STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| APRIL D. ADAMS AND JEFFREY FLOYD ADAMS, INDIVIDUALLY AND ON BEHALF OF AND AS PARENTS AND NATURAL GUARDIANS OF ELIZABETH ANN ADAMS, A MINOR, | ) | |
| Petitioners, | ) | |
| vs. | ) | Case No. 08-3472N |
| FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION, | ) | |
| Respondent, | ) | |
| and | ) | |
| MICHELLE MCLANAHAN, M.D., | ) | |
| Intervenor. | ) | |

## FINAL ORDER

With the parties' agreement, this case was resolved on an agreed record.

## APPEARANCES

For Petitioners: C. Rufus Pennington, III, Esquire
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Jacksonville Beach, Florida 32250

For Respondent: M. Mark Bajalia, Esquire
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800 West Monroe Street
Jacksonville, Florida 32202

For Intervenor: Richard E. Ramsey, Esquire
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## STATEMENT OF THE ISSUE

At issue is whether Elizabeth Ann Adams, a minor, qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

## PRELIMINARY STATEMENT

On July 17, 2008, April D. Adams and Jeffrey Floyd Adams, individually and on behalf of and as parents and natural guardians of Elizabeth Ann Adams (Elizabeth), a minor, filed a petition with the Division of Administrative Hearings (DOAH) to resolve whether Elizabeth qualified for coverage under the Plan.[1]

DOAH served the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the petition on July 17, 2008, and on September 18, 2008, 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 Elizabeth did not suffer a "birth-related neurological injury," as defined by the Plan, and requested that a hearing be scheduled to resolve the issue.

A hearing was scheduled for March 18, 2009, to resolve whether the claim was compensable. In the interim, Michelle McLanahan, M.D., was granted leave to intervene, and on

March 10, 2009, the parties filed a Joint Motion to Submit Stipulated Factual Record and Written Argument in Lieu of a Contested Hearing, together with a Pre-hearing Stipulation. An Amended Pre-hearing Stipulation was filed March 12, 2009.

By Order of March 13, 2009, the parties' motion was granted, and the hearing scheduled for March 18, 2009, was cancelled. The parties' stipulated record, Exhibits 1-28, was duly-filed and accepted.[2]

The parties were accorded until March 30, 2009, to file written argument or proposed orders. Petitioners elected to file a Memorandum Regarding Final Order and Respondent elected to file a Proposed Final Order. The parties' submittals have been duly-considered.

## FINDINGS OF FACT

### Stipulated facts

1. April D. Adams and Jeffrey Floyd Adams are the natural parents of Elizabeth Ann Adams, a minor. Elizabeth was born a live infant on September 17, 2004, at St. Luke's Hospital, a licensed hospital located in Jacksonville, Florida, and her birth weight exceeded 2,500 grams.

2. Obstetrical services were delivered at Elizabeth's birth by Michelle McLanahan, 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.

3. Sufficient notice of participation in the Florida Birth-Related Neurological Injury Compensation Plan on the part of Michelle McLanahan, M.D., and St. Luke's Hospital was provided to April D. Adams.

Coverage under the Plan

4. Pertinent to this case, coverage is afforded by the Plan for infants who suffer a "birth-related neurological injury," defined as an "injury to the brain . . . caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired."[3] § 766.302(2), Fla. Stat. See also §§ 766.309 and 766.31, Fla. Stat.

5. Here, Petitioners were of the view that Elizabeth suffered a subgaleal hemorrhage[4] (a bleed) and resulting subgaleal hematoma[5] (a collection of blood within the tissue) between the skull and scalp (outside the brain) resulting from the use of the vacuum extractor during delivery, and that the hemorrhage was substantial enough to result in hypovolemia, and ultimately hypoxic-ischemic brain injury.[6] (Petitioners' Memorandum Regarding Final Order, pp. 5-7). In contrast, NICA

was of the view that the record failed to support the conclusion that Elizabeth's brain injury was caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period and that, regardless of the etiology of her brain injury, Elizabeth was not permanently and substantially mentally and physically impaired. Intervenor expressed no position on the issue.

