STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

EMAN MUSTAFA, a minor, by her parents and natural guardians, SHIREN MUSTAFA AND NEHAD MUSTAFA,	)	
Petitioners,	)	
vs.	)	Case No. 04-3847N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
CARYN L BRAY, M.D. and UNIVERSITY COMMUNITY HOSPITAL, INC.,	)	
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 December 2, 2005, by video teleconference, with sites in Tallahassee and Tampa, Florida.

APPEARANCES

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For Intervenor University Community Hospital, Inc.:

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STATEMENT OF THE ISSUES

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

2. If so, whether the hospital and the participating physician gave the patient notice, as contemplated by Section 766.316, Florida Statutes, or whether any failure to give notice was excused because the patient had an "emergency medical condition," as defined by Section 395.002(9)(b), Florida Statutes, or the giving of notice was not practicable.

PRELIMINARY STATEMENT

On October 26, 2004, Shiren Mustafa and Nehad Mustafa, as parents and natural guardians of Eman Mustafa (Eman), a minor, filed a petition (claim) with the Division of Administrative Hearings (DOAH) to resolve whether Eman qualified for compensation under the Plan.

DOAH served the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the claim on October 26, 2004, and on March 11, 2005, NICA gave notice that it was of the view Eman did not suffer a "birth-related neurological injury," as defined by Section 766.302(2), Florida Statutes, and requested that a hearing be scheduled to resolve whether the claim was compensable. In the interim, Caryn L. Bray, M.D., and University Community Hospital, Inc. (University Community Hospital) were granted leave to intervene, and on April 12, 2005, Petitioners filed an Amended Petition, which apart from requesting a hearing to resolve whether the claim was compensable, requested a finding that Dr. Bray, the physician who provided obstetrical services at Eman's birth, and University Community Hospital, the hospital at which Eman was born, failed to comply with the notice provisions of the Plan. Consequently, the hearing held on December 2, 2005, was noticed to resolve whether the claim was compensable and whether the healthcare providers gave notice, as required by the Plan.

At hearing, Petitioners' Exhibits 1-8, and University Community Hospital (UCH) Exhibits 1 and 2 were received into evidence.[1] Post-hearing, Respondent's Exhibit 1 was received into evidence.[2] No witnesses were called, and no further exhibits were offered.

The transcript of the hearing was filed February 7, 2006, and Respondent's Exhibit 1, the deposition of Michael Duchowny, M.D., taken post-hearing, was filed March 7, 2006. Consequently, the parties were accorded until March 17, 2006, to file proposed orders. (Transcript, page 21). Petitioners and Respondent elected to file proposed orders, but Intervenors declined the opportunity to do so. The parties' proposals have been duly-considered.

FINDINGS OF FACT

Stipulated facts

1. Shiren Mustafa and Nehad Mustafa are the natural parents and guardians of Eman Mustafa, a minor. Eman was born a live infant on February 22, 2002, at University Community Hospital, a hospital located in Tampa, Florida, and her birth weight exceeded 2,500 grams.

2. The physician providing obstetrical services at Eman's birth was Caryn L. Bray, 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.

Eman's birth and immediate postnatal course

3. At or about 8:00 p.m., February 21, 2002, Mrs. Mustafa, with an estimated delivery date of February 15, 2002, and the fetus at 40 6/7 weeks' gestation, was admitted to University Community Hospital, for induction of labor, and proposed vaginal birth, after prior cesarean section (VBAC). At the time, Mrs. Mustafa's membranes were intact; irregular contractions were noted; vaginal examination revealed the cervix closed, effacement at 60-70 percent, and the fetus at station -2; and fetal monitoring revealed a reassuring fetal heart rate, with a baseline in the 130-beat per minute range.

4. At 9:00 p.m., Cervidil was placed to soften the cervix overnight, and by 7:15 a.m., February 22, 2002, vaginal examination revealed the cervix at 1-2 centimeters dilation, effacement at 90 percent, and the fetus at station -1. Cervidil was removed; at 7:40 a.m., the membranes spontaneously ruptured, with clear fluid noted; and Pitocin was started to augment labor. Fetal monitoring contained to reveal a reassuring fetal heart rate.

