STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

LORNA MERKLINGER AND SCOTT MERKLINGER, on behalf of and as parents and natural guardians of DANIEL S. MERKLINGER, a minor,	)	
Petitioners,	)	
vs.	)	Case No. 03-3856N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
FLORIDA HOSPITAL WATERMAN and JOSE RAMON GONZALEZ, M.D.,	)	
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 September 1, 2004, in Leesburg, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

Whether Daniel S. Merklinger, a minor, qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan.

PRELIMINARY STATEMENT

On October 20, 2003, Lorna Merklinger and Scott Merklinger, on behalf of and as parents and natural guardians of Daniel S. Merklinger (Daniel), 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).[1]

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

October 21, 2003, and on March 4, 2004, NICA filed a Motion for Summary Final Order, predicated on the opinion of its expert that Daniel did not show evidence of a substantial mental or motor impairment. By Order of April 8, 2004, NICA's Motion for Summary Final Order was denied, and on April 16, 2004, NICA gave notice that it was of the view that Daniel did not suffer a "birth-related neurological injury," as defined by Section 766.302(2), Florida Statutes (2001).[2] By Notice of Hearing dated May 14, 2004, a hearing was scheduled for September 1, 2004, to resolve whether the claim was compensable.

At hearing, Respondent's Exhibits A-K, and Intervenors' (Hospital's/Physician's) Exhibits 1-4, were received into evidence. No witnesses were called, and no further exhibits were offered.

The transcript of the hearing was filed September 10, 2004, and the parties were accorded 10 days from that date to file proposed final orders. Respondent and Intervenors elected to file such proposals, and they have been fully considered.

FINDINGS OF FACT

Preliminary findings

1. Lorna Merklinger and Scott Merklinger are the natural parents and guardians of Daniel S. Merklinger, a minor. Daniel was born a live infant on November 17, 2001, at Florida

Hospital Waterman, a hospital located in Eustis, Florida, and his birth weight exceeded 2,500 grams.

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

Daniel's birth and postnatal course

3. At or about 6:50 a.m., November 16, 2001, Mrs. Merklinger, with an estimated delivery date of November 23, 2001, and the fetus at 39 weeks gestation, presented to Florida Hospital Waterman, for induction of labor. At the time, Mrs. Merklinger's membranes were noted as intact, and vaginal examination revealed the cervix at fingertip dilation, effacement at 60 percent, and the fetus at -1 station. Uterine contractions were noted as mild, irregular and with a duration of 60 seconds, and external fetal monitoring revealed a reassuring fetal heart rate, with a baseline at 130 to 140 beats per minute.

4. Pitocin induction was started at or about 7:00 a.m., and continued until 3:51 p.m., when it was discontinued following a vaginal examination that revealed no progress in cervical dilation.[3] Given the lack of progress, Cytotec was

inserted vaginally at 4:34 p.m., and again at 1:10 a.m., November 17, 2001.

5. From 8:18 a.m., when Pitocin induction was restarted, until 7:00 p.m., when Dr. Gonzalez ordered Mrs. Merklinger prepared for delivery, Mrs. Merklinger's labor progress was slow, but, until 6:20 p.m., when prolonged decelerations in the 90 to 102 beat per minute range were noted, fetal monitoring continued to reveal a reassuring fetal heart rate.

6. Starting at 7:25 p.m., vacuum delivery was attempted on three occasions, unsuccessfully, and between 7:30 p.m., and 7:32 p.m., forceps were applied three times. Then, after delivery of Daniel's head, a right shoulder dystocia was noted, and relieved with suprapubic pressure and McRoberts maneuver, and Daniel was delivered at 7:42 p.m.