Elizabeth's birth and immediate newborn course

6. At or about 11:24 a.m., September 16, 2004, Mrs. Adams, with an estimated delivery date of September 20, 2004, the fetus at 39 3/7 weeks' gestation, and a history of mild pregnancy induced hypertension (PIH), was admitted to St. Luke's Hospital for induction of labor. There, initial physical examination revealed her membranes were intact, no vaginal bleeding, and external fetal monitoring revealed a reassuring fetal heart rate baseline of 150-160 beats per minute, average long term variability and no decelerations.

7. At or about 12:40 p.m., an IV was started for hydration, and at 3:14 p.m., Mrs. Adams' membranes spontaneous ruptured, with clear fluid noted. At the time, vaginal examination revealed the cervix at 2 centimeters dilation, effacement at 70 percent, and the fetus at -3 station. In the interim, external fetal monitoring was reassuring for fetal

well-being. Thereafter, Cytotec ("miso[prostol]") was placed vaginally to soften the cervix (for induction of labor).

8. Mrs. Adams' progress continued to be monitored, and at 6:10 p.m., vaginal examination revealed the cervix unchanged. However, at 6:58 p.m., vaginal examination revealed some change, with the cervix at 3-4 centimeters, effacement at 70 percent, and the fetus at -3 station, and an intrauterine pressure catheter (IUPC) was placed to measure the force of contractions during labor. Fetal monitoring continued to be reassuring for fetal well-being, with a fetal heart rate baseline of 145-160 beats per minute, average long term variability, and no decelerations.

9. At 8:16 p.m., Pitocin infusion (for labor induction) was started, and at 8:37 p.m., contractions were noted at 1-2 minutes, and vaginal examination revealed the cervix at 5 centimeters dilation, effacement at 70 percent, and the fetus at -1 station. Fetal monitoring continued to be reassuring, with a baseline in the 150s.

10. Mrs. Adams' progress continued, albeit slowly, with a prolonged second stage of labor (the expulsion/pushing stage) lasting more than two and a half hours,[7] and at 5:03 a.m., September 17, 2004, Elizabeth was delivered vaginally, with vacuum assistance (three attempts). Of note, approximately three hours before delivery, recurrent variable decelerations

and a mild baseline tachycardia developed, and approximately eight minutes before delivery severe, repetitive variable decelerations developed which prompted the vacuum-assisted delivery.

11. At delivery, Elizabeth was dried, stimulated, and bulb-suctioned, otherwise no resuscitation measures were required. Apgar scores were good (8 and 9, at one and five minutes).[8] Physical examination at 5:10 a.m., revealed no abnormalities, with the exception of an elevated temperature (102.7, rectal) and skin color (acrocyanosis was noted).[9] By 5:40 a.m., skin color was noted as pink.

12. Elizabeth roomed-in at her mother's bedside, and was routinely monitored by hospital staff. Of note, Elizabeth's temperature remained elevated until 1:30 p.m., when it was documented at 98.1 (auxiliary). In the interim, at 11:58 a.m., with temperatures of 100.0 (auxiliary) and 100.7 (rectal), complete blood count (CBC) and blood cultures were drawn.

13. The CBC results revealed an elevated white blood count. Under the circumstances, the attending physician (Dr. Schwartz) noted, at 4:34 p.m., "[w]ill repeat CBC in a.m. . . . [w]ill not st[art] ABX unless temps elevated again." Blood culture was subsequently reported as negative.

14. It also may be noted, although not shown to be clinically significant, that Elizabeth's behavior was, starting

at 6:10 a.m., periodically described as "irritable" and "fussy." (Exhibit 18, pp. 22-24). Otherwise, Elizabeth's newborn stay was without incident, with normal newborn examinations, breastfeeding well, and voiding and stooling appropriately, until 8:35 p.m., when the attending nurse made the following entry in the records:

> Assumed care of infant. Infant/Mom ID # checked/verified. Physical assessment done and noted. Infant noted to be jittery and irritable. Mom states that infant has not breastfed since 1700-1730. Temp stable now at 98.8. Infant noted to settle after wrapping. Placed in mother's arms. Mom will breastfeed infant shortly. Will eval infant's next feeding.