5. Mrs. Mustafa's labor rapidly progressed and by 8:30 a.m., vaginal examination revealed the cervix at 5 centimeters,[3] effacement complete and the fetus at station 0, and

by 9:30 a.m., vaginal examination revealed complete dilation and effacement, and the fetus at station +2. Late decelerations were also noted at 9:30 a.m., but fetal heart rate was otherwise reassuring.

6. Dr. Bray was paged at 9:32 a.m., and returned the page at 9:39 a.m. At the time, Dr. Bray was notified of Mrs. Mustafa's status and requested that the patient start pushing. However, due to the low station of the fetus, staff requested Dr. Bray's presence for pushing, and Dr. Bray stated she would be bedside in approximately 10 minutes. Thereafter, at 9:58 a.m., further decels were noted, and Pitocin was stopped.

7. At 9:59 a.m., Dr. Bray was noted at bedside, oxygen was applied, fluid bolus started, and fetal heart rate decels to 60 beats per minute were documented. Thereafter, at 10:03 a.m., Mrs. Mustafa was pushing, complaining of pain when abdomen palpated, and fetal heart rate in the 50-beat per minute range was noted. Then, at 10:07 a.m., fetal heart rate in the 50s was noted, with brief accelerations to the 110-beat per minute range, and Dr. Bray requested a Kiwi vacuum.

8. At 10:09 a.m., Kiwi vacuum-assisted delivery, with patient pushing, proved unsuccessful, and fetal heart rate was noted in the 110-beat per minute range, with deceleration back to the 60-beat per minute range. At 10:11 a.m., Dr. Bray

requested fundal pressure, with patient pushing, but again Kiwi vacuum-assisted delivery was unsuccessful, despite three attempts. Medela vacuum was called for and at 10:17 a.m., two attempts at delivery with the Medela vacuum and fundal pressure proved unsuccessful. Then, at 10:19 a.m., with fetal heart rate remaining in the 60-beat per minute range, a stat cesarean section was called for non-reassuring fetal heart rate and suspected uterine rupture.

9. At 10:22 a.m., Mrs. Mustafa was taken to the operating room, where she was admitted at 10:25 a.m.; surgery started at 10:30 a.m., at which time uterine rupture was confirmed; and Eman was delivered at 10:32 a.m., with Apgar scores of 1, 3, and 6, at one, five, and ten minutes respectively.[4] According to the medical records, Eman required resuscitation at birth, with tracheal intubation, IPPV, and cardiac massage, and was then transferred to the neonatal intensive care unit (NICA), where she developed spontaneous respirations, and within two to three hours was weaned from the ventilator.

10. Eman's subsequent newborn course was without incident or evidence of residual effects of birth trauma, and she was discharged with her mother on February 25, 2002. Eman's Discharge Summary included the following observations:

> PHYSICAL EXAMINATION: A term female infant, weight 3329 grams, length 51 cm, and hip circumference 32 cm. Temperature 97.3,

heart rate 158, respiratory rate 62, blood pressure 51/48. HEENT: Normocephalic. Eyes examined at discharge: Pupils were reactive and the red reflex seen. No nasal flaring. Neck supple. Lungs: No retractions. Good air entry. Heart regular rate and rhythm. No murmur. Abdomen soft, no masses, three-vessel cord. Genitalia: Female. Extremities: Moving all limbs, hips stable. No rashes. Neurological: Good tone.

INITIAL IMPRESSION:

1. Term female infant.
2. Perinatal depression.
3. Maternal uterine rupture.
4. Respiratory distress.
5. At once (STAT) cesarean section.

INITIAL TREATMENT:

1. NICU admission.
2. Pulse oximetry monitoring.
3. Conventional mechanical ventilation.
4. Nothing by mouth.
5. Intravenous fluids.
6. Sepsis workup.
7. Antibiotics.
8. Chest x-ray.