7. At delivery, Daniel was depressed (limp, with poor respiratory effort), and required resuscitation measures, including oxygen and bag/mask for four to five minutes. Apgar scores were recorded as 3, 6, and 8, at one, five, and ten minutes, respectively.[4]

8. Following delivery, Daniel was transported to the nursery, where he remained until approximately 6:10 p.m., November 18, 2001, when he was transferred via ambulance to the neonatal intensive care unit at Arnold Palmer Hospital for Children & Women. Reason for transfer was noted as fractured

skull and subdural hematoma. Daniel's history and diagnoses at Florida Hospital Waterman were summarized by his attending physician (Dr. Thomas Carlson) in Daniel's discharge summary, as follows:

> HISTORY OF PRESENT ILLNESS: Baby boy Merklinger is a product of a pregnancy complicated by a maternal age of 41, maternal chronic hypertension and asthma. Labor was induced with Pitocin. Toward the termination of delivery, the child became distressed and delivery was urgent . . . . Mother suffered a third degree laceration in the rapid delivery, and the child's head was quite bruised . . . . I was called at the time of delivery and was in Orlando. I transferred the call to the doctor on call, Dr. Burgos. When she was reached, the baby had already been born and was breathing, so she elected not to go in at that time. The baby was born at 1958 [sic] hours. My examination was complete and note written at 2130 hours. The child was, according to the nurse, bagged for approximately 5 minutes postpartum, but then did well.
>
> When I saw the baby under the warmer, I immediately noticed severe bruising and abrasions of the forehead, on through the occiput with large quantity of subcutaneous blood under the scalp. The right cornea was noted to be cloudy. The chest was clear. Heart regular without murmur. The child was breathing well with good oxygen saturation, good capillary refill on room air. There was also noted an apparent fracture of the right clavicle, and the left arm had some decreased movement probably from pulling of the nerve plexus at birth. Impression at that time was traumatic birth doing well . . . .

> The following morning, it was noted that the hemoglobin and hematocrit were dropping . . . . It was noted that the head circumference was growing . . . . Intravenous antibiotics and fluids were begun. I ordered a CT of the head, chest x-ray and came in to see the child. IV antibiotics were begun. The chest x-ray showed mildly displaced right clavicular fracture. The heart and lungs appeared normal. No pneumothorax identified. CT of the brain without contrast revealed a frontal subdural hematoma, 11 mm in thickness with mild mass effect and midline shift. Scalp hematoma noted on physical exam was also present. . . . [Mildly] depressed left frontal skull fracture, minimally displaced left posterior fossa fracture at the lambdoid suture inferiorly. A right anterolateral scalp hematoma with slight suture separation at coronal suture, and a minimally depressed fracture extending back towards the right lambdoid. No intraventricular hemorrhage. With this finding, it was elected to immediately transfer the child to Arnold Palmer Hospital because a neuro surgeon was needed. The child was then transferred out.
>
> DIAGNOSES
>
> Traumatic birth.
> Multiple skull injuries with depressed fractures and subdural hematomas.
> Traumatized right cornea.
> Mild Erb's palsy on the left.
> Fractured right clavicle.

9. At approximately 7:11 p.m., November 18, 2001, Daniel was admitted to Arnold Palmer Hospital. Upon admission, Daniel was examined by Dr. Michael McMahan, who noted that:

> . . . On arrival of the team, tonic colonic motions of the lower extremity noted, could not be suppressed. Phenobarbital . . .

> given . . . . Ampicillin and Claforan begun after blood culture obtained . . . . The infant has been feeding well, but with question of seizures infant was made n.p.o. and placed on IV fluids . . . . PHYSICAL EXAM: . . . Irritable. Molding. Severe bruising of the scalp. Very large caput as well as cephalohematomas. Question of subgaleal bleed. Fontanelle is full. Eyes are open. Cloudy right cornea . . . . Chest: Right clavicle with palpable fracture/crepitus . . . . Neuro: Normal tone and motor strength, moves all extremities . . . . Bruises on chest.
>
> IMPRESSION:
>
> 1. Term AGA male
> 2. Intracranial bleed.
> 3. Possible seizures.
> 4. Rule out sepsis

10. On November 18 and 19, 2001,[5] with a diagnosis of "depressed left temporal skull fracture with underlying epidural hematoma," Daniel underwent a "[l]eft temporal craniotomy for elevation of skull fracture and evacuation of epidural hematoma," and "[p]lacement of left frontal external ventricular drain with Codman monitor." The surgeon was Eric Trumble, M.D., a pediatric neurosurgeon, who noted that Daniel "tolerated the procedure well, was sent to NICU postoperatively."

