof to support a conclusion that Faith is permanently and substantially physically impaired, because of a brain injury.

27. Here, the opinions of the experts offered by the parties, as well as the other proof of record, have been carefully considered. So considered, it must be resolved that, while Faith's delivery was traumatic and there is evidence to suggest that she may have suffered oxygen deprivation during labor, delivery and resuscitation, as well as mechanical injury, as evidenced by the cephalhematoma, the proof fails to support the conclusion that, more likely than not, any oxygen deprivation or mechanical injury she may have suffered resulted in significant brain injury, or that she is permanently and substantially physically impaired. In so concluding, it is noted that Faith's hospital course post-delivery was not consistent with Faith having suffered an acute brain injury; that the imaging studies do not reveal brain injury, (i.e., evidence of atrophy) and are therefore most consistent with cerebral malformation; that Faith's current deficits have a congenital basis, at least in part; that Dr. Duchowny, as opposed to Dr. Charash, examined Faith, and based on his training and experience is most qualified to address the neurologic issues in this case; and that Dr. Duchowny, as opposed to Dr. Charash, was most candid, and his opinions were most consistent with the other proof of record. Consequently, it is resolved that the more credible proof demonstrates that Faith's impairment, more likely than not, resulted from cerebral

malformation, as opposed to brain injury caused by oxygen deprivation or mechanical injury during labor, delivery or resuscitation, and that, regardless of the cause, Faith is not permanently and substantially physically impaired.

CONCLUSIONS OF LAW

28. The Division of Administrative Hearings has jurisdiction over the parties to, and the subject matter of, these proceedings. § 766.301, et seq, Fla. Stat.

29. 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. § 766.303(1), Fla. Stat.

30. 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. §§ 766.302(3), 766.303(2), 766.305(1), and 766.313, Fla. Stat. 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." § 766.305(3), Fla. Stat.

31. 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. § 766.305(6), Fla. Stat. 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. §§ 766.304, 766.309, and 766.31, Fla. Stat.

32. 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.

§ 766.309(1), Fla. Stat. 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." § 766.31(1), Fla. Stat.

33. 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 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.

34. As the proponents of the issue, the burden rested on Petitioner and Intervenor to demonstrate that Faith suffered a "birth-related neurological injury." § 766.309(1)(a), Fla. Stat. See also Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349, 350 (Fla. 1st DCA 1997)("[T]he burden of proof, apart from statute, is on the party asserting the affirmative issue before an administrative tribunal.").

35. Here, the proof failed to support the conclusion that, more likely than not, Faith suffered an "injury to the brain . . . caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation . . . which render[ed] . . . [her] permanently and substantially mentally and physically impaired." Consequently, the record developed in this case failed to demonstrate that Faith suffered a "birth-related neurological injury," within the meaning of Section 766.302(2), and the claim is not compensable. §§ 766.302(2), 766.309(1), and 766.31(1), Fla. Stat. 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).

36. 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." § 766.309(2), Fla. Stat. Such an order constitutes final agency action subject to appellate court review. § 766.311(1), Fla. Stat.

CONCLUSION

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

ORDERED that the claim for compensation filed by Linda J. Davidson Lapp, individually, and on behalf of and as natural guardian of Faith Lapp, a minor, is dismissed with prejudice.

DONE AND ORDERED this 30th day of April, 2004, in Tallahassee, Leon County, Florida.

WILLIAM J. KENDRICK
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of April, 2004.

ENDNOTES

1/ The Apgar scores assigned to Faith are a numerical expression of the condition of a newborn infant, and reflect the sum points gained on assessment of heart rate, respiratory effort, reflex irritability, muscle tone, and color, with each category being assigned a score of 0 through a maximum score of 2. As noted, at one minute Faith's Apgar score totaled 1, with heart rate being graded at 1, and respiratory effort, reflex irritability, muscle tone, and color being graded at 0 each. At five minutes, Faith's Apgar score totaled 6, with heart rate being graded at 2, and respiratory effort, reflex irritability, muscle tone, and color being graded at 1 each. Faith's one-minute Apgar score was clearly depressed, and her five-minute Apgar score was slightly depressed, being just below a normal score of 7.