PROGRESS:

1. Respiratory: The infant was extubated and weaned to room air within approximately two to three hours of admission. Initial chest x-ray was not significant.

2. Rule out sepsis: The infant was treated with antibiotics; namely, ampicillin and gentamicin for 48 hours. These were discontinued when the cultures remained negative.

3. Fluids and electrolytes: On admission, the infant was given early intravenous fluids, approximately 24 to 48 hours enteral

> feeds were begun and increased progressively. At the present time the infant is breastfeeding only. She is voiding well, passing stools.
>
> 4. Neurological: The infant has good tone and good reflexes, no clonus, and appears to be neurologically normal.
>
> SUMMARY: This is a term female infant who was delivered after having maternal uterine rupture. The infant did require neonatal resuscitation but recovered very quickly. At the present time the infant is doing well and feeding well.
>
> FINAL DIAGNOSIS:
>
> 1. Term female infant.
> 2. Cesarean section.
> 3. Perinatal depression.
> 4. Rule out sepsis.
> 5. Respiratory distress.

Eman's subsequent development

11. Eman's early development was apparently without significant concern until approximately 19 months of age, when she was referred by her pediatrician (Issaam Albanna, M.D.) to Jose Ferreira, M.D., a physician board-certified in neurophysiology and neurology with special qualification in child neurology, for evaluation concerning "some gait disturbance with falling and some coordination problems." Pertinent to this case, Dr. Ferreira reported the results of his initial evaluation of October 6, 2003, as follows:

> I had the pleasure of seeing Eman for initial evaluation today accompanied by her mother and aunt. The main concern is some

gait disturbance with falling and some coordination problems.
They report that she started walking somewhat late at 14-15 months and was doing better initially and then seems to be falling more frequently recently and will walk on her toes at times. There is also some deficits with the coordination where she seems to be "clumsy" at times, hands "clinched" frequently and her muscles "give out" on her apparently more frequently then expected for age. She has been developing speech with about 5 words at this point. She tends to drool frequently . . . . She is potty training currently as she starts to talk with 5-6 words vocabulary . . . .

PAST MEDICAL HISTORY: She was born at full term pregnancy. Birth weight was 7 lb 8 ounces. There was some traumatic delivery as she describes it with uterine rupture and labor requiring a stat cesarean section. She went home with her mother. There was no other problems noted initially.

* * *

GENERAL PHYSICAL EXAMINATION: HC: 45 cm (5th percentile) WT: 23 lb HR: 90 and regular.

HEENT: Unremarkable. Normocephalic. . . . The extremities have full range of motion with no edema, deformities or joint tenderness. The midline back shows no midline defects and no point tenderness to percussion. The skin shows no neurocutaneous findings of significance and there was no dysmorphic features.

NEUROLOGICAL EXAMINATION: Shows she was alert. She was initially showing significant stranger anxiety and then was more comfortable with the examiner as the interview took place. She was able to follow some simple commands from her mother. She did not say any words during the

examination. The cranial nerve examination revealed full extraocular movements and visual fields full to confrontation. The pupils were equal and reactive. The funduscopic exam showed bilateral red reflex. The face is symmetric and the tongue midline with no fasciculations. There was some degree of drooling noted. Her motor exam shows she had no focal weakness. There is no significant increased resistance to pass of motion other than possibly the right upper extremities. She tended to maintain her hands fisted with some cortical thumbs at times specially when she walked. The gait shows she was somewhat stooped forward to a mild degree but otherwise wide based appropriate for age. She tended to fall occasionally. There was no asymmetry of the use of her extremities otherwise except that she tended to hold the right arm more flexed and the right hand more frequently closed and pronated. The deep tendon reflexes showed 2+. There is no sustained ankle clonus. The plantar responses were extensor bilaterally. Gait and coordination showed there was no tremors and no ataxia [failure of musculature coordination][5] of significance other than the tendency to fall which was somewhat limited coordination. The plantar responses were extensor bilaterally.