11. On November 27, 2001, at 10 days of age, Daniel was discharged home on Phenobarbital, with instructions to follow up with his pediatrician within one week, Dr. Trumble in 2-3 weeks, and the development center. Discharge examination noted:

> . . . active, alert, no distress. Head and neck: Large cephalohematoma. Incision healing. Chest clear. No murmur. Abdomen soft. Normal motor strength. Slightly decreased tone left arm.

Discharge summary noted the following problems addressed during Daniel's hospitalization:

> 2. Depressed skull fracture: Neurosurgery consult obtained. Infant was taken to OR on November 18 for left temporal craniotomy and evacuation of EDH. CT scan of the head on November 19 showed extensive scalp swelling, multiple nondepressed skull fractures, small amount of intracranial hemorrhage, question status of intracranial pressure with low density changes inferiorly raising possibility of increased intracranial pressure. Infant continued on phenobarbital. Skull incision clean and healing. Large cephalohematomas remain present. MRI was done on November 27. This showed scalp hematoma which crosses the midline over the vertex, evidence for parenchymal hemorrhage adjacent to the atria/occipital horn, right lateral ventricle mixed signal intensity consistent with evolving hemorrhage. Additionally, posterior extra-axial hemorrhage is appreciated, likely subdural hemorrhage. Small amount of hemorrhage also seen along the interhemispheric fissure towards the vertex. Small areas of parenchymal signal abnormality seen in the left periventricular parenchyma likely related to ventricular shunt placement. An increased signal intensity is seen on both ADC and T2 weighted sequences within the white matter of the right parieto-occipital region likely reflecting edema. No midline shift. Midline structures intact.
> No ventriculomegaly. Infant has slightly decreased tone in the left arm compared to the right. No seizure activity noted. He

> is discharged home on phenobarbital 6 mg p.o.q. 12 hours for follow up with Dr. Trumble in 2-3 weeks . . . .
>
> 3. Possible sepsis: Treated with ampicillin and Claforan times seven days. Blood culture negative.
>
> * * *
>
> 5. Ophthalmology: Eye exam on November 20 with diffuse hemorrhage OU. Follow up on November 27 improved, but still significant hemorrhage present. Guarded visual prognosis OD. For recheck in three weeks with Dr. Gold.

Final diagnoses were:

> 1. Term AGA (appropriate for gestational age) male.
>
> 2. Depressed skull fracture, status post evacuation of hematoma.
>
> 3. Possible seizures.
>
> 4. Possible sepsis.
>
> 5. Left corneal opacification.
>
> 6. Anemia.

Daniel's subsequent development

12. Following discharge from Arnold Palmer Hospital, Daniel was referred to Pediatric Neuroscience, P.A., where he was initially followed by Dr. Trumble, who had performed his surgery. Dr. Trumble first examined Daniel on December 20, 2001, and in a letter to Daniel's pediatrician (Thomas Carlson, M.D.) reported his impressions, as follows:

> I have just had the opportunity to see Daniel with his mother in the neurosurgery clinic today. As you know, he is a 1-month-old child whose last neurosurgery intervention was a craniotomy for evacuation of epidural hematoma on 11/19/01. He has been doing very well since that time without headaches, nausea or vomiting and meeting developmental milestones.
>
> On examination, Daniel is bright, alert, and interactive. He weighs 9 pounds 8 ounces and has a head circumference of 37.25 cm. His incision is well healed. He remains neurologically intact. Eom's are intact. Disc margins are sharp bilaterally. His anterior fontanelle is soft and flat. He does have a bony ridge palpable about the posterior aspect of the left craniotomy and a scalp ridge in the right occipital region.
>
> I am pleased with the improvement Daniel has had thus far. I would like to see him back in the neurosurgery clinic in 3/02 with a repeat head CT for routine follow-up. He may discontinue all neuro-active medications from my stand-point, including anti-convulsants.

