STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ROBERT BENNETT AND TAMMY BENNETT, INDIVIDUALLY AND AS PARENTS AND NATURAL GUARDIANS OF TRISTAN BENNETT, A MINOR CHILD,	)	
Petitioners,	)	
vs.	)	Case No. 06-2422N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
WILLIAM H. LONG, M.D., ST. VINCENT'S MEDICAL CENTER, INC., and NORTH FLORIDA OBSTETRICAL AND GYNECOLOGICAL ASSOCIATES, P.A.,	)	
Intervenors.	)	

FINAL ORDER

Pursuant to notice, the Division of Administrative Hearings (DOAH), by Administrative Law Judge William J. Kendrick, held a hearing in the above-styled case on July 9, 2007, in Tallahassee, Florida.

APPEARANCES

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For Intervenors William H. Long, M.D., and North Florida Obstetrical and Gynecological Associates, P.A.:

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STATEMENT OF THE ISSUES

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

2. Whether the hospital and the participating physician provided the patient notice, as contemplated by Section 766.316, Florida Statutes, or whether notice was not required 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 July 12, 2006, Robert Bennett and Tammy Bennett, individually and as parents and natural guardians of Tristan Bennett (Tristan), a minor, filed a petition with the Division of Administrative Hearings (DOAH) to resolve whether Tristan qualified for coverage under the Plan, and whether the hospital and the participating physician complied with the notice provisions of the Plan.[1]

DOAH served the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the petition on July 12, 2006, and on October 3, 2006, following an extension of time within which to do so, NICA responded to the petition and gave notice that it was of the view that Tristan 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 the issue. Requests for leave to intervene filed on behalf of William H. Long, M.D., St. Vincent's Medical Center, Inc. (St. Vincent's Medical Center), and North Florida Obstetrical and Gynecological Associates, P.A. (North Florida OB/GYN) were granted by orders of August 1, 2006, October 4, 2006, and January 10, 2007, respectively.

Given the issues raised, a hearing was scheduled for April 11 and 12, 2007, then rescheduled for July 9-13, 2007, to address compensability and notice, and leaving the amount of an award, if any, to be addressed in a separate proceeding. § 766.309(4), Fla. Stat

At hearing, Exhibits 1-32, as identified in the Notice of Filing Stipulated Record, filed July 5, 2007, were received into evidence, as well as Dr. Long's (Doctor's) Exhibits 1-3 and St. Vincent's Medical Center's (Hospital's) Exhibit 1. Petitioners called Tammy Bennett as a witness, and Intervenors presented the testimony of Gary Hawkins, M.D.

The transcript of the hearing was filed July 31, 2007, and the parties were initially accorded until August 10, 2007, to file proposed orders. However, at the parties' request the time for filing proposed orders was extended to August 17, 2007. The parties elected to file such proposals and they have been duly-considered.

FINDINGS OF FACT

Stipulated facts

1. Robert Bennett and Tammy Bennett are the natural parents of Tristan Bennett, a minor. Tristan was born a live infant on September 26, 2001, at St. Vincent's Medical Center, a licensed hospital located in Jacksonville, Florida, and her birth weight exceeded 2,500 grams.

2. Obstetrical services were delivered at Tristan's birth by William H. Long, 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.

Mrs. Bennett's antepartum course and Tristan's birth

The accident

3. Mrs. Bennett's antepartum course was without apparent complication until approximately 7:05 a.m., September 26, 2001, when Mrs. Bennett was involved in a motor vehicle accident in Macclenny, Florida, when the right front tire of the SUV she was driving at low speed slid into a drainage ditch in front of her home and struck a culvert, flattening the tire.[2] At the time, the fetus was at term (38+ weeks' gestation), with an estimated delivery date of October 8, 2001. However, given a previous cesarean section and breech presentation, Mrs. Bennett was scheduled to have a cesarean section at St. Vincent's Medical Center on October 3, 2001.

4. Baker County Emergency Medical Services (EMS) responded to the scene, and following arrival (at 7:15 a.m.) noted a chief complaint of lower back and abdominal pain. Assessment revealed the abdomen to be soft, but tender.

5. Mrs. Bennett was immobilized supine on a backboard, provided oxygen (O_2) by nasal cannula (nc), and transported to Ed

Fraser Memorial Hospital (also known as Baker County Community Hospital) in Macclenny.[3]

The Ed Fraser Memorial Hospital admission

6. Mrs. Bennett arrived at Ed Fraser Memorial Hospital at 7:33 a.m. Initial vital signs were obtained at 7:42 a.m., showing a blood pressure of 134/101, heart rate of 108, and oxygen saturation of 97%. Chief complaint when triaged at 7:45 a.m., was noted as "MVA Restrained G[ravida]3 P[ara]2 back/abd[ominal] pain." She was noted to be alert and cooperative, with coherent speech, and physical examination was within normal limits.

7. Cheryl Kennedy, R.N., an ER nurse in the Ed Fraser Memorial Hospital emergency department, used a handheld Doppler to evaluate fetal heart tones "[i]mmediately upon the patient arriving in the emergency room." Mrs. Kennedy testified that her note "FHT 118 (placenta)" on the Triage Sheet meant that "[t]he sound from the Doppler was more indicative that that was the placenta that we were picking the heart rate up from, versus from the fetus." Stated otherwise, the entry most likely reflected a maternal heart rate and not a fetal heart tone (FHT). (Exhibit 14, pages 10, 11, and 42).

8. At 8:00 a.m., Mrs. Bennett was evaluated by the emergency room physician, Wayne Oberti, M.D. Dr. Oberti's history documented a complaint of lower back pain, denial of

abdominal pain, minimal chest tightness, no neck pain, no change in vision, and the development of some nausea, vomiting and diarrhea over the course of her admission. Dr. Oberti's physical examination noted the abdomen as soft, nontender; that movement of the right lower extremity precipitated low back pain; and that he was unable to identify fetal heart beat (FHB) with handheld Doppler.[4] Other findings were not shown to be remarkable. A one-view lumbar spine x-ray and pregnancy sonogram for fetal heart rate (FHR) were ordered by Dr. Oberti.