IMPRESSION:

1. Gait disturbance associated with a mild degree of incoordination with her age with some mild upper motor neuron dysfunction signs as described above in the neurological examination.

* * *

RECOMMENDATIONS:

1. She will have an MRI of the brain without contrast.

> 2. She will have a metabolic screening including serum amino acids, ammonia levels, thyroid functions studies, total carnitine levels, ammonia and lactate and CPK levels.
>
> 3. She will be seen for follow up here in approximately one and a half to two months or earlier if there is any acute changes. Physical and occupational therapy may be recommended at this point . . . .

(Petitioners' Exhibit 2).

12. Eman was reevaluated by Dr. Ferreira on December 15, 2003, and he reported the results of that visit, as follows:

> I had the pleasure of seeing Eman for follow up today accompanied by her parents. As you know, she has a history of difficulties with her gait and some developmental delay and coordination difficulties. She had an MRI of the brain, which was normal with the exception of some sinusitis. She also had a metabolic screen and had elevated T4[,] and T3 and TSH was normal. She continues having difficulties with her gait and coordination. She has had some drooling at times. Her speech has been somewhat delayed and she has approximately 10-15 word vocabulary but difficult to understand and does not show any signs to suggest regression. She has been sleeping and eating well.
>
> * * *
>
> HEENT: Unremarkable. . . . The extremities had full range of motion and no edema.
>
> NEUROLOGICAL EXAMINATION: She was alert and friendly. She was cooperative. Cranial nerve exam revealed full extraocular movements and visual fields grossly full to confrontation. The pupils are equal and reactive. The funduscopic exam shows bilateral red reflex. The face is symmetric and the tongue was midline with no

fasciculations. The motor exams shows she had some difficulties with fine motor coordination. She did not have a good pincer grasp and she tended to keep her hands mostly in a pronated position and somewhat flexed at the elbow and especially when she walked. Her muscle tone was minimally increased in all extremities. Deep tendon reflexes were 2+/2+. The plantar responses were extensor bilaterally. Her gait was minimally spastic with a slightly wide base. She tended to walk somewhat stood forward to a mild degree. When she was sitting she also had some mild degree of truncal ataxia.

IMPRESSION:

1. History of developmental disorder with mild speech and language delay as well as some drooling.

2. Mild degree of spasticity with gait disturbance.

3. There is history of sinusitis.

RECOMMENDATIONS:

1. As her MRI did not show any intracranial pathology an EEG will be done to evaluate for any encephalopathic changes.

2. She was referred to occupational, speech and physical therapy.

3. The thyroid function (T4 was mildly elevated) will be repeated.

4. She will be seen for follow up here in three to four months or earlier if there is any acute changes . . . .

(Petitioners' Exhibit 2).

13. Eman was last evaluated by Dr. Ferreira on February 11, 2004, and he reported the results of that visit, as follows:

> I had the pleasure of seeing Eman for follow up today accompanied by her parents for a history of gait disturbance with some developmental delay and coordination difficulties. She had an EEG done today which showed a mild abnormality with the right occipital rhythm being slightly lower voltage than the left. The EEG was otherwise normal. She is now in physical, occupational and speech therapy. This just started so it is difficult to say whether or not improvement has been noted. Her parents feel however that she has improved. She is learning new words and her parents feel that she is steadily showing improvement. She is falling still but is moving around better than she has previously. They also feel her drooling has improved. She is eating and sleeping well and they have no new concerns today.
>
> * * *
>
> HEENT: Unremarkable. . . . Extremities had full range of motion.
>
> NEUROLOGICAL EXAMINATION: She is awake and alert. She is very cooperative and friendly. She was speaking at times and was smiling. Cranial nerve and motor exams were unchanged from the last evaluation. Her pincer grasp was still not as good as expected for her age and she tended to keep her hands pronated when walking. Her muscle tone was still mildly increased. Deep tendon reflexes were 2+ and she was walking with a slightly wide based gait for age. She was sitting without assistance for short periods of time today but continued with a mild degree of truncal ataxia.

