

STATE OF FLORIDA  
DIVISION OF ADMINISTRATIVE HEARINGS

LAURA STEVER, AS PERSONAL )  
REPRESENTATIVE OF THE ESTATE OF )  
HARPER DEAN STEVER, A DECEASED )  
MINOR, AND LAURA STEVER AND )  
JOSEPH DEAN STEVER, JR., )  
INDIVIDUALLY AND AS THE NATURAL )  
PARENTS OF HARPER DEAN STEVER, )  
A DECEASED MINOR, )  
 )  
Petitioners, )  
 )  
vs. ) Case No. 06-2487N  
 )  
FLORIDA BIRTH-RELATED )  
NEUROLOGICAL INJURY )  
COMPENSATION ASSOCIATION, )  
 )  
Respondent, )  
 )  
and )  
 )  
ORLANDO REGIONAL HEALTHCARE )  
SYSTEM, INC., d/b/a ORLANDO )  
REGIONAL SOUTH SEMINOLE )  
HOSPITAL, )  
 )  
Intervenor. )  
\_\_\_\_\_ )

FINAL ORDER

Pursuant to notice, the Division of Administrative Hearings, by Administrative Law Judge William J. Kendrick, held a hearing in the above-styled case on February 26, 2007, by video teleconference, with sites in Tallahassee and Orlando, Florida.

For Petitioners: William E. Ruffier, Esquire  
Dellecker Wilson King McKenn  
& Ruffier, LLP  
719 Vassar Street  
Orlando, Florida 32804-4920

For Respondent: Robert J. Grace, Jr., Esquire  
Stiles, Taylor & Grace, P.A.  
Post Office Box 460  
Tampa, Florida 33606

For Intervenor: Bradley P. Blystone, Esquire  
Marshall, Dennehey, Wagner, Coleman  
& Goggin  
315 East Robinson Street, Suite 550  
Orlando, Florida 32801

STATEMENT OF THE ISSUE

At issue is whether Harper Dean Stever, a deceased minor, qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

PRELIMINARY STATEMENT

On July 6, 2006, Laura Stever, as Personal Representative of the Estate of Harper Dean Stever (Harper), a deceased minor, filed a petition (claim) with the Division of Administrative Hearings (DOAH) for compensation under the Plan. Subsequently, Laura Stever and Joseph Dean Stever, Jr., individually and as the natural parents of Harper, were joined as Petitioners. (Order, dated February 26, 2007.)

DOAH served the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the claim on July 17, 2006, and on August 30, 2006, NICA responded to the

petition and gave notice that it was of the view that Harper 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. In the interim, Orlando Regional Healthcare System, Inc., d/b/a Orlando Regional South Seminole Hospital (South Seminole Hospital), was accorded leave to intervene.

At hearing, Respondent's Exhibits 1 and 2,<sup>1</sup> and Intervenor's Exhibits 1-5<sup>2</sup> were received into evidence. Post-hearing, the deposition of Charles Brill, M.D., was filed and, with the parties' agreement, received into evidence as Intervenor's Exhibit 6. No witnesses were called, and no further exhibits were offered.

The transcript of the hearing was filed March 21, 2007, and the parties were accorded 10 days from that date to file proposed orders. Respondent and Intervenor elected to file such proposals and they have been duly-considered.

#### FINDINGS OF FACT

##### Stipulated facts

1. Laura Stever and Joseph Dean Stever, Jr., are the natural parents of Harper Dean Stever, a deceased minor, and Mrs. Stever is the Personal Representative of her deceased son's estate.

2. Harper was born a live infant on October 16, 2004, at South Seminole Hospital, a licensed hospital located in Longwood, Florida, and died October 22, 2004. Harper's birth weight exceeded 2,500 grams.

3. The physician providing obstetrical services at Harper's birth was Christopher Quinsey, 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.

4. The hospital and the participating physician complied with the notice provisions of the Plan. § 766.316, Fla. Stat.  
Harper's birth and newborn course

5. At or about 8:42 a.m., October 16, 2004, Mrs. Stever, with an estimated delivery date of October 10, 2004, and the fetus at 40 6/7 weeks' gestation, presented to South Seminole Hospital with complaints of contractions and blood-tinged fluid discharge since 6:00 a.m. At the time, moderate, regular contractions (at a frequency of 1 1/2 to 2 minutes) were noted; the membranes were intact; vaginal examination revealed the cervix at 2 centimeters dilation, 90 percent effacement, and the fetus at -1 station; and fetal monitoring was reassuring for fetal well-being, with a fetal heart rate in the 150s, with positive long-term variability, accelerations, and no decelerations.

6. Following admission, Mrs. Stever was given morphine with Vistaril for pain (at 9:15 a.m.), and monitoring continued to reveal a reassuring fetal heart rate in the 150s and regular uterine contractions. However, at approximately 9:20 a.m., fetal monitoring began to evidence fetal tachycardia (with a fetal heart rate above 160 beats per minute), with some decrease in variability, and at 10:20 a.m., Mrs. Stever recorded a temperature of 100.2, with a fetal heart rate in the 170s.

7. Mrs. Stever was given an IV for hydration (at 10:30 a.m.), Tylenol for her fever (at 10:40 a.m.), and Ampicillin for presumed early chorioamnionitis (at 10:42 a.m.). Nevertheless, fetal tachycardia continued, and at 11:30 a.m., the fetal heart rate was noted as 180 with decreasing long-term variability. Therefore, since the tachycardia had not responded to the hydration, antibiotics, and Tylenol, and notwithstanding Mrs. Stever's labor had progressed ("to 4 cm dilated, 90% effaced, with a bulging bag"), the decision was made (at 12:05 p.m.) to proceed with a cesarean section because of "extended fetal tachycardia with non-reassuring fetal surveillance."

8. Mrs. Stever was prepared for surgery, and at 12:22 p.m., the external fetal monitor was removed and Mrs. Stever was moved to the operating room, where she was received at 12:27 p.m. Of note, when removed, the fetal monitor

revealed a fetal heart tone of 175 to 180 beats per minute, minimal variability, no accelerations, and no decelerations. Of further note, the Intraoperative Nurses Notes reveal a fetal heart tone of 182 beats per minute at 12:36 p.m. (Intervenor's Exhibit 1, page 109.)