9. Mrs. Bennett was removed from the backboard after Dr. Oberti's examination, and at 8:10, following an episode of vomiting, was taken to x-ray via stretcher, where she had an x-ray of her lumbar spine (that was unremarkable). Then Mrs. Bennett was moved into the hallway, where she waited on the stretcher for the sonogram. There she had an episode of nausea, vomiting and diarrhea, was cleaned and taken into a room for the sonogram, and then returned to the emergency room at 9:00 a.m.

10. The extent of Mrs. Bennett's sonogram is a subject of controversy. One film/sheet containing six sonogram images exists for the sonogram study. Each of the images on the film contain the time the image was taken. The first image was timed at 8:45 a.m., and the last image was timed at 9:00 a.m. Two of the six images contain a fetal heart rate, the first reading being 146 beats per minute and the second reading, obtained at

9:00 a.m., being 133 beats per minute, all within normal limits (120 to 160 beats per minute). However, Jessica Knabb, the ultrasound technician, testified it was likely more images were obtained, since there were usually four to five sheets for such a study. (Exhibit 15, page 7). Moreover, at the time it was the hospital's policy to provide the original films if a request to review the study was made by third parties, and the study was requested on a number of occasions. (Exhibit 21). Therefore, it is likely that some of the films from the sonogram study (taken after Mrs. Bennett's episode of nausea and before the film that exists for 8:45 a.m., to 9:00 a.m.) are missing.

11. Although the film of record documents a reassuring fetal heart rate, Dr. Oberti testified that he was advised by "whoever answered the phone in the ER" that the sonogram study revealed a heart rate in the 80s, and he so documented the report on the Emergency/Outpatient Department record as "FHR 80s" and initiated Mrs. Bennett's transfer via helicopter (LifeFlight) to St. Vincent's Medical Center for presumed "fetal distress." The Physician Certificate of Transfer, signed by Dr. Oberti at 9:10 a.m., noted the availability of labor and delivery services, with fetal monitoring and back-up surgical services at St. Vincent's Medical Center, as the reasons for transfer. (Exhibit 16, pages 22, 23, and 79; Exhibit 3).

12. Before transfer, and following her return to the emergency room at 9:00 a.m., Mrs. Bennett was given O_2 via nc, normal saline (NS) by IV for hydration, Phenergan for nausea, and a Foley catheter was placed in preparation for her transfer to St. Vincent's Medical Center by LifeFlight. Notably, the records of Baker County EMS and Ed Fraser Memorial Hospital make no mention of Mrs. Bennett being in labor, Dr. Oberti and Mrs. Bennett were of the opinion she was not in labor,[5] and monitoring on presentation to St. Vincent's Medical Center, discussed infra, provides support for their opinions.

LifeFlight

13. LifeFlight arrived at Ed Fraser Memorial Hospital at 9:25 a.m., and departed with Mrs. Bennett at 9:41 a.m. The LifeFlight records note that Mrs. Bennett complained of high abdominal pain and low back pain following a car accident at a low rate of speed in which she was a restrained driver. The LifeFlight record then states:

> . . . Pt was taken to x-ray for a sonogram at which FHT were noted to be in the 80's for about a 10 min. period. . . . It was determined that there was fetal distress and LifeFlight was called for emergent transport.

Notably, the LifeFlight records do not reflect where the information regarding the "10 min. period" of fetal bradycardia came from, and LifeFlight personnel did not recall who provided

the information. Moreover, Dr. Oberti denied that a fetal heart rate in the 80s was ever reported for a 10 minute period, and the hospital records contain no such documentation. (Exhibit 16, pages 32 and 33; Exhibit 3).

14. The LifeFlight records also state that Dr. Oberti performed a vaginal/cervical examination of Mrs. Bennett at Ed Fraser Memorial Hospital:

> . . . Cervical exam done by Dr. Oberti at 0800 with report of 2cm dilation and no drainage or bloody show.

However, Dr. Oberti denied having performed a vaginal examination of Mrs. Bennett, and the hospital records contain no such documentation. (Exhibit 16, pages 38, 53, and 74; Exhibit 3).

15. Here, there is no reason to question the integrity and professionalism of the LifeFlight paramedics. Indeed, they had no apparent reason to fabricate the information reported and the most likely source of the information was hospital personnel. However, under the circumstances, that does not make the information reliable and it remains hearsay which, there being no apparent exception to its admissibility, cannot support a finding of fact. § 120.57(1)(c), Fla. Stat. ("Hearsay evidence may be used for the purpose of supplementing or explaining other evidence, but it shall not be sufficient in itself to support a

finding unless it would be admissible over objection in civil actions.")

St. Vincent's Medical Center

16. Mrs. Bennett's transfer via LifeFlight was without incident, and at 9:59 a.m., she was admitted to labor and delivery at St. Vincent's Medical Center and placed on external fetal monitoring. At the time, an "irritable" uterus was noted, with contractions of mild intensity, lasting 30-45 seconds, consistent with placental abruption (at an unknown stage) and not labor.[6] Fetal monitoring was reassuring, with a fetal heart rate baseline in the 150s, with average long-term variability and accelerations present.

17. Mrs. Bennett was continuously monitored until 12:47 p.m., when fetal monitoring was discontinued and she was taken to the operating room for a cesarean section delivery. During that period, Mrs. Bennett's contractions were always mild, and did not increase in intensity, did not increase in duration, and demonstrated a pattern consistent with an irritable uterus due to placental abruption, unlikely to produce cervical change.[7] Stated otherwise, the record reveals that, more likely than not, Mrs. Bennett was not in labor, when monitoring was discontinued at 12:47 p.m., or, there being no persuasive evidence to support a contrary conclusion, thereafter.[8] During the same period, fetal monitoring continued

to reveal a reassuring fetal heart rate, with a fetal heart rate baseline in the 160s, with average long-term variability.[9]