> RECOMMENDATIONS:
>
> 1. The thyroid panel will be repeated as it was requested at the last visit but unable to be completed.[6]
>
> 2. She will continue in the therapies . . . .

(Petitioners' Exhibit 2).

14. According to Dr. Ferreira, as of the last time he saw Eman (February 11, 2004) she was still showing some neurologic deficits, which he described as a mild degree of spasticity (increased muscle tone), with gait disturbance; mild upper motor dysfunction, with a less than age-appropriate pincer grasp and tendency to pronate her hands when walking; and a mild speech and language delay. (See Dr. Ferreira's reports of December 15, 2003, and February 11, 2004, supra, and Petitioners' Exhibit 2, pages 15-21, 28-32, and 42). As for permanency, Dr. Ferreira declined (given the limited contact he had with Eman) to offer an opinion regarding the significance of any dysfunction that might persist. Moreover, Dr. Ferreira, who was not familiar with Eman's birth records or those medical records that predated his evaluation of October 6, 2003, offered no opinion, within a reasonable degree of medical certainty, as to the likely etiology of Eman's neurologic defects (i.e., whether they resulted from brain injury caused by oxygen deprivation or mechanical injury occurring during labor delivery or

resuscitation, or another etiology) or whether Eman suffered any mental impairment.

Subsequent neurologic evaluations

15. On February 23, 2005, Eman was, at NICA's request, evaluated by Michael Duchowny, M.D., a pediatric neurologist associated with Miami Children's Hospital. Dr. Duchowny reported the results of his evaluation, as follows:

> PRE-AND PERINATAL HISTORY: Eman was born in Tampa at University Hospital after a full term gestation. Her birth weight was 7 pounds 9 ounces, and she remained in the nursery for three days.
>
> Eman walked at eighteen months and said single words at two years. She is just beginning toilet training. She is fully immunized and has no known allergies. She has never undergone surgery and has not been hospitalized after birth.
>
> PHYSICAL EXAMINATION reveals an alert, well-developed and well-nourished, cooperative 3-year-old girl. Eman weighs 36 pounds and is 45 inches tall. The skin is warm and moist. There are no neurocutaneous stigmata . . . The spine is straight. The head circumference measures 45.8 centimeters, which is below the 3rd percentile for age. There are no cranial or facial anomalies or asymmetries. The neck is supple without masses, thyromegaly or adenopathy. The cardiovascular examination is unremarkable, and the lung fields are clear. There is no palpable abdominal organomegaly. Peripheral pulses are 2+ and symmetric.
>
> Eman's NEUROLOGIC EXAMINATION reveals her to be socially interactive and cooperative. She has a good attention span and is quite inquisitive. She smiles frequently. She is

> able to understand commands and completes them very clearly. She is quite interactive playing games. She knows body parts. She is behaviorally intact. Cranial nerve examinations reveal full visual fields to confrontation testing. The pupils are 3mm and briskly reactive to direct and consensually presented light. There are full and conjugate extraocular movements. Funduscopic examination is unremarkable with well-defined optic disc margins. There are no significant facial asymmetries. The tongue movements are poorly coordinated. Drooling is noted intermittently. Motor examination reveals static hypotonia with a mild increase in tone in all extremities. There are no contractures and there is full range of motion in all joints. The gait is complex with the left heel being slightly elevated with a mild degree of circumduction at the hips and internal rotation at the ankles. Deep tendon reflexes are 1+ in the upper extremities, 3+ at the knees, and 1+ at the ankles. Plantar responses are downgoing. Sensory examination is intact to withdrawal of all extremities to stimulation. Neurovascular examination reveals no cervical, cranial or ocular bruits and no temperature or pulse asymmetries.

(Petitioners' Exhibit 3).