9. At 12:43 p.m., the incision was made (surgery started), and at 12:48 p.m., Harper was delivered. According to the medical records, a copious amount of thick meconium stained fluid was extruded through the incision at the time of entry into the uterine cavity, and Harper's head was delivered without difficulty and his nose and mouth were DeLee suctioned by Dr. Quinsey on the abdomen. Then, the nuchal cord was reduced and the rest of Harper was delivered atraumatically, the cord was doubly clamped and cut (so the cord blood could be drawn, and the child's blood chemistry at the time of birth ascertained), and Harper was passed off to the awaiting resuscitation team.

10. Harper was immediately placed in a preheated radiant warmer, dried briefly, and suctioned. Heart rate was initially noted at 100 and Harper was given free flow oxygen. However, he still did not breathe spontaneously, and his heart rate rapidly slowed to 60, requiring Ambu bag and mask, and chest compressions. At 12:50 p.m., with a heart rate still at 60 and Harper's color noted as cyanotic, a "Code Blue 45" was called.

11. At 12:51 p.m., Harper was intubated (with an endotracheal tube), and his heart rate returned to 160 with 40 seconds of chest compressions and ventilation. At 12:55 p.m., heart rate remained at 160, color was noted as pink, and ventilation continued with Ambu and endotracheal tube (ET). By 1:05 p.m., the code ended, and Harper (with a heart rate above 140) was moved to the special care nursery by the code team, with continued ventilation by Ambu and ET. Notably, although successfully resuscitated (revived) in the operating room, the respiratory failure Harper suffered since birth persisted, and he would require continuous respiratory support to survive.

12. Harper's Apgar scores were noted as 1, 5, and 7, at one, five, and ten minutes respectively. (Intervenor's Exhibit 1, page 91.) Cord blood was drawn at 1:00 p.m., and revealed an umbilical artery pH of 7.112, PCO<sub>2</sub> of 75.3, PO<sub>2</sub> of 4.5, O<sub>2</sub>-SAT of 1.3%, and BE of -8.0. (Intervenor's Exhibit 1, page 9; Intervenor's Exhibit 2, page 677.)

13. The Apgar scores assigned to Harper are a numerical expression of the condition of a newborn infant, and reflect the sum points gained on assessment of heart rate, respiratory effort, reflex irritability, muscle tone, and color, with each category being assigned a score ranging from the lowest score of 0 through a maximum score of 2. See Dorland's Illustrated

Medical Dictionary, 28th Edition, 1994; Intervenor's Exhibit 1, page 91. Such scores help the physician decide what resuscitative efforts may be required for the baby.

(Respondent's Exhibit 1, page 41.)

14. As noted, Harper's one minute Apgar score was 1, with heart rate being graded at 1 (under 100 beats per minute), and respiratory effort (none), reflex irritability (absent), muscle tone (flaccid), and color (central cyanosis) being graded at 0. At five minutes, Harper's Apgar score totaled 5, with heart rate being graded at 2 (above 100 beats per minute), reflex irritability (medium), muscle tone (lazy) and color (peripheral cyanosis) being graded at 1 each, and respiratory effort being graded at 0. At ten minutes, Harper's Apgar score totaled 7, with heart rate, reflex irritability (good), and color (pink) being graded at 2 each, muscle tone being graded at 1, and respiratory effort being graded at 0. (Intervenor's Exhibit 1, page 91.)

15. Following admission to the special care nursery (at 1:05 p.m.) Harper was assessed and placed on a ventilator (full ventilatory support with endotracheal intubation). Newborn assessment noted a heart rate of 140, pale pink color, hypotonic tone, depressed activity, and no cry. Blood sugar at 1:20 p.m., was noted as 51 (hypoglycemic). (Intervenor's Exhibit 2, pages 601 and 675.)



16. Given Harper's acute respiratory failure, an order was entered to transfer Harper to the neonatal intensive care unit (NICU) at Arnold Palmer Hospital for Children and Women, and at 1:50 p.m., the Arnold Palmer Hospital neonatal transport team arrived at South Seminole Hospital to assume responsibility for Harper's care. In the interim, the progress notes reveal Harper to have been fairly stable on the ventilator, with oxygen (O<sub>2</sub>) saturations above 95 percent, color pale pink and responding to tactile stimulation. (Intervenor's Exhibit 2, pages 675.)

17. When the transport team assumed Harper's care at 1:50 p.m., he appeared relatively stable, with a mean blood pressure of 49, and an O<sub>2</sub> saturation level of 92 percent. (Intervenor Exhibit 2, page 285.) However, by 2:30 p.m., he appeared dusky with poor perfusion, and his O<sub>2</sub> saturation level was 85 percent. In response, Harper was given a volume expander (normal saline) and Ambu'd with 100 percent oxygen. However, while his O<sub>2</sub> saturation level briefly improved to 99 percent, it remained unstable and over time, despite efforts to stabilize Harper (with Ambu ventilation, sodium bicarbonate for metabolic acidosis, volume expanders, Dobutamine, Fentanyl, Ampicillin, and Gentamicin) it dropped to the 70s (by 3:45 p.m.) and 60s (by 4:40 p.m.), and his mean blood pressure dropped into the 30s. Chest X-ray at 2:37 p.m., was reported as follows:

FINDINGS: . . . Lungs are distinctly abnormal showing severe opacification bilaterally in a very diffuse pattern. On the first day of life I would not expect the child to present hyaline membrane disease. I do not see blunting of the costophrenic angles to suggest pleural fluid associated with Beta strep pneumonia. Pneumonia is not ruled out but I am more suspicious of edema from heart disease or meconium aspiration that is quite severe . . . .

IMPRESSION:

1. Severe lung opacity bilaterally raising question of edema from meconium aspiration . . . .

18. The transport team left South Seminole Hospital at 4:50 p.m. (with O<sub>2</sub> saturations at 65 percent and mean blood pressure at 40) and arrived at Arnold Palmer Hospital at 5:30 p.m. (with O<sub>2</sub> saturations at 57 percent and a mean blood pressure of 37). During transport, Harper was Ambu'd with Fi O<sub>2</sub> 100 percent.