18. Of note, Dr. Long wrote an Admit Note at 12:15 p.m., which stated:

> C[hief]/c[omplaint]/ A[utomobile]A[ccident] this AM H[istory] 31 y[ear] o[ld] G[ravida]3 P[ara]2 L[ast]M[enstrual]P[eriod] = 12-31-00 = EDC 10-8-01 [with] E[stimated]G[estational]A[ge]38 wks S[tatus]/P[ost] previous C[esarean]/S[ection] involved in single car A[utomobile]A[ccident] this AM [with] blunt trauma from steering wheel to abd[omen]. Pt was taken by rescue to Frazier Memorial Hosp where eval showed no evidence of sig[nificant] trauma but ? FHT to 80 B[eats]P[er]M[inute]. Pt sent to St V's by helicopter. On arrival here F[etal]H[eart]T[ones] in 150's. Pt c[omplained]/o[f] uterine c[ontraction] & vague discomfort. She has sl[ight] lower back pain. Fetus is active. No vag[inal] bleeding or ROM.
> P[ast]M[edical]H[istory] Migraines . . .
> Exam [Blood pressure] 131/86 [Pulse] 87 [Temperature] 99.2 {Respirations] 18
> F[etal]H[eart]T[ones] 150-160's . . .
> Abd[omen] F[undal]H[eight][consistent with] term [gestation] Breech Sl[ightly] tender diffusely. C[ervi]x Post[erior] 1-2 [cm dilated] 30[% effaced] -3 [station] BR[eech] Ext(remities] w[ithin]n[ormal]l[imits] E[lectronic]F[etal]M[onitor] [shows] mild [every] 1-2 min ctx F[etal]H[eart]T[ones] 160.
> Ass[essment]: Previous C[esarean]/S[ection] at term; Breech; A[utomobile]A[ccident] with ? abruption.
> Plan: Will proceed with repeat C/S . . .

(Exhibit 7; Exhibit 20, pages 40-42).

19. Of further note, Dr. Long wrote an addendum at 12:40 p.m., which stated:

> Pt has had no urine output since admission. Foley has been replaced [with] only small am[ount] of blood tinged fluid. U[ltra]/S[ound] ? [shows] no fluid vis[ible] in bladder.
>
> * * *
>
> Ass[essment]: No urine output. Prob[able] adeq[uate] hydration R[ule]/O[ut] Bladder injury; R[ule]/O[ut] developing anemia ? hypovolemia ? ?U[rinary]O[utput]. Pl[an]: Will repeat CBC, PT PTT. Will proceed [with] C[esarean]/S[ection] & abd[ominal] exploration & eval[uation] g[enito]u[rinary] for poss[ible] trauma.

20. With regard to Tristan's delivery, the medical records reveal that at 1:16 p.m., the operation started (the incision was made/delivery began); at 1:21 p.m. Mrs. Bennett's membranes were ruptured, with clear fluid noted; and at 1:22 p.m., Tristan was delivered without difficulty or trauma. Evidence of a partial placental abruption was noted.

21. At delivery, Tristan did not cry, had minimal respiratory effort, and required resuscitation, with bulb, free flow oxygen, mechanical suction, and bag and mask ambu. Apgar scores of 6 and 8 were reported at one and five minutes respectively.[10] Cord blood gas revealed profound metabolic acidosis, with an arterial cord pH of 6.76, PCO_2 51.2, PO_2 of 17,

and a base excess (BE) of -28. Venous cord pH was reported as 7.18, PCO_2 as 46.6, PO_2 as 20 and BE as -10.3.

22. Following delivery, Tristan was transferred to the newborn nursery, where she was received at 1:45 p.m., and placed on a heated warming table. Initial assessment noted slight wetness throughout lung fields, bilateral chest rise, tachypnea, no nasal flaring, occasional expiratory grunting, no retractions, pale pink color with slight acrocyanosis, and improving tone. Arterial blood gas collected at 1:47 revealed a pH of 7.14, PO_2 of 90, PCO_2 of 31.7, and BE of -16.4. Under the circumstances, Tristan was transferred to the special care nursery for further management, due to moderate respiratory distress and metabolic acidosis.

23. Tristan was admitted to the special care nursery at 2:10 p.m., and placed on a radiant warmer. Initial assessment noted oxygen saturation (SaO_2) at 97% on room air; color pale, pink; mild grunting, with slight retractions; and moderate lethargy. Tristan was provided respiratory support (NS bolus, free flow oxygen, and O_2 via nc) and bicarbonate therapy; her respiratory distress and metabolic acidosis resolved fairly quickly; and by 9:30 p.m., her respiration was noted as unlabored, skin remained pale/pink, and she was sleeping quietly.

Tristan's subsequent neonatal course

24. The medical records related to Tristan's subsequent neonatal course reveal that prior to her pulmonary arrest on October 3, 2001, Tristan suffered from renal failure and acute tubular necrosis (ATN), with resulting oliguria, fluid retention, and hyponatremia; respiratory distress; elevated liver enzymes; and was placed on empiric antibiotics for possible sepsis. However, while Tristan's metabolic acidosis and multi-organ system failure support the conclusion she suffered a hypoxic ischemic insult before, during, and likely immediately following delivery, physician progress notes during the days following her delivery repeatedly document the absence of neurologic involvement or neurological damage. Pertinent entries read:

[9/28/01]

> PE: pink, alert, active . . . appears clinically stable.

[9/28/01 3:15 p.m.]

> Neuro grossly intact, symmetric exam, no focal deficits . . . Suspect renal failure/ATN, and probably . . . hyponatremia . . . Suspect must have suffered some asphyxia damage in MVA.

[9/29/01 7:45 a.m.]

> Neuro-Active Alert . . .

[9/30/01 5:30 p.m.]

No evidence of CNS [central nervous system] dysfunction at present.

[10/1/01 10:05 p.m.]

Neuro grossly intact . . . (8)Asphyxia - infant [with] S[ymptoms] C[onsistent]/w[ith] asphyxial/hypoxic organ damage. Remains in ATN, oliguric phase, [with] blood, pro[ein] in urine. Creatinine cont to increase. LFT's also elevated, though actually improving.

No other organ damage evident @ this time.

* * *

(10) CNS - No neuro abnormalities noted . . . .

[10/2/01 11:45 a.m.]

No focal neuro deficits, Active & Alert . . . .

(8) Asphyxia: Multiorgan failure . . . .

(10) CNS No obvious neuro abnormalities.

[10/3/01 a.m.]

#8 Asphyxia: Multiorgan involvement . . . . No evidence of CNS involvement.