Thereafter, at 8:42 p.m., the attending nurse made the following entry:

> Called into room by parents. States that infant shreiked then arched her back and turned purple. Upon enter room infant's color noted to be dusky with purple lips. Left eye noted to be turned in and rt eye gazed. Unwrapped and body noted to be modled but no shaking present at this time. Infant taken to nicu for immediate evaluation.

15. Elizabeth's subsequent care was summarized in her Discharge Summary, as follows:

> . . . Nursing brought the infant to this Special Care Nursery and it was felt that the infant was having seizure activity. At this point a complete septic workup was performed. The infant was placed on IV antibiotics and further cultures including spinal fluid were sent. The workup was

> initially benign; however, a CT scan [on September 18, 2004] was within normal limits except that J. Norman Patton, M.D., Division of Cardiovascular Diseases, Internal Medicine, could not completely rule out some mild evidence of inflammatory response in the brain . . . .

16. The CT scan of September 18, 2004, was done to rule out a bleed as the cause of Elizabeth's seizures, and was read as follows:

> CT head without and with contrast.
> Iodinated contrast was given per protocol.
> Nonionic contrast was utilized.
> Small subgaleal hematoma in the biparietal locations. The intracranial contents appear unremarkable. Specifically, there is no evidence for parenchymal/extra-axial hemorrhage, nor pathologic enhancement. The ventricle volume is within normal limits, and without midline shift.

A subgaleal hematoma or hemorrhage is a bleeding between the skull and the skin on the outside of the skull (scalp), and not within the brain. (Exhibit 18, pp. 15, 16, and 18).

17. The Discharge Summary continued, and documented Elizabeth's care as follows:

> At this point acyclovir was also added to the antibiotic regimen. The CSF PCR was negative, but surface cultures revealed positive HSV [herpes simplex virus] in the rectal swab, although negative in the oropharynx. For this reason the infant was continued on acyclovir for a total of 21 days. After negative cultures the ampicillin and gentamicin were discontinued. The infant also required mild oxygen in this period and was placed on 1.5 liters 30-40%. Over the next several days this was able to

> be discontinued. Dr. Gamma, Pediatric Neurology, was involved in the patient's case and consulted on a regular basis. EEG was consistent with seizure activity. The infant was on phenobarbital and later secondary to continued occasional seizures, was started on Cerebyx. The goal was to get this infant's phenobarbital level to between 20 and 30; however, the infant metabolized the phenobarbital very well and despite increasing the dose, the phenobarbital level remained in the 19-20 range. Eventually the Cerebyx was discontinued and the infant is discharged home only on phenobarbital. The infant initially was fed fairly slowly, but by the end of admission was eating well and gaining weight steadily. The infant was ready for discharge on 10/09/04 following 21 days of acyclovir and at this point the infant had a phenobarbital level of 19.3 and a weight of 3940 grams or 8 pounds 11 ounces. The parents have been very involved with the infant, visited often, and have demonstrated good care for this baby. The infant's workup also includes urine for amino acids, which was within normal limits. Liver function tests were within normal limits. Screening CBCs were within normal limits. Ammonia was normal at 36. Urine organic acids were within normal limits . . . .

18. An MRI performed on September 22, 2004, revealed:

> . . . restricted diffusion in the left occipital lobe, both parietal and frontal lobes, worse on the left, consistent with cytotoxic edema as seen in infarction, secondary to ischemic and or sequelae of severe meningoencephalitis . . . . The ventricle volume is within normal limits, and without midline shift.