19. On admission to the neonatal intensive care unit at Arnold Palmer Hospital, Harper was noted to be cyanotic (pale gray), with saturations in the 50s despite positive pressure ventilation, poor perfusion, and adventitial breath sounds (rales and rhonchi) over all fields. Diagnoses on admission included hypotension, meconium aspiration syndrome, persistent pulmonary hypertension newborn, pneumonia-congenital, respiratory distress-newborn, and sepsis-newborn.

20. Harper was started on high frequency oscillator ventilation (HFOV) and Dopamine was added to his interventions to support his blood pressure (BP). However, Harper's condition did not improve, and at 7:44 p.m., he was placed on veno-venous extracorporeal membrane oxygenation (V-V ECMO).<sup>3</sup> Chest X-ray at 6:14 p.m. (pre-ECMO) revealed "[h]yperinflation, diffuse infiltrates and right pleural effusion," and chest X-ray at 10:27 p.m., revealed "[w]orsening diffuse pulmonary infiltrates, now severe." (Intervenor's Exhibit 2, pages 301 and 297.) Ultrasound Echoencephalogram pre-ECMO was read as normal, with the following findings:

The ventricles are of normal size and symmetrical bilaterally. No intracerebral hemorrhages or other intracranial abnormalities are apparent.

21. Harper continued to require increasing pressor support with little effect (i.e., a "mean BP of 40 and arterial saturations of 75% on maximal ventilatory support"). Accordingly, given Harper's continued deterioration, he was changed from V-V ECMO to veno-arterial (V-A) ECMO on October 17, 2004, at 2:15 p.m. Oxygen saturations were noted to rise to 85 percent and blood pressure rose to a mean of 70. Ultrasound Echoencephalogram on October 17, 2004, was normal.

22. On October 18, 2004, Harper remained on V-A ECMO, with saturations in the 90s, and on Dopamine and Dobutamine, with a

mean BP of 58. At 7:30 a.m., twitching was noted, consistent with seizure activity, and again at 2:30 p.m., and 10:15 p.m. (Intervenor's Exhibit 2, page 630.) Phenobarbital was prescribed. Ultrasound Echoencephalogram revealed "[s]mall bilateral Grade I germinal matrix hemorrhages."

23. On October 19, 2004, Harper remained on V-A ECMO, with saturations in the mid 90s, and on Dopamine and Dobutamine, with a mean BP of 44-49. Seizure episodes continued, as did treatment with Phenobarbital. Ultrasound Echoencephalogram revealed "[s]table bilateral Grade I intracranial hemorrhages," and no new hemorrhages.

24. On October 20, 2004, Harper remained on V-A ECMO, with saturations in the mid 90s, and on Dopamine and Dobutamine, with a mean BP of 40-50s. Seizure activity continued, and Harper was treated with Phenobarbital and Fosphenytoin. Ultrasound Echoencephalogram revealed a "[s]uspected bilateral Grade II intracranial hemorrhage."

25. On October 21, 2004, Harper remained on V-A ECMO, with saturations in the mid 90s, and on Dopamine and Dobutamine, with a mean BP of 50-60s. Some increase in acidosis over the last 24 hours was noted. Seizure activity continued, as did treatment with Phenobarbital and Fosphenytoin. Ultrasound Echoencephalogram revealed "[s]uspect bilateral choroid plexus hemorrhages."

26. On October 22, 2004, neurologic evaluation noted that Harper continued with frequent seizure episodes, and near continuous clonic, jerking activity of the lower extremities. Harper was noted to be acidotic, with generalized edema, jaundice, no spontaneous movement, boggy scalp, and decreased movement. Ultrasound Echoencephalogram revealed "a new 1.5 x 2.1 cm hemorrhagic cyst within the right parietal cerebral parenchyma . . . equivalent to a Grade IV germinal matrix hemorrhage."

27. Given Harper's heparinization<sup>4</sup> and contraindications of ECMO with severe intracranial hemorrhage, Harper was removed from ECMO and died soon thereafter, at 12:40 p.m., October 22, 2004. At the time, active diagnoses included hypotension, intraventricular hemorrhage, meconium aspiration syndrome, persistent pulmonary hypertension newborn, pneumonia-congenital, and sepsis-newborn.

28. An autopsy was performed October 22, 2004. The report included the following anatomic findings:

II. RESPIRATORY SYSTEM:

- A. Hyaline membrane disease.
- B. Acute bronchopneumonia with large areas of necrosis.
- C. Fungal lung abscess with secondary cyst formation.

III. CENTRAL NERVOUS SYSTEM:

- A. Intraventricular hemorrhage.
- B. Arachnoidal congestion and hemorrhage.
- C. Cerebellar fungal infarct.
- D. Periventricular leukomalacia.

IV. PLACENTA (S-04-31353) Large for gestational age placenta, three vessel cord, no acute chorioamnionitis is seen.<sup>[5]</sup>

The likely cause and timing of Harper's brain injury

29. To address the cause and timing of Harper's brain injury, the parties offered the medical records related to Mrs. Stever's antepartal course, as well as those associated with Harper's birth and subsequent development. Additionally, the parties offered the deposition testimony of William D. Rhine, M.D., a physician board-certified in pediatrics, and neonatal-perinatal medicine; Charles B. Brill, M.D., a physician board-certified in pediatrics, and neurology with special competence in child neurology; and Donald C. Willis, M.D., a physician board-certified in obstetrics and gynecology, and maternal-fetal medicine.<sup>6</sup>

30. The medical records and the testimony of the parties' experts have been thoroughly reviewed. Having done so, it must be resolved that among the physicians who addressed the cause and timing of Harper's brain injury, Dr. Rhine was the more

qualified to address the issues, and his testimony most candid and compelling.<sup>7</sup>

31. Dr. Rhine expressed his opinions on the likely cause and timing of Harper's brain injury, as follows:

[Examination by Mr. Grace]

A. [Harper suffered] [p]rocesses during birth, including meconium aspiration during labor and delivery, that led to respiratory failure and ultimately to his death. Along with that, that respiratory failure that was obviously caused by . . . meconium in his lungs [, were] bouts of low oxygen and low blood pressure in the first couple hours of life that led to ongoing resuscitative efforts and escalation of care until he finally got onto ECMO bypass.