25. On October 3, 2001, at approximately 9:30 a.m., the Special Care Nursery Flow Sheet documents that Tristan suffered from a pulmonary hemorrhage, with frank blood noted orally, and a moderate amount of blood was suctioned by bulb. At 10:30 a.m., Tristan was noted to be apneic (not breathing), with a heart rate below 80 beats per minute and slowly decreasing;

oxygen saturation (SaO_2) was decreasing to the 40 percent (%) range; and a large amount of frank blood was noted coming from the mouth. At 11:00 a.m., Tristan was intubated, placed on a ventilator, and received transfusions of red blood cells and fresh frozen plasma beginning at 11:18 a.m. and 11:30 a.m., respectively.

26. At 3:00 p.m., Tristan's heart rate was noted in the 40s, with saturations at 45%, and suctioning obtained a large amount of blood-tinged mucous. At 3:23 p.m., Tristan's heart rate was 53, saturations decreased from 40% to 23%, and CPR, with Ambu and chest comparisons, was begun. At 3:26 p.m., CPR was stopped; at 3:27 p.m., heart rate was noted at 77 and saturations at 68%; and at 3:29 p.m., heart rate was noted at 90, slowly increasing to 108, and saturations at 65%. Tristan's arterial blood gas collected at 3:34 p.m., showed a pH of 7.03 and a BE of -12.2. At 3:39 p.m., a large amount of thick, blood-tinged mucous was again suctioned, and at 3:43 p.m., more blood-tinged mucous was suctioned.

27. At 3:48 p.m., Tristan's heart rate had decreased to 28, and her saturations to 39%. By 3:55 p.m., Tristan's heart rate had increased slowly to 66, and saturations to 50%, and at 3:57 Tristan's heart rate had increased to 132, and saturations

to 89%. Arterial blood gas collected at 4:10 p.m., showed a pH of 6.88 and a BE of -23.5.

28. Tristan remained critically unstable throughout the rest of the day and evening of October 3, 2001, and between 11:20 p.m., and 11:30 p.m., staff noted the likely onset of seizure activity ("Baby having stiffening of legs & arm trembling."). Physician's Progress notes document additional neurologic abnormalities following the October 3 arrest and resuscitation:

> [10/4/01 11:20 a.m.]
>
> Possible seizure last night . . .
> #10 CNS: Had no obvious CNS dysfunction till last night.
>
> [10/5/01 11:00 a.m.]
>
> (10) CNS tremors on PB [Phenobarbital] . . . EEG in progress. Dr. Gama consulted office aware.
> (A) ? Seizures Encephalopathy?
> (P) Neuro consulted . . . CT when stable.

29. A neurological consult by Dr. Gama on October 5, 2001, describes Tristan's hospital course leading up to the October 3, 2001, arrest and then states:

> The baby developed thrombocytopenia and then progressively started bleeding with associated pulmonary bleeding. This was controlled with appropriate ventilatory support; however, a second episode of pulmonary hemorrhage occurred, this time associated with significant decline and requiring some resuscitation. This occurred on 10/3. The patient following this was

noted to have some jerking movements of her extremities which were easily controlled with pressure. However because of her clinical decline, it was felt that this represented seizure activity. The baby was bloused with phenobarbital. The level was followed but because of recurrence of these symptoms, the patient was rebolused today. The patient's phenobarbital is 23 today. An electroencephalogram has been obtained but is still pending in its results. Neurologic consultation is obtained.

* * *

PHYSICAL EXAMINATION:

The patient's examination demonstrates a head circumference of 33.5 cm. The baby is sedated, intubated, and with an umbilical catheter in place. The head demonstrates a normotensive anterior fontanelle. The sutures are unremarkable. There is some scalp edema secondary to slight fluid overload most likely secondary to her renal disease process. Pupils were 1 mm and equal. Doll's eyes were present. The patient's sucking reflex is decreased. Rooting reflex is decreased. She is intubated through her mouth. The patient's motor examination shows that she is floppy with decreased muscle tone throughout, retraction response is absent, head control is absent, motor reflex is absent. The baby withdraws extremities to touch. The deep tendon reflexes are hypoactive. Babinski could not be elicited. Palmar and plantar grasp are decreased. Spine shows no particular abnormalities . . . .

IMPRESSION

1. New onset seizures most likely secondary to multiple factors including:

a. Status post pulmonary hemorrhage.
b. Hypoxic ischemic encephalopathy.

c. Metabolic as well as possible dysmorphogenic causes.
d. Rule out central nervous system hemorrhage.

2. Acute tubular necrosis secondary to hypotension, metabolic acidosis and possibly hypoxemia.

3. Liver dysfunction.

4. Disseminated intravascular coagulation.

5. Status post metabolic acidosis.

6. Status post hypertension.

7. Status post maternal motor vehicle accident and trauma . . . .

30. CT scan performed October 29, 2001, showed multicystic encephalomalacia of the cortex. EEG's performed October 5, 2001, October 8, 2001, October 17, 2001, and November 2, 2001, were all abnormal, showing background disorganization suggestive of diffuse cerebral dysfunction.

31. Tristan was discharged home on November 14, 2001, with follow-up appointments with her primary care physician (Carithers Pediatrics), as well as nephrology (for renal status), neurology (Dr. Gama), and physical and occupational therapy.

32. Thereafter, on November 27, 2001, Dr. Gama reported the results of a follow-up neurologic evaluation to Tristan's pediatrician (Dr. Julie Baker), and concluded:

> In general, it is my opinion that Tristan is status post severe perinatal distress with hypoxic ischemic encephalopathy, metabolic acidosis, associated with coagulopathy and complicated with one cardiac arrest requiring resuscitation while at the special care nursery. The result of all these complications is culminated with what appears to be a severe hypoxic ischemic encephalopathy with multicystic encephalomalacia and seizure disorder . . .

(Exhibit 10).

Coverage under the Plan

33. 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 . . . 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."[11] § 766.302(2), Fla. Stat. See also §§ 766.309 and 766.31, Fla. Stat.