16. Based on his neurologic evaluation and review of the medical records, Dr. Duchowny was of the opinion that Eman's impairments were most likely developmentally based (the product of atypical brain development), as opposed to birth trauma (brain injury caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery or resuscitation). In so concluding, Dr. Duchowny noted that following delivery,

Eman's hospital course was inconsistent with traumatic brain damage (there being an absence of significant prolonged respiratory depression, an absence of systemic organ involvement, and an absence of seizure activity), and her MRI scan of November 13, 2003, was normal. Dr. Duchowny also noted that Eman's presentation on February 23, 2005, with a pattern of immature muscle control and expressive language delay, was typical of children with developmental disabilities, as opposed to disabilities associated with birth trauma. Finally, Dr. Duchowny was of the opinion that Eman's expressive language delay was mild to moderate, and her motor disability was moderate, as opposed to substantial, and that her condition was likely to improve with time. (Petitioners' Exhibit 4; Respondent's Exhibit 1).

17. Subsequently, on March 11, 2005, Eman was, at University Community Hospital's request, evaluated by S. Parrish Winesett, M.D. a physician board-certified in pediatrics and neurology with special qualification in child neurology. Dr. Winesett reported the results of his evaluation, as follows:

> PHYSICAL EXAMINATION:
> General: Shows a young lady who is alert, who is quite interactive. She smiles easily. She has no obvious dysmorphic features. She has normally placed eyes, ears, nose, philtrum and mouth. Her mental status is that she said single words during my exam. I did not really hear her say sentences. She was rather quiet for the

most part. She seemed to follow directions well. Cranial nerve exam showed her pupils were equal and responsive to light. She seemed to have full visual fields. Her extraocular eye movements were intact. Range of motion in all directions was full. Face was symmetrical with good facial movements in both the upper and lower face. Tongue was midline without any fasiculations. Palate raised symmetrically. She shrugged her shoulders will.

Motor exam seemed to show that she was strong in all four extremities. I could not get her to fully resist me and give her full effort in trying to resist me, but she did seem to be fairly strong in what resistance I could elicit. She does not seem to have any obvious atrophy of the muscles. She seemed to have normal tone and bulk. In particular, I did not detect any asymmetry of tone nor did I detect any hypertonia.

Reflexes in the upper extremities were normal in the biceps, brachial radialis and triceps. In the lower extremities, she did not have any pathologic increase in reflexes, but her patella and ankle reflexes were brisk.

Her motor coordination showed that in reaching with both hands, she seemed to be somewhat jerky and has a very slow approach in reaching for my tape measure. She did not seem to be particularly adept at pushing the buttons and pulling the tape as I would expect a child of three to be. She seemed to be very slow. Finger tapping also seemed to be slow and somewhat labored. She did not diminish her amplitude as she tapped.

Sensation was not extensively tested, but she did seem to acknowledge being touched in all four extremities in a normal fashion. Her gait was clearly abnormal. Her hands while sitting never showed any adduction of the thumbs within the palms. When she

walked, she immediately assumed a posture in which she pulled her arms close to her side, bent her elbows and brought her thumbs within her palm. This was seen each time she started to walk. She did not circumduct her legs but instead seemed to drag her lower extremities and have an almost slapping motion of her feet as she pulled her legs forward. She did not particularly scissor while she was walking. She did not space out her gait while she was walking.

* * *

Review of the medical records provided to me of both the child, as well as the mother . . . showed the following. The child was born on February 22, 2002 as the product of a 41 week pregnancy. There was an attempted vaginal birth after previous C-section. At approximately 10:02, the fetal heart rate was noticed to be decelerating. The obstetrician was called at that time. The child had heart deceleration during this period that was noted in the nurses notes to be down in the 50's and noted in the physician's notes to be in the 70's. The child was then taken to the operating room where the child was born at approximately 10:32. The child, at that time, was handed over to the neonatal resuscitation team who started resuscitation effort and gave the child Apgar scores of 1, 3 and 6 at 1, 5 and 10 minutes. The patient had been intubated by the 3rd Apgar score. The child was taken back to the NICU where at 10:45, a blood gas was performed which showed a pH of 7.31, a PC02 of 22 and a base excess of -18. The child recovered quite quickly and was extubated in approximately two hours. Review of the operating notes showed that there was reported 200 to 300 cc of blood in the uterus and that there was a uterine rupture noted by the physicians at the operation. The child was discharged from the NICU on February 25, 2002 with the neurological exam reported to be normal.