I think before he got onto ECMO bypass, that more likely than not, he had suffered substantial injury from his low oxygen and low blood pressure. Ultimately, that substantial injury was impacted by him being on ECMO and was a significant or proximate cause of his having bleeding into his brain, which led to the decision for the cessation of ECMO and his death thereafter.

Q. . . . Let's back up for a minute, Doctor. Did an hypoxic event occur?

A. Did a hypoxic event occur?

Q. Yes, sir.

A. Yes. Actually, I mean several events occurred.

Q. Were you talking about several hypoxic events?

A. Yes.

Q. Will you take me through them and point out each hypoxic event as you have found in the records.

A. I think even before birth, there was enough hypoxic event to lead to this child having pulmonary hypertension and passage of meconium. Okay?

Q. Uh-huh.

A. And then there was a transient hypoxic event right at birth . . . .

And then in the hours after he was born, as his care was escalated and they still tried to stabilize his respiratory or pulmonary status, he had basically prolonged episodes of low oxygen and low blood pressure until he finally got onto ECMO in the evening of the 16th of October.

\* \* \*

Q. Now, with regard to this first hypoxic event that you have identified sometime before birth, as you termed it, did it actually lead to injury to the child?

A. Yes.

Q. And what was the injury?

A. Well, it led to meconium -- the passage of meconium, which led to meconium aspiration and the evolution of pulmonary hypertension.

\* \* \*

Q. Okay. Was there a brain injury when the child was born?

A. I don't know.



Q. You have no opinion with regard to that?

A. Not to a reasonable medical probability, no.

Q. Do you have an opinion, Doctor, if the child did in fact suffer a brain injury during labor and delivery?

A. Again, I don't know.

Q. Do you have an opinion whether the child suffered a brain injury at any time prior to being placed on ECMO?

A. Yes, I do have an opinion.

Q. What is that opinion?

A. That he did suffer a brain injury in the hours after delivery and before he got put on ECMO.

Q. And at what point did the child suffer the brain injury? Are you able to pinpoint that for us?

A. Not with precision in terms of time. I can describe the physiologic events that I think were associated with the brain injury, and that itself describes the timeframe.

Q. Okay.

A. So there is -- first of all, I think that there is a compromise of blood and oxygen flow in the minutes after birth, and there is limited improvement physiologically thereafter, and then within two and a half hours, he starts having the onset of low levels of oxygen and low levels of blood pressure that more likely than not are going to lead to brain -- that did lead to brain injury.

Q. And this is two and a half hours after birth, Doctor?

A. Yes.

Q. Is that the first event you could look at that your opinion would lead to brain injury?

A. No. I talked to someone about the compromise right around birth. That -- you know, the fact that he needed to be resuscitated, gets cardiac compressions, gets intubated, et cetera, that's going to be an initial insult. I can't say whether or not that alone, in and of itself, would have caused substantial injury, but it contributed to the injury that I did think became substantial later on that afternoon once his saturations and blood pressures fell again.

Q. Okay. And how did it contribute?

A. Well, basically, the way that the brain responds to low blood and oxygen levels is that you can have a compromise of oxygen to the tissues, and then if it's repeated and recurrent, you are that much more susceptible to oxygen and blood deprivation within the next couple of hours or so.

\* \* \*

Q. Do you place any significance on the cord gas ph in terms of ruling in or out neurological injury?

A. Yes.

Q. Okay. And in terms of this child, what was the cord gas ph?

A. . . . [I]t is 7.11. So the one that's collected at 13:07, that one? [<sup>8</sup>]

Q. Yes, sir.

A. Okay. . . . assuming it's umbilical artery, the oxygen level is quite low, but it is not profoundly acidotic, and the acidosis is both a mixed, metabolic and respiratory.

\* \* \*

Q. What about the base excess level, Doctor?

A. . . . The base axis is minus eight.

Q. So my question is going to be do you place any significance on the base excess level being minus eight?

A. Yes.

Q. And what significance do you attach to that?

A. [F]irst of all, I should say this is very minimal metabolic acidosis. . . . [I]f this is an umbilical arterial gas, there is probably not enough acidosis to be associated with brain injury at that time.

Q. And that is at the time the cord gas level is taken, correct?

A. Well, it's actually at the time of birth. It took about 19 minutes for them to get over to the cord and to draw it or something. But the cord gas reflects what's happened at birth.

\* \* \*

Q. At any time in your review of this case -- or did you review the fetal monitor strips?

A. Yes.

Q. And would you agree that the only abnormality was fetal tachycardia and decreased variability?

A. Yes.

Q. Can a maternal infection alone cause fetal tachycardia?

A. Yes.

Q. And do you have an opinion whether maternal infection here caused the fetal tachycardia?

A. I think it contributed to it.

Q. So you do think there is a maternal infection?

A. Well, again, mom had a fever, and I think that that temperature is associated with the fetal -- had at least some contribution to the fetal tachycardia.

Q. Okay. Is it still your opinion, though, you don't know one way or the other whether there was a maternal infection?

A. Correct.

\* \* \*

Q. Doctor, a minute ago, you talked about . . . an ischemic event versus an hypoxic event. You talked about narrowing down the definitions, or did I have that wrong?

A. No. No. I did mention that.

Q. Okay. Tell me what you were referring to with regard to this specific case when you brought that up.

A. I just wanted to point out that there are basically two ways of getting

brain injury from oxygen deprivation, and that is your oxygen level can be low in your blood [hypoxia]; or you can have not enough blood circulating [ischemia] . . . .

Q. And in terms of not having enough blood circulation, do you have an opinion as to whether that was applicable to Harper Stever, the baby in this case?

A. Yes.

Q. What's that opinion?

A. I think that there were two episodes, one when he was first born and had a low heart rate, that is, that there was an abnormal amount of blood being delivered to his brain during that time, and then later on in the afternoon of the 16th, he is profoundly hypotensive, and that, too, is associated with inadequate blood and oxygen delivery to the brain.