34. Here, it is undisputed that Tristan suffered brain injury, caused by oxygen deprivation, which rendered her permanently and substantially mentally and physically impaired. What must be resolved is whether the record supports a conclusion that, more likely than not, such injury occurred "in the course of labor, delivery, or resuscitation in the immediate postdelivery period," as required for coverage under the Plan. As to that issue, Petitioners were of the view that while

Tristan may have suffered oxygen deprivation at St. Vincent's Medical Center between 12:47 p.m. (when the fetal monitor was disconnected and Mrs. Bennett was moved from labor and delivery to the operating room for a cesarean section delivery) and 1:22 p.m., September 26, 2001 (when Tristan was delivered), Mrs. Bennett was never in labor, and Tristan did not suffer neurologic injury or evidence profound neurologic impairment ("permanent and substantial mental and physical impairment") until after her pulmonary arrest on October 3, 2001. In contrast, NICA was of the view that Tristan's neurologic impairments resulted from a brain injury caused by oxygen deprivation (secondary to a partial placental abruption), that occurred following the automobile accident the morning of September 26, 2001, and prior to her transfer from Ed Fraser Memorial Hospital to St. Vincent's Medical Center, and that Mrs. Bennett was not in labor at the time. Finally, Intervenors were of the view that Tristan suffered a brain injury, and profound neurologic impairment, caused by oxygen deprivation at St. Vincent's Medical Center between 12:47 p.m. and 1:22 p.m., that Mrs. Bennett was in labor when the fetal monitor was disconnected, and that injury likely continued into the immediate postdelivery period. (Prehearing Stipulation).

The statutory presumption

35. Pertinent to this case, Section 766.309(1)(a), Florida Statutes, provides:

> . . . 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. 766.302(2).

36. "Claimant," as that term is used in the Plan, is defined by Section 766.302(3), to mean:

> . . . any person who files a claim pursuant to s. 766.305 for compensation for a birth related neurological injury to an infant. Such a claim may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, personal representative, or other legal representative thereof.

37. Notably, in this case it is not the Petitioners (Claimants) who seek the benefit of the presumption, but the Intervenors, who urge its application over Petitioners' objection. Consequently, it must be resolved whether any party, other than Petitioners (Claimants) may claim the presumption (i.e., that the injury occurred "in the course of labor, delivery, or resuscitation in the immediate postdelivery period"). If so, it must then be resolved whether there was

credible evidence produced to support a contrary conclusion and, if so, whether absent the aid of such presumption the record demonstrates, more likely than not, that Tristan's injury occurred during labor, delivery, or resuscitation.[12]

38. The ultimate goal in construing a statutory provision is to give effect to legislative intent. Bellsouth Telecommunications, Inc. v. Meeks, 863 So. 2d 287 (Fla. 2003). "In attempting to discern legislative intent, we first look to the actual language used in the statute." Id. at 289. "If the statutory language used is unclear, we apply rules of statutory construction and explore legislative history to determine legislative intent." Id. at 289. "Ambiguity suggests that reasonable persons can find different meanings in the same language." Forsythe v. Longboat Key Beach Erosion Control District, 604 So. 2d 452, 455 (Fla. 1992). "[I]f the language of the statute under scrutiny is clear and unambiguous, there is no reason for construction beyond giving effect to the plain meaning of the statutory words." Crutcher v. School Board of Broward County, 834 So. 2d 228, 232 (Fla. 1st DCA 2002).

39. Here, the language chosen by the legislative is clear and unambiguous. The presumption is for Petitioners' (Claimants') benefit, and is not available to aid other parties in satisfying their burden to establish that Tristan's brain injury occurred in the course of labor, delivery, or

resuscitation. 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 of an issue before an administrative tribunal."). Moreover, there was credible evidence produced (in Tristan's medical records) to support a contrary conclusion, and to require resolution of the issue without regard to the presumption.

The likely timing of the brain injury that rendered Tristan profoundly, neurologically impaired

40. To address the cause and timing of Tristan's neurologic impairment, the parties offered the medical records related to Mrs. Bennett's antepartal course, as well as those associated with Tristan's birth and subsequent development. Additionally, the parties offered the deposition testimony of many of the health care providers who were involved with Mrs. Bennett's care on September 26, 2001, and Tristan's birth. Finally, the parties offered the testimony of four expert witnesses to support their respective positions. Offered by Petitioners was the testimony of Richard Fields, M.D., a physician board-certified in obstetrics and gynecology, and Norman Pryor, M.D., a physician board-certified in pediatrics and pediatric nephrology; offered by Respondent was the testimony of Donald Willis, M.D., a physician board-certified in

obstetrics and gynecology, and maternal-fetal medicine; and offered by Intervenors was the testimony of Gary Hankins, M.D., a physician board-certified in obstetrics and gynecology and maternal-fetal medicine. Oddly, no party offered the testimony of a neurologist or neonatologist to address, apart from the observations of the health care providers who were involved in Tristan's care, the likely timing of the brain injury that rendered Tristan profoundly, neurologically impaired.

41. The medical records, as well as the testimony of the physicians and other witnesses, have been thoroughly reviewed. Having done so, it must be resolved that the record developed in this case compels the conclusion that, more likely than not, Tristan suffered multi-system failure as a consequence of the oxygen deprivation she suffered between 12:47 p.m. (when the fetal monitor was disconnected and Mrs. Bennett was moved to the operating room) and 1:22 p.m. (when Tristan was delivered), that likely continued during the immediate postdelivery resuscitative period. However, it is unlikely Tristan suffered a brain injury or substantial neurologic impairment until after she experienced profound episodes of oxygen deprivation on October 3, 2001, following the onset of pulmonary hemorrhaging and pulmonary arrest.

42. In so concluding, it is noted that Tristan was delivered atraumatically, she responded rapidly to resuscitation

immediately after delivery, her neurologic examinations during the first seven days of life were normal, she suffered prolonged and severe decreases in fetal heart rate and saturations on October 3, 2001, she manifested prolonged and severe acidosis following her arrest, and she evidenced seizure activity and neurologic decline thereafter. Given the proof, it is likely, more so than not, that Tristan's profound neurologic impairments resulted from a brain injury caused by oxygen deprivation that occurred October 3, 2001, and not during labor, delivery, or resuscitation in the immediate postdelivery period in the hospital. Consequently, Tristan was not shown to have suffered a "birth-related neurological injury" as defined by the Plan, and the claim is not compensable. § 766.302(2), Fla. Stat. See also Nagy v. Florida Birth-Related Neurological Injury Compensation Association, 813 So. 2d 155, 160 (Fla. 4th DCA 2002)("According to the plain meaning of the words written, the oxygen deprivation or mechanical injury must take place during labor and delivery, or immediately afterward.").