> The child has subsequently been seen by Dr. Jose Ferriera for the same complaints that they presented to me with. He has done an MRI which was read as normal by the Tampa Children's Hospital radiologist. Thyroid function tests were ordered and showed a mild elevation of T_4. . . . A speech therapy evaluation including the Rossetti Infant Toddler Language Scale showed that she scored at the 15 month range at the age of 23 months for her speech skills. There was apparently some splintering of the scoring but mostly within the 15 to 18 month range. An auditory comprehension subtest, she scores at 23 months which is normal. She is also noted to have some oral motor speech difficulties. Physical and occupational therapy evaluations were reviewed but not as significantly to the data.
>
> IMPRESSION: Eman is a young lady who is presenting with predominantly problems in gait disturbance, as well as speech problems. Many of her speech problems could be related to problems in the coordination of her speech. There is a mild increase in reflexes in the lower extremities; however, it does not appear to be a significant degree of hypertonia. Overall, this child appears to have predominant problems with dyscoordination.
>
> This is not a typical presentation for a neonatal hypoxic ischemic encephalopathy syndrome. In addition, the fact that the child recovered so quickly and was extubated within two hours and was discharged within two days makes it highly unlikely that the hypoxia suffered at birth is the cause of the neurologic syndrome.

(Petitioners' Exhibit 3).

18. Based on his neurologic evaluation and review of the medical records, Dr. Winesett was of the opinion that, while of

unknown etiology, it was unlikely Eman's neurologic problems were related to birth trauma. Dr. Winesett also described Eman's motor difficulties as moderate, as opposed to substantial, and offered no opinion regarding her cognitive function. (Petitioner's Exhibit 3, pages 18, 19, 22-26, and 36).

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 an "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."[7] § 766.302(2), Fla. Stat. See also §§ 766.309(1) and 766.31(1), Fla. Stat.

The etiology and significance of Eman's impairments

20. Here, among the physicians who have examined Eman, and who were particularly qualified to address the etiology and significance of her impairments, none concluded that Eman's impairments most likely resulted from brain injury caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitating in the immediate postdelivery period in the hospital, or that Eman was

permanently and substantially mentally and physically impaired. See, e.g., Wausau Insurance Company v. Tillman, 765 So. 2d 123, 124 (Fla. 1st DCA 2000)("Because of the medical conditions which the claimant alleged had resulted from the workplace incident were not readily observable, he was obliged to present expert medical evidence establishing that causal connection."); Ackley v. General Parcel Service, 646 So. 2d 242 (Fla. 1st DCA 1995)(determining cause of psychiatric illness is essentially a medical question, requiring expert medical evidence); Thomas v. Salvation Army, 562 So. 2d 746, 749 (Fla. 1st DCA 1990)("In evaluating medical evidence, a judge of compensation claims may not reject uncontroverted medical testimony without a reasonable explanation."). Therefore, the proof fails to support the conclusion that Eman suffered a "birth-related neurological injury," as required for coverage under the Plan.

The notice provisions of the Plan

21. Given that Eman did not suffer an injury compensable under the Plan, it is unnecessary to address whether the healthcare providers complied with the notice provisions of the Plan. See, e.g., Galen of Florida, Inc. v. Braniff, 696 So. 2d 308, 309 (Fla. 1997)("[A]s a condition precedent to invoking the Florida Birth-Related Neurological Injury Compensation Plan as a patient's exclusive remedy, healthcare providers must, when practicable, give their obstetrical patients notice of their

participation in the plan a reasonable time prior to delivery."); O'Leary v. Florida Birth-Related Neurological Injury Compensation Association, 757 So. 2d 624, 627 (Fla. 5th DCA 2000)("We recognize that lack of proper notice does not affect a claimant's ability to obtain compensation from the Plan. However, a healthprovider who disputes a plaintiff's assertion of inadequate notice is raising the issue of whether a claim can only be compensated under the plan.").