13. Dr. Trumble next examined Daniel on March 14, 2002, at which time he noted that Daniel had a "progressive right occipital flatness with the right ear anterior to the left and subtle right frontal bossing," and prescribed an occipital molding band. Otherwise, there was no change in Dr. Trumble's impression of Daniel's progress, and he noted the "repeat head CT done at Arnold Palmer Hospital on 3/5/02 . . . was intracranially normal. The fractures healing well."

14. Following March 14, 2002, Daniel was seen by Dr. Trumble on June 10, 2002; July 22, 2002; and September 26, 2002, during which time Daniel's occipital flatness improved and Dr. Trumble remained pleased with Daniel's progress. Dr. Trumble's impressions for this time period may be gleaned from the text of his letter to Daniel's pediatrician of September 26, 2002, as follows:

> I have just had the opportunity to see Daniel with his mother in the neurosurgery clinic today. As you know, he is a 10-month-old child whose last neurosurgical intervention was a craniotomy for evacuation of epidural hematoma on 11/19/01. He has been doing very well since that time without headaches, nausea or vomiting and meeting developmental milestones. His right occipital flatness has improved since he obtained his occipital molding band, initially in 3/02 with a replacement in late 5/02. He comes in for routine follow-up today. Mother notes that he was recently developmentally graded advanced.[6]
>
> On examination, Daniel is bright, alert, and interactive. He weighs 16 pounds, 12 ounces and has a head circumference of 44.3 cm. His left temporal incision is well healed. He remains neurologically intact. Eom's are intact. Disc margins are sharp bilaterally. His anterior fontanelle is soft and flat. He has mild right occipital flatness, with his right ear anterior to his left and mild, compensatory right frontal bossing. These findings are very subtle and much improved since he was placed in the occipital molding band.
>
> As part of his ongoing work-up, Daniel had a repeat head CT that was intracranially normal. His bone flap is integrating well.

> I am pleased with the improvement Daniel has had thus far. I do not feel that neurosurgical intervention is warranted at this time. We will be happy to see them back at any time but don't feel that they need[] routine neurosurgical follow-up.

15. Following Dr. Trumble's September 26, 2002, evaluation, Daniel has been followed by Ronald Davis, M.D., a pediatric neurologist. Dr. Davis first evaluated Daniel on June 27, 2003, and reported the results of his evaluation to Daniel's pediatrician, as follows:

> I had the opportunity to evaluate Daniel. As you well know, he is a 19-month-old who was born with a delivery complicated by multiple skull fractures and subdurals as a result of forceps delivery. He subsequently had some transient seizure activity and was on Phenobarb, but was able to wean off. He underwent a number of surgical repairs, but developmentally has done well.
>
> Over the course of the last number of weeks he had events where he vomits out of the blue, turns pale, cold and clammy. He has some eye deviation and becomes unresponsive and still. It lasts for a number of minutes and he can be sleepy afterwards. He has had somewhere between 7-8 of these events. They are very discrete events without any clear tonic or clonic activity. They have been occurring on a cycle range about every 4-8 days.
>
> As a result of this he has had an EEG. It actually demonstrated the presence of right frontotemporal sharp wave discharges. Interestingly, in the past mother had wondered whether or not he had also had some headache like activities where he would seem to grab his head and wince in pain.

Though he has had a number of CT scans he has not had an MRI. He has not been started on any medications.

PAST MEDICAL HISTORY: Otherwise notable for the subdurals and the fractures. He has some right facial injury and a right orbital injury.

* * *

ON EXAM:

General: He is a well-developed, healthy-appearing male with some slight facial asymmetry, right over left . . . . HEENT, patient is normocephalic. Pupils are reactive . . . . .

NEUROLOGICAL EXAM:

Mental Status: He was awake, alert, oriented. He was attentive and interactive. His speech was fluent. He had no anomia. He could follow directions appropriately. He had good right-left orientation.

Cranial nerves II-XII: Intact. Full EOM's. Fundi were sharp bilaterally. Tongue was midline.