The notice issue

43. Apart from contesting compensability, Petitioners also sought the opportunity to avoid a claim of Plan immunity in a civil action, by requesting a finding that the notice provisions were not satisfied by the health care providers. See 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, health care providers must, when practicable, give their obstetrical patients notice of their participation in the plan a reasonable time prior to delivery."). Consequently, it is necessary to resolve whether the hospital and the participating physician complied with the notice provisions of the Plan. Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings, 948 So. 2d 705, 717 (Fla. 2007)("[W]hen the issue of whether notice was adequately provided pursuant to section 766.316 is raised in a NICA claim, we conclude that the ALJ has jurisdiction to determine whether the health care provider complied with the requirements of section 766.316."). Accord O'Leary v. Florida Birth-Related Neurological Injury Compensation Association, 757 So. 2d 624, 627 (Fla. 5th DCA 2000)("All questions of compensability, including those which arise regarding the adequacy of notice, are properly decided in the administrative forum."); University of Miami v. M.A., 793 So. 2d 999 (Fla. 3d DCA 2001); Tabb v. Florida Birth-Related Neurological Injury Compensation Association, 880 So. 2d 1253 (Fla. 1st DCA 2004).

The notice provisions of the Plan

44. At all times material hereto, Section 766.316, Florida Statutes, prescribed the notice requirements of the Plan, as follows:

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

45. Section 395.002(9)(b), Florida Statutes, defines "emergency medical condition" to mean:

> (b) With respect to a pregnant woman:
>
> 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

> 2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
>
> 3. That there is evidence of the onset and persistence of uterine contractions[13] or rupture of the membranes.

46. The Plan does not define "practicable." However, "practicable" is a commonly understood word that, as defined by Webster's dictionary, means "capable of being done, effected, or performed; feasible." Webster's New Twentieth Century Dictionary, Second Edition (1979). See Seagrave v. State, 802 So. 2d 281, 286 (Fla. 2001)("When necessary, the plain and ordinary meaning of words [in a statute] can be ascertained by reference to a dictionary.").

The NICA brocure

47. Responding to Section 766.316, Florida Statutes, NICA developed a brochure (as the "form" prescribed by the Plan), titled "Peace of Mind for an Unexpected Problem" (the NICA brochure), which contained a clear and concise explanation of a patient's rights and limitations under the Plan, and distributed the brochure to the participating physicians and hospitals so they could furnish a copy of it to their obstetrical patients.[14] (Exhibit 4 to Exhibit 25).

Findings related to notice

48. Mrs. Bennett received her prenatal care at St. Vincent's Division I, one of a number of offices in the

Jacksonville area operated by North Florida OB/GYN, a group practice comprising numerous physicians. At the time, three obstetricians who delivered babies were on staff at St. Vincent's Division I: Dr. William Long, Dr. Thomas Virtue, and Dr. Scott Wells. Dr. Long, who had delivered Mrs. Bennett's two previous children (boys, born in 1993 and 1997), was Mrs. Bennett's primary ob/gyn. However, as a group practice, all physicians rotated delivery calls at the hospital, so it was possible another physician would participate in the delivery. Consequently, a patient commonly saw all the delivering physicians during prenatal care. Notably, all physicians associated with the St. Vincent's Division I, who delivered babies, were participating physicians in the Plan.

49. On February 5, 2001, Mrs. Bennett presented to St. Vincent's Division I for her initial prenatal visit. At the time, consistent with established routine, Kathryn Becker, R.N., the OB care coordinator, met with Mrs. Bennett to discuss her case, take a patient history, and provide her with a number of forms to complete and sign, including: a Consent for Obstetrical Delivery form; Florida's Healthy Start Prenatal Risk Screening Instrument; a Consent for Human Immunodeficiency Virus form; a Genetic Screening Supplement; and a Notice to Obstetric Patient form (to acknowledge receipt of the NICA brochure) and a NICA brochure. The Notice to Obstetric Patient provided:

NOTICE TO OBSTETRIC PATIENT
(See Section 766.316, Florida Statutes)

I have been furnished information by North Florida OB/GYN prepared by the Florida Birth Related Neurological Injury Compensation Association, and have been advised that they are a participating practice in the program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth Related Neurological Injury Compensation Association (NICA), Barnett Bank Building, 315 South Calhoun Street, Suite 312, Tallahassee, Florida 32301, (904) 488-8191. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this _____ day of _____, 2001.

_____ Attest:_____
Signature of Patient Nurse/Physician

_____ Date:_____
(Name of Patient) Printed

_____
Social Security Number

_____
Witness to Signature

Mrs. Bennett signed the form, acknowledging receipt of the NICA brochure and Nurse Becker witnessed her signature.

50. Here, there is no dispute that Mrs. Bennett signed the Notice to Obstetric Patient or any debate that she received a copy of the NICA brochure on her initial visit. Rather, what is at issue is whether the form, which provides "I have been

furnished information by North Florida OB/GYN prepared by the Florida Birth-Related Neurological Injury Compensation Association, and have been advised that they are a participating practice in the program," coupled with what Mrs. Bennett was told during her initial visit, was adequate to place Mrs. Bennett on notice that Dr. Long was a participant in the Plan.

51. As described by Nurse Becker, during the course of the initial visit, her custom and practice when discussing NICA was to inform the patient that "all of the doctors in our practice that deliver babies participate" and then "explain the pamphlet . . . [,] point out the information inside, that it tells them briefly about it [,and] [t]he back tells them who it's with and how to contact them." Here, Nurse Becker is confident she followed her routine, since she witnessed Mrs. Bennett's signature on a number of documents, including the Notice to Obstetric Patient, and documented her routine through an entry on the ACOG Antepartum Record. That entry read "NOB [new obstetric] Interview [with] PNV, PNL, Consents, NICA, Healthy Start, prentatal education & literature completed; PTL, SAB & safety info given." (Exhibit 25, pages 6, 15, and 39; Exhibit 1 to Exhibit 25).

52. Giving due consideration to the proof, it must be resolved, contrary to Petitioners' view, that the Notice to

Obstetric Patient, although it did not specifically name St. Vincent's Division I, was not misleading, and that when coupled with Nurse Becker's disclosure that "all of the doctors in our practice that deliver babies participate," was adequate to place Mrs. Bennett on notice that all physicians at that office who delivered babies participated in the Plan. In so concluding, it is noted that Mrs. Bennett had been a patient of Dr. Long's for an extended period, that all her prenatal care was at St. Vincent's Division I, and the only logical conclusion a reasonable person could draw from receiving this information was that Dr. Long and the other physicians in the office who did deliveries were participating physicians. Accordingly, the proof demonstrates Dr. Long satisfied the notice provisions of the Plan. See Jackson v. Florida Birth-Related Neurological Injury Compensation Association, 932 So. 2d 1125 (Fla. 5th DCA 2006).