Q. Okay. Do you see when the child had a low heart rate?

A. Yes.

Q. When did that occur, specifically?

A. At birth.

Q. And where is that reflected, Doctor?

A. Well, in the code record and by the fact that he got cardiac compressions.

Q. Okay. And when the baby was coded and had this low heart rate, you testified to, do you have an opinion on whether it caused brain injury?

A. Well, I think what I said before, I think in light of what happened later that day, I think it contributed to it. Whether

or not it would have caused it on its own, I don't -- I don't know, and actually, I would dare say probably not.

Q. Okay. Then move on, if you will. Tie it into what happened later on that day.

A. Well, he continues to have ongoing care to try to stabilize him --

Q. Uh-huh.

A. -- in the post delivery period, and that care includes prolonged artificial ventilation, if you will, as well as support of his circulation, and despite that, he has episodes of drops in his saturations and ultimately in his blood pressure, as well, before he goes onto ECMO bypass.

\* \* \*

Q. And in terms of meconium aspiration, Doctor, do you know whether the baby actually aspirated the meconium in utero or whether it was perhaps after birth?

A. It's usually a combination of both.

Q. But there is generally no way to know; is that correct?

A. Well, severe meconium aspiration, there is usually a component of it that has occurred before a baby is born.

Q. Okay. In severe meconium aspiration?

A. Yes.

Q. In this particular case, would you categorize it as severe meconium aspiration?

A. Yes.

Q. And what do you base that opinion on, Doctor?

A. Well, the fact that there was such respiratory failure, as well as the radiographic changes seen.

\* \* \*

[Examination by Mr. Blystone]

Q. . . . Next, if you would turn to page 285 of the medical record of Baby Stever, which is entitled a "Neonatal Transport Flow Sheet." Do you see that?

A. Yes.

Q. Okay. Now, correct me if I'm wrong. Is this at the point when the neonatal transport team arrives and takes over the care of Harper Dean Stever until his ultimate delivery to Arnold Palmer Hospital?

A. Yes.

Q. Is there anything clinically significant to you on this record as far as Harper Dean Stever's vital signs and oxygen saturation level and so forth are concerned?

A. Yes. Normal saturation for babies is going to be in the 90s, and yet they can tolerate saturations down to the 80s or even usually into the 70s without sustaining injury to their vital organs, including their brain.

However, persistent levels below 70 are going to be associated with neurologic injury, and the fact that the first dip is at 15:15, and at 16:40 drops below 70 and stays below 70 until he's left that unit or, you know, and soon thereafter, he arrives at Arnold Palmer.

Q. In your opinion as a neonatologist, would significant brain damage be occurring in Harper Dean Stever when his oxygen saturation levels drop and stay below the 80 mark?

A. 70. I'm not going to say 80, but I think staying below 70, also in concert with blood pressures -- again, the normal mean blood pressure for a baby is going to be 40 or more. So when it drops down as low as 30 in conjunction with a saturation of 68 percent, that's likely to be adding to his injury, and that continues on to Arnold Palmer for the next couple hours, as well, before he goes onto ECMO, which sort of is the continuation of those type of vital signs.

\* \* \*

Q. On page 287 of that same neonatal transport flow sheet, I note that at 15:20, and then again at 15:30, Harper Dean was administered sodium bicarb. What was the reason for that?

A. To compensate for acidosis.

Q. What type of acidosis?

A. Metabolic acidosis.

Q. At the time that Harper Dean Stever was being administered sodium bicarb, you stated that he then -- that was because he was having metabolic acidosis at the time?

A. Yes.

Q. And when a child such as Harper Dean Stever is having metabolic acidosis, that they had risk for brain injury?

A. Yes, because that reflects inadequate blood and oxygen delivery to their body.



Q. Now, you were pointing out to me before, I think, that Harper Dean Stever's oxygen saturation levels continued to be below the 70 mark by the time of the admission to the neonatal intensive care unit at Arnold Palmer Hospital, correct?

A. Correct.

\* \* \*

Q. And it appears that generally, his O<sub>2</sub> saturation levels were staying in the 60s<sup>9</sup> to 60s range. Is that fair to say?

A. Yes. There is a brief increase at 17:52 to 17:55. But by 18:10, it's back below 65, where it stays for over half an hour, and then it goes up to 69, 75, and back down to 63, and then 59 percent.

Q. And this is from the timeframe of 17:30 through 19:00 on October 16th, correct?

A. Correct.

Q. And how was Harper Dean Stever's blood pressure doing during that timeframe?

A. Well, unfortunately, it was even worse than it had been before, with his blood pressure means falling into as low as 24.

Q. So in your opinion as a neonatologist, from the time of Harper Dean Stever's arrival to Arnold Palmer Hospital at 17:30, through this time period, 19:00, represented on this neonatal intensive care flow sheet, was he suffering significant brain damage during that time?

A. Yes.

Q. And why is that?

A. . . . Because there is other evidence -- there is evidence that he still has ongoing metabolic acidosis. He has blood gasses that instead of being only minimally metabolically acidotic, they are going up to the moderate to severe range, and that is after the administration of bicarb, which should, in theory, counteract that metabolic acidosis.

So he clearly is having inadequate blood and oxygen delivery. He is clearly becoming acidotic. He clearly has a level of cardiac performance and -- or cardiac poor performance and inadequate oxygen to sustain his vital physiology, including his brain function.

And then ultimately, one thing that should be mentioned is that his ultimate autopsy does show periventricular leukomalacia, which would be the type of injury that would arise from this pattern of low blood pressure and low oxygen level that he really doesn't sustain anywhere else during his run, during his hospital course once he gets stabilized by virtue of going on ECMO.

\* \* \*

Q. Dr. Rhine, had Harper Dean Stever not passed away, do you have an opinion within a reasonable degree of medical probability whether he would have been substantially, permanently mentally and physically impaired as a result of his brain injury to which you testified to?