2/ The CT scan, done January 30, 1998, was reported, as follows:

> There is blood along the inner hemispheric fissure adjacent to the falx cerebrum posteriorly. There probably is also some blood adjacent to the tentorium in the posterior fossa. There is slight prominence of the subarachnoid spaces over the anterior and left temporoparietal region, but these are relatively low density. The ventricles show no midline shift, and no intraventricular hemorrhage is present.
>
> IMPRESSION:
>
> 1. There is some central subdural bleeding along the tentorium and falx cerebrum of a small amount.
>
> 2. Slightly prominent extra-axial space in the left temporal region, but this may still be a variation of normal. No large hematoma or mass effect is seen.

3/ Of record, the only subsequent evaluation was one by Ronald Davis, M.D., who reported the results of his evaluation to Faith's pediatrician (Jennifer Thielhelm, M.D.), by letter of March 28, 2003. In that letter, Dr. Davis reported his impression, as follows:

> IMPRESSION: Faith is a 5-year-old with traumatic brain injury with resultant microcephaly, behavioral discontrol issues, cognitive difficulties, near-complete visual blindness likely as a result of cortical blindness and the possibility of an abnormal EEG given her behavioral outbursts.
>
> * * *
>
> It is clear that her traumatic brain injury has left her with these resultant cognitive and behavioral issues, which do need fairly close attention and likely intervention . . . .

Notably, Dr. Davis does not explain the basis for his opinion; does not disclose the records on which he bases his opinion; and offers no new data or imaging studies to support his impression that Faith suffered traumatic brain injury that resulted in cognitive and behavioral issues. Consequently, there being no new information mentioned to support Dr. Davis' impression, and since his impression is contrary to the imaging studies of record, Dr. Davis' impression is rejected as unpersuasive.

4/ Faith's retinal detachments were inoperable; however, she subsequently had surgery on the right eye to remove a cataract and perform a lens implantation. That surgery apparently improved Faith's ability to appreciate images and colors.

5/ In his report of July 9, 1998, Dr. Trumble did not say that Faith's "hydrocephaly is a result of secondary atrophy, as opposed to some other reason." Rather, his statement was Faith was "clearly microcephalic on numbers although does not have craniosynostosis and this is probably secondary to atrophy." (Emphasis added.) Moreover, in his report of March 8, 1999, Dr. Trumble reported his review of a current CT scan, which he noted "identifies normal cerebral morphology without evidence of increased CSF spaces or definite atrophy."

6/ On November 7, 2003, Intervenor filed a Motion to Allow IME, whereby it requested authorization for Dr. Charash to examine Faith. That motion was granted by Order of November 21, 2003. Why Intervenors elected not to proceed with the examination is not of record.

7/ Dr. Charash was under the erroneous belief that if he could demonstrate that Faith's blindness was caused by a traumatic detachment of the retinas during delivery, as opposed to a congenital basis, the claim would be covered. (Intervenor's Exhibit 1, pages 27-31.) Here, whether the retinal detachments were of a congenital origin or resulted from a mechanical injury at birth, would not affect the decision in this case; however, Dr. Charash's conclusion, that the retinas were detached during delivery is rejected, and it is resolved that Faith's ophthalmologists were more qualified to speak to that issue.

COPIES FURNISHED:
(By certified mail)

Linda J. Davidson Lapp
9918 Bear Lake Road
Apopka, Florida 32703

Larry J. Townsend, Esquire
Mateer & Harbert, P.A.
225 East Robinson Street, Suite 600
Post Office Box 2854
Orlando, Florida 32802-2854

Lynn Walker Wright, Esquire
Lynn Walker Wright, P.A.
2716 Rew Circle, Suite 102
Ocoee, Florida 34761

Kenney Shipley, Executive Director
Florida Birth-Related Neurological
Injury Compensation Association
1435 Piedmont Drive, East, Suite 101
Post Office Box 14567
Tallahassee, Florida 32308-4567

Arnold Palmer Hospital for Children & Women
92 West Miller Street
Orlando, Florida 32806-2039

Stephen Carlan, M.D.
92 West Miller Street
Orlando, Florida 32806-2039

Penny A. Danna, M.D.
Physician Associates
21 West Columbia Street
Orlando, Florida 32806

Ms. Charlene Willoughby
Department of Health
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275

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.