53. In all, Mrs. Bennett had 14 prenatal visits at St. Vincent's Division I, with the last two being on September 18 and 24, 2001. Of note, on September 18, 2001, Mrs. Bennett, who had a previous cesarean section (with her second child) and presented with a breech, voiced her election to proceed with a repeat cesarean section. Accordingly, she met with staff at St. Vincent's Division I that day, staff coordinated with St. Vincent's Medical Center, and surgery was

scheduled for October 3, 2001. Notably, there is no proof that at any time prior to her admission of September 26, 2001, Mrs. Bennett visited or otherwise contacted St. Vincent's Medical Center.

54. At or about 9:59 a.m., September 26, 2001, Mrs. Bennett was admitted to labor and delivery at St. Vincent's Medical Center for monitoring, and at or about 11:20 a.m., she was formally admitted. At that time, her attending nurse, Christine May, R.N., provided Mrs. Bennett with a number of forms to sign, including a Consent to Anesthesia, Parental Acknowledgment of Preventative Safety Measures, and a Notice to Obstetric Patient (to acknowledge receipt of the NICA brochure) and a NICA brochure. The Notice to Obstetric Patient provided:

> NOTICE TO OBSTETRIC PATIENT
> (See Section 766.316, Florida Statutes)
>
> I have been furnished information by St. Vincent's Medical Center prepared by the Florida Birth Related Neurological Injury Compensation Association, and have been advised that Dr. Long[15] is a participating physician in the program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth Related Neurological Injury Compensation Association (NICA), Barnett Bank Building, 315 South Calhoun Street, Suite 312, Tallahassee, Florida 32301, (904) 488-8191. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this ____ day of _____, 2001.

_____
Signature of Patient

_____
(Name of Patient) Printed

_____
Social Security Number

_____
Witness to Signature

Attest:

_____
Nurse or Physician

Date:_____

Mrs. Bennett signed the form, acknowledging receipt of the NICA brochure, and Nurse May witnessed her signature.

55. Here, Petitioner contends that "[g]iven the fact that Mrs. Bennett had pre-registered for her scheduled cesarean section delivery, it was practicable for St. Vincent's Medical Center to have given Mrs. Bennett notice of NICA participation prior to two hours before delivery." Therefore, Petitioners conclude, "St. Vincent's Medical Center failed to comply with the notice provisions of the Plan." (Petitioners' Proposed Final Order on Compensability and Notice, paragraph 54). However, as previously noted, the scheduling of Mrs. Bennett's cesarean section with St. Vincent's Medical Center was done by

staff at St. Vincent's Division I, and there is no proof that Mrs. Bennett visited or had any contact with St. Vincent's Medical Center. Accordingly, the notice provided Mrs. Bennett on September 26, 2001, was timely, as prior notice was not practicable.[16]

CONCLUSIONS OF LAW

Jurisdiction

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

Compensability

57. 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.

58. 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.

59. 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.

60. 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.

61. 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.

62. As the proponent of the issue, the burden rested on Intervenors to demonstrate that Tristan 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.").

63. Here, the proof failed to support the conclusion that, more likely than not, Tristan suffered an injury to the 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 that rendered her permanently and substantially mentally and physically impaired. Indeed, the more compelling proof demonstrated that any injury Tristan suffered, that resulted in profound neurologic impairment, post-dated the immediate postdelivery period. Consequently, given the provisions of Section 766.302(2), Florida Statutes, Tristan 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); Nagy, 813 So. 2d at 160 ("[T]he oxygen deprivation or mechanical

injury must take place during labor, delivery, or immediately afterward.").

Notice

64. Apart from contesting compensability, Petitioners also sought the opportunity to avoid a claim of Plan immunity in a civil action, by requesting a finding that the notice provisions of the Plan were not satisfied by the health care providers. As the proponent of the immunity claim, the burden rested on the health care providers to demonstrate, more likely than not, that the notice provisions of the Plan were satisfied. See Tabb v. Florida Birth-Related Neurological Injury Compensation Association, 880 So. 2d 1253, 1260 (Fla. 1st DCA 2004)("The ALJ . . . properly found that '[a]s the proponent of the issue, the burden rested on the health care provider to demonstrate, more likely than not, that the notice provisions of the Plan were satisfied.'"). Galen of Florida, Inc. v. Braniff, 696 So. 2d 308, 311 (Fla. 1997)("[T]he assertion of NICA exclusivity is an affirmative defense."); id. at 309 ("[A]s a condition precedent to invoking the Florida Birth-Related Neurological Injury Compensation Plan as a patient's exclusive remedy, health care providers must, when practicable, give their obstetrical patients notice of their participation in the plan a reasonable time prior to delivery."). Here, for reasons appearing in the Findings of Fact, the participating physician and hospital

demonstrated that they complied with the notice provision of the Plan.

Disposition

65. 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 petition filed by Robert Bennett and Tammy Bennett, individually and as parents and natural guardians of Tristan Bennett, a minor, is dismissed with prejudice.

DONE AND ORDERED this 3rd day of October, 2007, 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
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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of October, 2007.

ENDNOTES

1/ According to the petition, the claim was filed following the entry of an order abating a civil suit "pending administrative determination" of compensability under the Plan.

2/ Mrs. Bennett testified she was restrained (with shoulder harness and lap belt), described the ditch as two to three feet deep, and estimated her speed to be 3-5 miles per hour. While the front tire was blown, no further damage to the vehicle was noted.

3/ Ed Fraser Memorial Hospital had no obstetrical services. However, it was apparently the closest medical facility that could screen Mrs. Bennett after her motor vehicle accident.

4/ The hospital was not equipped to provide continuous monitoring for fetal heart rate and uterine activity.

5/ On examination, Dr. Oberti noted Mrs. Bennett's abdomen as soft, nontender, did not feel any contractions, and concluded she was not in labor. (Exhibit 16, pages 55, 56, and 71).