A. Yes. My opinion is that he would have had substantial neurologic impairment.

\* \* \*

Q. Dr. Rhine, do you have an opinion as to when Harper Dean Stever was undergoing

metabolic acidosis to the extent that it was causing significant brain injury?

A. As I mentioned before in the afternoon of the 16th after his birth, during that resuscitation and attempted stabilization, I think that's when it occurred.

32. Dr. Willis was of the opinion that the medical records failed to support the conclusion that Harper suffered a lack of oxygen substantial enough to cause brain injury during labor, delivery, or resuscitation immediately following delivery, and that the tachycardia Harper experienced was most likely related to maternal infection. As for the likely cause of Harper's respiratory failure, Dr. Willis was of the opinion it was most likely the result of infection and meconium aspiration. As for whether Harper suffered a significant brain injury after he was transported to the special care nursery, Dr. Willis deferred to the neonatologists and pediatric neurologists.

33. Contrasted with the opinions of Doctors Rhine and Willis, Dr. Brill was of the opinion that Harper suffered two hypoxic injuries. The first being present at birth, and the second an ongoing injury from the time Harper was an hour old (when Dr. Brill notes poor perfusion and dusky skin is documented) until he died.<sup>10</sup>

34. As for the timing of the first injury, Dr. Brill was of the opinion it occurred within 24 hours preceding birth, and

probably shortly before delivery. As for the cause of the injury, Dr. Brill was of the opinion it was most likely caused by a profusely hemorrhagic placenta, which resulted in oxygen deprivation (hypoxia) to the baby. Dr. Brill's conclusion that Harper presented with a profound brain injury at birth was premised on "several features: Number one is . . . the placenta is described as profusely hemorrhagic, so that there's a cause for lack of oxygen to the baby; and that event had abnormal fetal monitoring strips; was born with meconium stained fluid; and had very low Apgar to begin with; and persistent apnea." (Intervenor's Exhibit 6, page 19.)

35. As for the cord pH of 7.112, Dr. Brill acknowledged it was only mildly depressed, but was of the opinion it was taken "when the baby was 12 minutes old after he had been resuscitated." (Intervenor's Exhibit 6, pages 22, 23, and 60.) Dr. Brill was also of the opinion that had the cord pH been taken within the first two minutes of life it would likely have been below 7. (Intervenor's Exhibit 6, pages 41 and 42.)

36. Dr. Brill's observations regarding Harper's cord pH are not credible. The Blood Gas Summary reveals that the blood sample was drawn from the umbilical cord, and not the infant. (Intervenor's Exhibit 2, page 677.) The cord pH reflects the infant's pH and other chemistry at birth, not following resuscitation. (Intervenor's Exhibit 5, page 26; Respondent's

Exhibit 1, pages 50 and 51.) See also "Blood," "cord b." ("blood contained within the umbilical vessels at the time of delivery of the infant."), Dorland's Illustrated Medical Dictionary, 28th Edition, 1994). Dr. Brill's observations to the contrary detract from the credibility of his testimony regarding the presence of a hypoxic brain injury at delivery. However, except for the onset of the injury, Dr. Brill's observations regarding brain injury following the arrival of the transport team are consistent with those of Dr. Rhine, and are credited. As for the onset of the injury, Dr. Rhine's conclusion that it began at two and a half hours of life (2:30 p.m.) is the more credible. (See Endnote 10.)

37. Given the proof, it is resolved that, more likely than not, Harper did not suffer brain injury due to oxygen deprivation that occurred during labor, delivery, or resuscitation immediately following delivery. Rather, it is most likely that Harper began to suffer hypoxic ischemic brain damage (due to low oxygen saturation levels and low blood pressure) following the arrival of the transport team at South Seminole Hospital, when evidence of profound pulmonary hypotension was noted, at about two and a half hours of life, and that his brain injury progressively worsened until a point in time, likely prior to his placement on ECMO, when the injury

was so severe permanent and substantial mental and physical impairment would necessarily ensure.

Coverage under the Plan

38. 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."<sup>11</sup> § 766.302(2), Fla. Stat. See also §§ 766.309 and 766.31, Fla. Stat.

39. Here, it has been resolved that Harper did suffer an injury to the brain caused by oxygen deprivation that rendered him permanently and substantially mentally and physically impaired. However, it was also resolved that Harper's brain injury began about two and a half hours after birth, following the arrival of the transport team at South Seminole Hospital. Nevertheless, Petitioners and Intervenor were of the view that Harper's brain injury occurred "in the immediate postdelivery period," because Harper had required continuous respiratory support since birth. In contrast, NICA was of the view that while Harper required continuous respiratory support, his brain injury postdated the "immediate postdelivery period," and therefore does not qualify for coverage.

40. The ultimate goal in construing a statutory provision is to give effect to legislative intent. BellSouth Telecomms, 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 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). "If 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).

41. In enacting the Florida Birth-Related Neurological Injury Compensation Plan, the Legislature expressed its intent, as follows:

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

§ 766.302(2), Fla. Stat.

42. In defining "birth-related neurological injury," the Legislature chose to limit coverage to brain injuries that occurred during "labor, delivery, or resuscitation in the immediate postdelivery period." § 766.302(2), Fla. Stat. However, the Legislature did not define "resuscitation in the immediate postdelivery period," and the term has no technical significance.<sup>12</sup> (Respondent's Exhibit 1, pages 43 and 44; Intervenor's Exhibit 5, page 30.)

43. "When necessary, the plain and ordinary meaning of words in a statute can be ascertained by reference to a dictionary." Seagrave v. State, 802 So. 2d 281, 286 (Fla. 2001). "Resuscitate" is commonly understood to mean "[t]o return to life or consciousness; revive." The American Heritage Dictionary of the English Language, New College Edition, 1979. Dorland's Illustrated Medical Dictionary, 28th Edition, 1994, defines "resuscitation" as "the restoration to life or consciousness of one apparently dead; it includes such measures as artificial respiration and cardiac massage." "Immediate" is commonly understood to mean "[n]ext in line or relation[;] . . . [o]ccurring without delay[;] . . . [o]f or near the present time[;] . . . [c]lose at hand; near." The American Heritage Dictionary of the English Language, New College Edition, 1979. Finally, "period" is commonly understood to mean "[a]n interval of time characterized by the occurrence of certain conditions or



events." The American Heritage Dictionary of the English Language, New College Edition, 1979.