Motor Exam: Normal tone and bulk with 5/5 strength. He did not have a drift.

Sensory Exam: Intact to light touch, vibration and cold.

Reflexes: 2+.

Toes: Down.

Coordination and Gait: No primary ataxia, dysmetria or tremor. He had appropriate gait for age.

> IMPRESSION: Daniel is a 19-month-old with seizure-like episodes, likely partial in nature with an abnormal EEG with trauma as the most likely inciting event.
>
> PLAN: At this point I am going to arrange for an MRI to rule out any structural abnormality.
>
> I have given them Diastat 5 mg to use for any prolonged events and they are going to think over the use of long-term antiepileptic medication. The side effects and risks of going on medicine as well as not going on antiepileptic medication on a routine basis were reviewed.

16. Following an MRI, Daniel had a follow-up visit with Dr. Davis on August 26, 2003. Dr. Davis reported the results of that evaluation, as follows:

> I had the opportunity to follow-up with Daniel. As you well know, he is our nearly 2-year-old who suffered traumatic fractures as a result of delivery by forceps, as well as the presence of subdurals. Since his last visit he has had an MRI and EEG. His EEG had, of course, demonstrated the presence of frontotemporal sharp wave discharges on the right. This did correlate with MRI abnormality. The MRI actually demonstrated thickening cortex in that region, as well as focal cystic encephalomalacia there, as well as in the right gyrus rectus and the basal ganglia. Additionally, there was periventricular leukomalacia noted bilaterally.
>
> He continues to do well developmentally. There are some mild delays, but he continues to advance without any evidence of regression or plateauing.

* * *

NEUROLOGICAL EXAM:

Mental Status: He was awake, alert, attentive and interactive. His speech is mildly disarticulate, but fluent. He is able to engage appropriately.

Cranial nerves II-XII: Intact with some estropia of the right.

Motor Exam: Demonstrates symmetric movement.

Reflexes: 1+

Coordination and Gait: No primary ataxia.

IMPRESSION: Daniel is a nearly 2-year-old with traumatic injury was described with resultant mild developmental delay, periventricular leukomalacia and an abnormal EEG.

PLAN: At this point we will just continue to have the Diastat 5 mg to use for any breakthrough seizures. We will continue to hold off on any routine antiepileptic medication as he has not had any breakthrough seizures.

17. Dr. Davis continues to follow Daniel's progress. On his most recent evaluation of July 19, 2004, Dr. Davis noted:

I had the opportunity to follow-up with Daniel. As you well know, he is our young man with history of traumatic fractures from delivery by forceps and subdural hematoma. He has abnormal EEG and periventricular leukomalacia on MRI.

He continues to do relatively well. He has not had any significant seizure activity, though mother does relate a time when he appeared to be having some type of partial spell in the face of being overheated. Interestingly, the grandfather also reports

that he sees Daniel put his head down at times as if he has some transient and/or paroxysmal head pain which can last for a number of seconds.

However, he did have a repeat EEG back in June which continued to demonstrate the presence of left frontocentral spike and wave discharges, as well as independent right frontocentral spike and wave discharges.

Cognitively he continues to advance. There appears to be no regression.

ON EXAMINATION:

General: He is well developed and healthy appearing. . . . HEENT. patient is normocephalic. Pupils are reactive . . . .

NEUROLOGIC EXAM:

Mental Status: He was awake, alert, attentive, interactive and engaging. His speech was mildly disarticulate, but fluent.

Cranial nerves II-XII: Intact. Full EOM's, though mild esotropia is noted of the right. He has some mild asymmetry of his facies.

Motor Exam: Normal tone and symmetric movement.

Reflexes: 1+.

Coordination and Gait: No primary movement disorder.

IMPRESSION: Daniel is a young man with traumatic brain injury in the face of periventricular leukomalacia with mild developmental issues and abnormal EEG.

PLAN: At this point I am concerned a little bit about these events that are both

> described by the grandfather, as well as the single event noted by the mother.
>
> Should these recur and/or persist I am going to arrange for a more prolonged ambulatory study.
>
> In the meantime we will continue to have the Diastat available and monitor him closely.