CONCLUSIONS OF LAW

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

23. 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.

24. 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), and 766.305(1), 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(4), Fla. Stat.

25. 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(7), 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.

26. 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 postdelivery 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 postdelivery 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.

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

> injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

28. As the proponent of the issue, the burden rested on Petitioners to demonstrate that Eman 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.")

29. Here, the proof failed to support the conclusion that, more likely than not, Eman's neurologic impairment was the result of a brain or spinal cord injury caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in the hospital, or that Eman was permanently and substantially mentally and physically impaired. Consequently, given the provisions of Section 766.302(2), Florida Statutes, Eman does not qualify for coverage under the Plan. See also §§ 766.309(1) and 766.31(1), Fla. Stat.; 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); 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 physical impairment.)

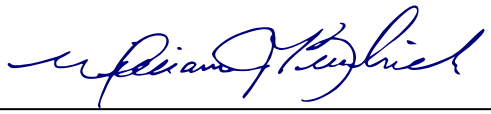
30. Where, as here, the administrative law judge determines that ". . . the injury alleged is not a birth-related neurological injury . . . she or he [is required to] enter an order [to such effect] and . . . cause a copy of such order to be sent immediately to the parties by registered or certified 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 the claim for compensation filed by Shiren Mustafa and Nehad Mustafa, as parents and natural guardians of Eman Mustafa, a minor, is dismissed with prejudice.

DONE AND ORDERED this 28th day of March, 2006, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of March, 2006.

ENDNOTES

1/ With regard to Petitioners' Exhibit 1, the deposition of Caryn Bray, M.D., Respondent reserved certain objections, and was directed to designate post-hearing, by page and line number, the questions and answers to which it had objection. (Transcript, pages 13 and 14). On December 12, 2005, Respondent filed its objection to the following questions and answers: page 98, lines 15-25; and page 99, lines 1 and 2. Upon consideration, it is noted that Dr. Bray's answer is not responsive to the question posed; the record lacks the requisite foundation to demonstrate that Dr. Bray, through her education, training, and experience, is qualified to render an opinion as to the etiology and significance of Eman's neurological problems; and the record lacks the requisite foundation to support a conclusion that Dr. Bray was familiar with the term "birth-related neurological injury," as defined by the Plan. Therefore, Respondent's object is sustained.

2/ With the parties' agreement, NICA took the deposition of Michael Duchowny, M.D., post-hearing, and it was received into evidence as Respondent's Exhibit 1.

3/ There is some discrepancy in the medical records regarding dilation of the cervix at 8:30 a.m. The Interdisciplinary Team

Progress Notes reflect 5 centimeters, whereas the Physician's Progress Notes reflect 6-7 centimeters. Here, the Interdisciplinary Team Progress Notes are likely more accurate; however, the exact extent of cervical dilation is unimportant to the resolution of this case. (See Petitioners' Exhibit 1, pages 56-58)

4/ The Apgar scores assigned to Eman are a numerical expression of the condition of a new born infant, and reflect the sum points gained on assessment of respiratory rate, heart rate, reflex, tone, and color, with each category being assigned a score ranging from the lowest score of 0 through a maximum score of 2. As noted, at one minute, Eman's Apgar score totaled 1, with heart rate being graded at 1, and respiratory rate, reflex, tone, and color being graded at 0. At five minutes, Eman's Apgar score totaled 3, with heart rate being graded at 2, color at 1, and respiratory rate, reflex, and tone being graded at 0. At ten minutes, Eman's Apgar score totaled 6, with respiratory rate and heart rate being graded at 2 each, tone and color being graded at 1 each, and reflex being graded at 0.

5/ See "ataxia," Dorland's Illustrated Medical Dictionary, Twenty-eighth Edition (1994).

6/ Whether the thyroid panel was repeated is not of record.

7/ The definition of "birth-related neurological injury" also includes an "injury to the . . . spinal cord . . . 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. However, in this case there is no contention or proof to support a conclusion that the infant suffered an injury to the spinal cord.

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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.