44. Under the statutory scheme then, the brain injury must occur during labor, delivery, or immediately thereafter. 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, delivery, or immediately thereafter."). Such conclusion is also consistent with "the requirement that statutes which are in derogation of the common law be strictly construed and narrowly applied." Nagy, 813 So. 2d at 159; Humana of Florida, Inc. v. McKaughn, 652 So. 2d 852, 859 (Fla. 2d DCA 1995)("Because of the Plan . . . is a statutory substitute for common law rights and liabilities, it should be strictly construed to include only those subjects clearly embraced within its terms."), approved, Florida Birth-Related Neurological Injury Compensation Association v. McKaughn, 668 So. 2d 974, 979 (Fla. 1996).

45. Under the facts of this case, resuscitation in the immediate postdelivery period ended not later than 1:05 p.m., when the code ended and Harper was transferred to the special care nursery. By then, Harper had been successfully resuscitated (revived), and his circulation restored. However, nothing further could be done to establish spontaneous

respirations (until the cause of his respiratory failure could be addressed), and he would remain on respiratory support for the remainder of his life. Harper's subsequent brain injury, which began at about two and a half hours of life, post-dated his "resuscitation in the immediate postdelivery period."

#### CONCLUSIONS OF LAW

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

47. 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.

48. 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.

49. 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.

50. 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.

51. 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.

52. As the proponent of the issue, the burden rested on Petitioners and Intervenor to demonstrate that Harper 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.").

53. Here, the proof failed to support the conclusion that, more likely than not, Harper 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. Indeed, the more compelling proof demonstrated that any brain injury Harper suffered post-dated the immediate postdelivery period. Consequently, given the provisions of Section 766.302(2), Florida Statutes, Harper 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 (The injury to the brain, whether by oxygen deprivation or mechanical injury, must take place during labor, delivery, or immediately thereafter).

54. 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 Laura Stever, as Personal Representative of the Estate of Harper Dean Stever, a deceased minor, and Laura Stever and Joseph Dean Stever, Jr., individually and as the natural parents of Harper Dean Stever, a deceased minor, is dismissed with prejudice.

DONE AND ORDERED this 30th day of April, 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  
Fax Filing (850) 921-6847  
www.doah.state.fl.us

Filed with the Clerk of the  
Division of Administrative Hearings  
this 30th day of April, 2007.

ENDNOTES

1/ Respondent's Exhibits 1 and 2 were described in its Notice of Filing (filed February 23 2007), as follows:

1. Deposition transcript of Dr. Donald C. Willis dated January 29, 2007, with exhibits.
2. Medical records of mother from Advanced Women's Health Special[ists] (to supplement medical composite filed by Intervenor).

2/ Intervenor's Exhibits 1-5 were described in its Notice of Filing (filed February 23, 2007), as follows:

1. Medical records of Laura Stever from Orlando Regional Healthcare System, Inc. (South Seminole Hospital and Arnold Palmer Hospital for Children and Women) from 10/16/04-10/20/04, pages 1-250.
2. Medical records of Harper Dean Stever from Orlando Regional Healthcare System, Inc. (South Seminole Hospital and Arnold

Palmer Hospital for Children and Women) from 10/16/04-10/22/04, pages 1-802.

3. Fetal Monitor Strips.
4. Autopsy report of Harper Dean Stever.
5. Deposition of William Rhine, M.D., with attachments.

3/ ECMO is a treatment method for critically ill newborns whose lungs are unable to provide sufficient oxygenation of the blood. ECMO therapy acts as an artificial heart and lung to oxygenate the baby's blood. (Respondent Exhibit 1, page 45 and 55; Intervenor Exhibit 6, page 65.)

4/ Heparin, an anticoagulant (or blood thinner), is required during ECMO therapy. Heparinization significantly increases the risk of bleeding. (Intervenor's Exhibit 5, page 37.)

5/ The placenta findings were likely taken from the Surgical Pathology Report (Pathology No. S-04-31353) on the evaluation of the placenta following Harper's birth at South Seminole Hospital. (Intervenor's Exhibit 1, page 101.) That report included the following historical diagnosis and gross description:

HISTOLOGICAL DIAGNOSIS:

PLACENTA: PLACENTA WITH THREE VESSEL CORD, LARGE FOR GESTATIONAL AGE (WEIGHT 625 GRAMS). NO ACUTE CHORIOAMNIONITIS, OR ACUTE FUNISITIS IS SEEN.

GROSS DESCRIPTION:

Received labeled with the patient's name, "Stever, Laura" . . . . The parenchyma is beefy red and diffusely hemorrhagic . . . .

6/ See, e.g., Wausau Insurance Company v. Tillman, 765 So. 2d 123, 124 (Fla. 1st DCA 2000) ("Because the medical conditions which the claimant alleged had resulted from the workplace incident were not readily observable, he was obligated to present expert medical evidence establishing that casual connection."); Ackley v. General Parcel Service, 646 So. 2d 242 (Fla. 1st DCA 1994) (determining cause of psychiatric illness is



essentially a medical question, requiring expert medical evidence).

7/ Dr. Rhine is a practicing neonatologist; medical director of the neonatal intensive care unit at the Lucile Packard Children's Hospital, Stanford University Medical Center; co-director of the ECMO Program, Stanford University Medical Center; and an associate professor of pediatrics at Stanford University. Dr. Rhine cares for critically-ill neonates, including their resuscitation; instructs other health professionals in neonatal resuscitation; has research interests in the metabolic and physiologic mechanisms of neurological injury, ECMO and inhaled nitric oxide for respiratory failure, and quality improvement in neonatal care; and has published extensively. (Intervenor's Exhibit 5.)

8/ The Blood Gas Summary reveals the blood sample was drawn from the umbilical cord at 1300 (1:00 p.m.) and collected at 1307 (1:07 p.m.). The summary further reveals the figures reported are arterial blood gases ("A.B.G."). (Intervenor's Exhibit 2, page 677.) Dr. Quinsey's Clinical Resume describes the results as an "umbilical artery pH" of 7.11. (Intervenor's Exhibit 1, page 9.)