18. On February 9, 2004, following the filing of the claim in this case, Daniel was, at Respondent's request, examined by Michael Duchowny, M.D., a pediatric neurologist. Dr. Duchowny reported the results of his neurology examination, as follows:

> PHYSICAL EXAMINATION reveals an alert, cooperative, well-developed and well-nourished 2-year-old boy. Daniel weighs 24 pounds and is 34 inches tall. The skin is warm and moist. There is one café-au-lait spot on the right thigh. There are no other neurocutaneous stigmata and no somatic dysmorphic features. The head circumference measures 48.5 cm, which is at the 50th percentile for age match controls. A bony ridge is palpated over the right skull vault and there is also a small area of depression. There are no facial asymmetries. There is some reddening beneath the eyes compatible with an allergic diathesis. The neck is supple without masses or thyromegaly. Bilateral anterior and posterior cervical adenopathy is palpated as well as small post auricular lymph nodes. The lungs' fields are clear and the heart sounds reveal a grade 2/6 innocent ejection systolic murmur. There is no palpable abdominal organomegaly. The abdomen is soft and non-tender. Peripheral pulses are 2+ and symmetric.
>
> NEUROLOGICAL EXAMINATION reveals an alert, well developed, cooperative and sociable 2-year-old. Daniel interacts very well and

shows a very high level of curiosity. He was not overly defensive and cooperated fully for the evaluation. Daniel has an appropriate attentional span for his age and spoke in long phrases. He articulated his needs well. He also anticipated maneuvers and assisted in getting himself dresse[d] and undressed. Cranial nerve examination reveals full visual fields to direct confrontation testing. I can see no evidence of corneal scarring. The pupils are 2 to 3 mm and react briskly to direct and consensually presented light. A brief funduscopic examination was unremarkable. The extraocular movements are full and conjugate. There are no facial asymmetries. The tongue and palate move well. The uvula is midline. Motor examination reveals symmetric strength, bulk and tone. There are no adventitious movements and no focal weakness or atrophy. The deep tendon reflexes are 2+ and symmetric and there are no pathologic reflexes. Both plantar responses are downgoing. Daniel's stance is narrowly based and he walks with good stability and symmetric arm swing. He turns crisply. He is able to get up from a sitting position without difficulty. Sensory examination is intact to the withdrawal of all extremities to stimulation. Neurovascular examination reveals no cervical, cranial or ocular bruits. There are no temperature or pulse asymmetries. Daniel is able to grasp with either hand and transfers readily.

In SUMMARY, Daniel's neurological examination reveals no significant findings. He does have some cranial dysmorphism secondary to his previous skull fractures and surgery. However, Daniel does not show evidence of a substantial mental or motor impairment . . . .

Coverage under the Plan

19. 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.

20. In this case, Petitioners and NICA are of the view that Daniel suffered an injury to the brain caused by the forceps delivery, but that he was not rendered permanently and substantially mentally and physically impaired. In contrast, Intervenors are of the view that Daniel's brain injury did result in permanent and substantial mental and physical impairment.

The significance of Daniel's impairment

21. To address the significance of any impairment Daniel may have suffered, the parties offered the records related to Daniel's birth and subsequent development, pertinent portions of which have been addressed supra (Respondent's Exhibits A-G); a color photograph of Daniel taken within the first 24 hours of birth (Intervenors' Exhibit 1); the deposition of

Michael Duchowny, M.D., an expert in pediatric neurology (Respondent's Exhibit H); the deposition of Ronald Davis, M.D., an expert in pediatric neurology (Respondent's Exhibit K); the deposition of Petitioner Lorna Merklinger (Respondent's Exhibit I); the deposition of Petitioner Scott Merklinger (Respondent's Exhibit J); the deposition of Loren Mann, Daniel's maternal grandmother (Intervenors' Exhibit 3); the deposition of Ruth Merklinger, Daniel's paternal grandmother (Intervenors' Exhibit 4); and the deposition of George Merklinger, Daniel's paternal grandfather (Intervenors' Exhibit 2).