6/ Dr. Long described uterine "irritability" as "some tightening of the uterus, but without any defined pattern or regularity." (Exhibit 20, page 32). "Labor" is commonly understood to mean the onset of regular contractions that result in cervical changes. See Exhibit 23, pages 31 and 61. See also "Labor" Dorland's Illustrated Medical Dictionary, 28th Edition, 1994 ("The first [stage of labor](the stage of cervical dilatation) begins with the onset of regular uterine contractions and ends when the os is completely dilated.").

7/ Dr. Long performed a vaginal exam at or about 12:15 p.m., and noted the cervix to be 1-2 centimeters dilated 30 percent effaced, and the fetus at -3 station. Notably, such is essentially an uneffaced cervix and essentially no different that she exhibited during prenatal examinations on September 12 and 18, 2001. See Exhibit 23, pages 58-61, and Exhibit 24, pages 39, 91, and 92.

8/ On this issue, the deposition testimony of Doctors Fields and Willis was most persuasive. (Exhibits 23 and 24).

9/ No fetal monitor strips exist after 12:47 p.m., that would assist in assessing fetal status. However, an isolated check just prior to surgery revealed a fetal heart rate of 166 beats per minute.

10/ The Apgar scores assigned to Tristan are a numerical expression of the condition of a newborn infant, and reflect the sum points gained on assessment of heart rate, muscle tone, respiratory effort, reflex irritability, and color, with each category being assigned a score ranging from the lowest score of 0 through a maximum score of 2. See Dorland's Illustrated Medical Dictionary, 28th Edition, 1994. Here, at one minute, Tristan's Apgar score totaled 6, with heart rate being graded at 2, and muscle tone, respiratory effort, reflex irritability, and color being graded at 1 each. At five minutes, Tristan's Apgar totaled 8, with heart rate, respiratory effort, and reflex irritability being graded at 2 each, and muscle tone and color being graded at 1 each. While low at one minute, Tristan's five minute Apgar was normal.

11/ In its entirety, Section 766.302(2), Florida Statutes, provides:

> (2) Birth-related neurological injury" means 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.

Here, there is no suggestion, or proof to support a conclusion that, Tristan suffered an injury to the brain caused by mechanical injury or that Tristan suffered an injury to the spinal cord. Consequently, those alternatives need not be addressed.

12/ Where, as here, a presumption is "established primarily to facilitate the determination of a particular action in which the presumption is applied, rather than to implement public policy, [it] is a presumption affecting the burden of producing evidence." § 90.303, Fla. Stat. The nature and effect or usefulness of such a presumption in assessing the quality of the proof was addressed in Berwick v. Prudential Property and Casualty Insurance, Co., 436 So. 2d 239, 240 (Fla. 3d DCA 1983), as follows:

> Unless otherwise provided by statute, a presumption established primarily to facilitate the determination of an action, as here, rather than to implement public policy is a rebuttable "presumption affecting the burden of producing evidence," see § 90.303, Fla. Stat. (1981), a "bursting bubble" presumption, see C. Ehrhardt, supra, at §§ 302.1, 303.1. Such a presumption requires the trier of fact to assume the existence of the presumed fact unless credible evidence sufficient to sustain a finding of the non-existence of the presumed fact is introduced, in which event the bubble bursts and the existence of the fact is determined without regard to the presumption. See § 90.302(1), Fla. Stat.

> (1981); C. Ehrhardt, supra, at § 302.1; see generally Ladd, Presumptions in Civil Actions, 1977 Ariz.St.L.J. 275 (1977)

Accord Caldwell v. Division of Retirement, 372 So. 2d 438 (Fla. 1979), Public Health Trust of Dade County v. Valcin, 507 So. 2d 596 (Fla. 1987), and Insurance Company of the State of Pennsylvania v. Estate of Guzman, 421 So. 2d 597 (Fla. 4th DCA 1982. See also Gulle v. Boggs, 174 So. 2d 26, 29 (Fla. 1965), citing with approval Tyrrell v. Prudential Insurance Co., 109 Vt. 6, 192 A. 184, 115 A.L.R. 392, wherein it was stated:

> Presumptions disappear when facts appear; and facts are deemed to appear when evidence is introduced from which they may be found.

13/ The first stage of "labor" is commonly understood to "begin[] with the onset of regular uterine contractions." Dorland's Illustrated Medical Dictionary, 28th Edition, 1994. "Regular," is commonly understood to mean "[o]ccurring at fixed intervals, periodic." The American Heritage Dictionary of the English Language, New College Edition (1979). Similarly, "persistent," as the term is used in Section 395.002(9)(b)3., Florida Statutes, is commonly understood to mean "[i]nsistently repetitive or continuous." Id.

14/ In their petition and Pre-Hearing Stipulation, Petitioners contended the NICA brochure did not comply with the notice provisions of the Plan because it did not include a "clear and concise explanation of a patient's rights and limitations under the plan." However, no party addressed that argument at hearing or post-hearing. Nevertheless, it is found that the NICA brochure "include[s] a clear ['[f]ree from doubt or confusion'] and concise ['[e]expressing much in few words; succinct'] explanation ['the process of making plain and comprehensible'] of a patient's rights and limitations under the plan." See "clear," "concise," "explanation," The American Heritage Dictionary of the English Language, New College Edition (1979). See also Jackson v. Florida Birth-Related Neurological Injury Compensation Association, 932 So. 2d 1125, 1128 (Fla. 5th DCA 2006)("The pamphlet contains a clear and concise explanation of a patient's rights and limitations under the NICA plan, as is required by the terms of the statute."); Dianderas v. Florida Birth-Related Neurological Injury Compensation Association, DOAH Case No. 04-3652, Final Order on Compensability and Notice, May 8, 2006, appeal pending; Coble v. Florida Birth-Related Neurological Injury Compensation Association, DOAH Case No. 06-

3883N, Order on Compensability and Notice, May 4, 2007, appeal pending.

15/ Dr. Long's name was handwritten on the form by Nurse May.

16/ The hospital's and physician's alternative suggestion that the giving of notice was excused because when she presented to St. Vincent's Medical Center on September 26, 2001, she had a "medical emergency" as defined by Section 395.002(9)(b), Florida Statutes, is not tenable since there is no competent proof of record to support such a conclusion.

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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.