9/ This is most likely a typographical error since Harper's O<sub>2</sub> saturation levels were in the 50s to 60s range. See Intervenor's Exhibit 2, page 605.

10/ The Neonatal Transport Sheet reflects that the transport team arrived at 1350 (1:50 p.m.) and that on arrival Harper's color was "dusky [with] poor profusion." (Intervenor's Exhibit 2, page 289.) However, the Neonatal Transport Sheet also notes Harper's color as 4/6 (pink/pale) at 1:50 p.m., and does not describe him as dusky until 1430 (2:30 p.m.), when his color is noted as 2/6 (dusky/pale) and he starts to demonstrate low oxygen saturation levels and low blood pressure. (Intervenor's Exhibit 2, page 285.) Considering the records, Dr. Rhine's observation that the injury began about two and a half hours after birth (about 2:30 p.m.) is more creditable than Dr. Brill's observation.

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 that, or proof to support a conclusion that, Harper suffered an injury to the brain caused by mechanical injury or that Harper suffered an injury to the spinal cord. Consequently, those alternatives need not be addressed.

12/ While the term "resuscitation in the immediate postdelivery period" has no special meaning in the medical community, the parties offered testimony from Doctors Rhine, Brill, and Willis concerning their interpretation of the phrase. As to the meaning of the phrase, Dr. Rhine observed:

Q. . . . Doctor, I know you earlier testified that you had a copy of the statute here, Chapter 766. Outside of the statute, are you familiar with the term "immediate post-delivery resuscitative period"?

A. Not in any technical sense.

Q. . . . You have never seen it defined in a text or periodical, have you?

A. Not that I'm aware of, no.

Q. All right. How would you define it in terms of this particular case, if you can, or do you not define it?

A. Well, I think it would entail the time it took to get him stabilized from a both cardiac and respiratory point of view until he was receiving a level of support where he

would be expected to not have ongoing injury, including to his brain.

Q. And in this particular case, when would that be in terms of how many minutes or hours after birth?

A. Well, I think it's hours before he goes onto ECMO bypass.

Q. So you're using that term, the post-delivery resuscitative phase as up until the child went on ECMO?

A. Yes.

(Intervenor's Exhibit 5, pages 30 and 31.) Dr. Brill observed:

Q. In your opinion, when did the resuscitation in the immediate post delivery period conclude in the matter of Harper Stever?

\* \* \*

THE WITNESS: I think it occurred for at least -- it depends on how you want to define it. I think it had to extend for at least the seven hours of life and one could say that it lasted for six days.

\* \* \*

Q. So you, as a pediatric neurologist, how do you define then the immediate post delivery resuscitation period?

\* \* \*

THE WITNESS: I would define it as the need for active resuscitation. And by the time he went on ECMO, which is a medical taking over of the heart and lung function, I think that's a reasonable time to say the

immediate post resuscitative period ended.

(Intervenor's Exhibit 6, pages 47 and 48.) Finally, Dr. Willis observed:

Q. What do you consider the immediate resuscitative period?

A. That's always the difficult question to answer because there's no definition, but I think, for practical purposes, we could just say about the time of the ten minute Apgar.

Q. That's just your personal opinion?

A. There is no definition in the textbooks for that, but it's basically from the time of birth until the baby is stabilized or unable to be stabilized after birth. And I would suspect by the time we hit that ten minute Apgar, the baby -- it was pretty clear at that point that this baby was not going to stabilize.

\* \* \*

Q. And what is the basis of your opinion of saying that the immediate post-delivery resuscitation period that first five to ten minutes after birth?

A. Well, the definition of the immediate post-delivery period or post delivery or post-delivery resuscitative period is that period from the time of birth until the baby is either stabilized or unable to be stabilized after birth. And so my opinion is that by the time we reach about that ten minute Apgar, either the baby is going to be -- you're either able to stabilize the baby or you're unable to stabilize the baby. And in this case they were unable to stabilize this baby. It continued to have respiratory distress and respiratory failure. And that just becomes what I would consider more of a newborn problem, not an immediate resuscitative period problem.

(Respondent's Exhibit 1, pages 43-46.) Here, since the phrase "resuscitation in the immediate postdelivery period" has no technical significance, the Doctors' opinions are largely irrelevant. However, Dr. Willis' opinion is consistent with the meaning of the words chosen by the legislature.

COPIES FURNISHED

(Via Certified Mail):

Kenney Shipley, Executive Director  
Florida Birth Related Neurological  
Injury Compensation Association  
2360 Christopher Place, Suite 1  
Tallahassee, Florida 32308  
(Certified Mail No. 7099 3400 0010 4399 2833)

William E. Ruffier, Esquire  
Dellecker Wilson King McKenn  
& Ruffier, LLP  
719 Vassar Street  
Orlando, Florida 32804-4920  
(Certified Mail No. 7099 3400 0010 4399 2826)

Bradley P. Blystone, Esquire  
Marshall, Dennehey, Wagner, Coleman  
& Goggin  
315 East Robinson Street, Suite 550  
Orlando, Florida 32801  
(Certified Mail No. 7099 3400 0010 4399 2819)

Robert J. Grace, Jr., Esquire  
Stiles, Taylor & Grace, P.A.  
Post Office Box 460  
Tampa, Florida 33606  
(Certified Mail No. 7099 3400 0010 4399 5575)

Christopher K. Quinsey, M.D.  
661 East Altamonte Drive, Suite 318  
Altamonte Springs, Florida 32701  
(Certified Mail No. 7099 3400 0010 4399 5568)

South Seminole Hospital  
555 West State Road 434  
Longwood, Florida 32750  
(Certified Mail No. 7003 1010 0001 2044 2414)

Charlene Willoughby, Director  
Consumer Services Unit - Enforcement  
Department of Health  
4052 Bald Cypress Way, Bin C-75  
Tallahassee, Florida 32399-3275  
(Certified Mail No. 7003 1010 0001 2044 2421)

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.