22. Dr. Duchowny, as revealed in his deposition, was of the opinion, based on his review of the medical records and his neurologic evaluation of Daniel on February 9, 2004, that Daniel was neither mentally nor physically impaired, much less substantially mentally and physically impaired, as required for coverage under the Plan. Dr Duchowny described his evaluation and conclusions, as follows:

> Q. Doctor, when you examined Daniel Merklinger, what physical and neurological exams did you conduct on him specifically? What did you have him do or what did you observe?
>
> A. Well, his weight and height were recorded. I looked at his skin. I looked at his head. I felt his head, measured his head circumference. Observed his face, his mouth, his throat.

I looked at and palpated his neck. I listened to his chest. I listened and felt his abdomen, looking for his internal organs, and palpated his extremities and his peripheral pulses.

On the neurological examination, I observed his behavior and his communication patterns, both expressive and receptive. I looked at his attention span, his social abilities, his ability to engage me in both the examination and in conversation. I looked at his ability to participate in the expected activities of daily living within a limited sense; for example, how he dressed or undressed himself.

I certainly observed his behavior, both with respect to me and with respect to his family. I performed a cranial nerve examination, which included an examination of the eyes, of the facial movements, and an observation of his hearing abilities. I also looked at the way his mouth moved, how he swallowed, how his tongue moved, whether or not there was any drooling.

I further looked at his motor abilities, including the movements of his extremities, his arm and legs. I evaluated his muscle tone. I looked to see if there was any atrophy, any abnormal movement, any lack of movement, any stiffness in any of his limbs.

I made sure that his gait was stable, that it was symmetric, that his coordination was appropriate for his age, that his hand use was appropriate, and that he had bimanual dexterity, that he transferred between hands, that he had good, fine motor coordination and pincer grasp.

I looked at his ability to show evidence of good muscle strength; for example, getting up from a sitting position, his ability to walk and turn and show coordinated movements.

I examined him for sensation, just looking at the way he moved his arms and legs in response to my touch and pressure, and also examined the patterns of the blood flow to his head by checking his neck and head for temperature, for the pulses, making sure there were no abnormalities or asymmetries.

I also listened to his neck and head to make sure that there were no abnormal sounds emanating from the vessels supplying blood to his head.

Q. Was his behavior age appropriate?

A. I thought so, yes.

Q. Was his communication ability age appropriate?

A. Yes.

Q. Was his motor ability and coordination age appropriate?

A. Yes.

Q. Did you see anything during your examination that led you to believe that he was physically impaired?

A. No.

Q. Did you see anything in your examination that led you to believe he was mentally impaired?

A. No.

Q. Do you have an opinion regarding whether or not he is substantially and permanently physically impaired?

A. Yes. I do not belie[ve] he is substantially impaired, mentally or physically.

(Respondent's Exhibit H, pages 34-37).

23. Dr. Davis, as revealed in his deposition, was of the opinion that Daniel suffered some developmental delays, but articulated no findings from which one could reasonably conclude that Daniel was either substantially mentally or physically impaired. Regarding Daniel's developmental delays, Dr. Davis described them as follows:

Q. Okay. And have you noticed . . . [any developmental issues] in your treatment of Daniel?

A. He has some disarticulation of his speech. In other words, his speech is difficult to understand. There is some slight inconsistencies in his motor skills, so you would see that. But then, also, when you go through some of the -- just the typical other developmental learning issues, he has some difficulty with that as well.

* * *

Q. . . . [W]hen I was asking you about developmental delays, could you be more specific about what it is that you base that upon as a clinical symptom?

A. In particular for Daniel or --

Q. Yes, yes. Specifically for Daniel.

A. He has some difficulty with his speech, which is the motor component of the way he moves his mouth, if you will, that sort of formation of words. There is some movement

abnormalities noted in his face, some asymmetry there.

And then his gait is a little -- this is more from recollection than from others, because I don't remember documenting it. But his -- he's a little bit wide based in his stance, so there are more subtle degrees there of his motor difficulties. But the more prominent is his disarticulation of speech, that formation, the mechanical formation of words.

* * *

Q. All right. Earlier, I believe you described his -- the motor dysfunction he's currently displaying as mild; is that correct?

A. I think that's in my note, yes.

* * *

Q. You . . . mentioned that the -- that Daniel has some developmental delays. What were you referring to? Was it just the speech and the --

A. And the motor, yes.

Q. Okay. And could you -- I think you've already gone over this a couple times, but for the motor dysfunction, other than the asymmetry in his face and speech disarticulation, was it anything other than the widened gait?

A. Not that I have documented here, no.

(Respondent's Exhibit K, pages 24, 29, 64, 65, and 69).

Notably, Dr. Davis did not opine that, or disclose any findings that would support a conclusion that, more likely than not, Daniel was mentally impaired, that Daniel was substantially

physically impaired, or that Daniel's brain injury would, at any time in the future, result in substantial mental or physical impairment.

24. As for the deposition testimony of Daniel's parents and grandparents, with regard to his current mental and physical presentation, they were all of the opinion, to the extent they were called upon to express one, that Daniel's mental and physical development were age appropriate. Their concerns for Daniel, to the extent they expressed them, were speculative in nature, and premised on their uncertainty as to whether Daniel's brain injury would, either through the manifestation of persistent seizure activity or developmental deficiencies, adversely affect him in the future. Such concerns are certainly natural, but insufficient to support a conclusion that, more likely than not, Daniel's brain injury has rendered him, or will render him, permanently and substantially mentally and physically impaired.

CONCLUSIONS OF LAW

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

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. As the proponents of the issue, the burden rested on Intervenors to demonstrate that Daniel 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.").

32. Here, the proof failed to support the conclusion that, more likely than not, Daniel 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] . . . [him] permanently and substantially mentally and physically impaired." Consequently, the record developed in this case failed to demonstrate that Daniel 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).

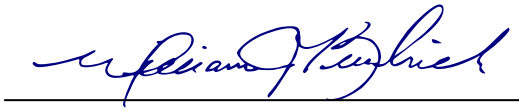
33. Where, as here, the administrative law judge determines that ". . . the injury alleged is not a birth-related neurological injury . . . he [is required to] enter an order [to such effect] and . . . cause a copy of such order to be sent immediately to the parties by registered or certified mail." § 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 Lorna Merklinger and Scott Merklinger, on behalf of and as parents and natural guardians of Daniel S. Merklinger, a minor, is dismissed with prejudice.

DONE AND ORDERED this 8th day of October, 2004, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of October, 2004.

ENDNOTES

1/ On October 24, 2003, Petitioners filed an amended petition to correctly reflect Daniel's date of birth as November 17, 2001.

2/ All citations are to Florida Statutes (2001) unless otherwise indicated.

3/ Vaginal examination at 3:45 p.m., again revealed the cervix at fingertip dilation, with effacement at 80 percent and the fetus at -1 station.

4/ The Apgar scores assigned to Daniel 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 skin color, with

each category being assigned a score ranging from the lowest score of 0 through a maximum score of 2. As noted, at one minute, Daniel's Apgar score totaled 3, with heart rate being graded at 2, respirator effort being graded at 1, and muscle tone, reflex irritability and skin color being graded at 0 each. At five minutes, Daniel's Apgar score totaled 6, with heart rate being graded at 2, and respiratory effort, muscle tone, reflex irritability and skin color being graded at 1 each. At ten minutes, Daniel's Apgar score totaled 8, with heart rate, respiratory effort, and reflex irritability being graded at 2 each, and muscle tone and skin color being graded at 1 each.

5/ Surgery was noted to start at 11:15 p.m., November 18, 2001, and end at 12:22 a.m., November 19, 2001.

6/ On September 17, 2002, Daniel was evaluated by Arnold Palmer's Developmental Center for Infant's and Children, and given a Mullen Scales of Early Learning test. The test measured his development in five categories: Gross Motor, Visual Reception, Fine Motor, Receptive Language, and Expressive Language. Daniel's scores were age appropriate or above in all areas.

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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.