A head ultrasound performed on September 30, 2004, was normal and reported, as follows:

> Using the anterior fontanelle as an acoustic window, routine coronal and sagittal images were obtained.
> No evidence for intracranial or germinal matrix hemorrhage. Ventricles are not dilated and appear normal in shape and position. No obvious parenchymal abnormality.

19. Elizabeth was discharged on October 9, 2004. Physical examination on discharge was noted in her Discharge Summary, as follows:

> Physical exam on discharge revealed a discharge weight of 3940 grams, length of 53 cm, and head circumference of 35.5 cm. The infant was well-developed, well-nourished, alert, pink non-jaundiced female in no acute distress. HEENT was negative. Anterior fontanelle was soft and flat. Lungs were clear to auscultation in no distress. Heart - Regular rhythm without murmur. Abdomen - Soft, benign and nontender. GU - Normal female. Back - Normal extremities, negative Ortolani, negative bilaterally. Neurologic exam intact.

Discharge medication was phenobarbital. Follow-up was recommended with pediatrics, neurology, Early Intervention Program at Shands, and Occupational Therapy and Physical Therapy at Nemours. Discharge Diagnoses were:

> 1) HSV ENCEPHALITIS - SEPSIS.
> 2) NEONATAL SEIZURES.
> 3) TERM FEMALE NEWBORN.

Of note, subsequent testing revealed that Elizabeth had not been exposed to the herpes simplex virus (HSV), and the positive HSV result was a false positive.

Elizabeth's subsequent development

20. Following Elizabeth's discharge from St. Luke's, she was evaluated by the Early Intervention Program (in October 2004) to resolve whether she qualified for services. At the time, it was felt Elizabeth did not qualify for the program, as her development was within normal limits (WNL) for her age. However, in March 2005, at age 6 months, Elizabeth was reevaluated and found eligible for occupational, speech, and physical therapy services due to motor and language delay. Those services were discontinued by October 2005, since Elizabeth's developmental growth appeared age appropriate. (Exhibit 7).

21. Elizabeth was weaned off phenobarbital at age 15 months (about December 2005) and remained seizure-free until October 13, 2006, when a seizure was noted and she was ultimately transported (after treatment in a local emergency room) to Wolfson's Childrens Hospital (Wolfson's) in Jacksonville. There she was loaded with phenobarbital and Dilantin, the seizures stopped, and on October 15, 2006, she was discharged on maintenance dosage of phenobarbital. However, on October 16th, she had a second seizure and was readmitted to Wolfson's, and then on October 18, 2006, discharged on an increased dosage of phenobarbital. Thereafter, in

December 2006, her medication was changed from phenobarbital to Trileptal. (Exhibit 9).

22. Since that time, Elizabeth has experienced seizures on four occasions, three of which she was treated at Wolfson's (April 17-19, 2007; March 19-20, 2008; and July 10, 2008) and the last of which (March 1, 2009) she apparently was treated at home in North Carolina. (Exhibits 9 and 27).

23. Apart from her seizure disorder, Elizabeth's health has been good, and developmentally she continued to make good progress, without the need for any therapies since they were discontinued in October 2005. Currently, Elizabeth attends a regular school program, and was shown to evidence very mild physical impairment and no mental impairment. (See, e.g., Exhibits 16, 17, and 19).

Whether Elizabeth suffered a "birth-related Neurological injury"

24. To address whether Elizabeth suffered a "birth-related neurological injury," the parties offered a Stipulated Record (Exhibits 1-28), that included the medical records associated with Mrs. Adam's antepartal course, the medical records associated with Elizabeth's birth and subsequent development, the deposition testimony of the delivering obstetrician (Dr. McLanahan), and the deposition testimony of Mr. and Mrs. Adams. The parties also offered the deposition testimony

of Donald Willis, M.D., a physician board-certified in obstetrics and gynecology, and maternal-fetal medicine, and Michael Duchowny, M.D., a physician board-certified in pediatrics, neurology with special competence in child neurology, electroencephalography, and neurophysiology.

25. Based on his evaluation of the medical records, it was Dr. Willis' opinion that Elizabeth did not suffer a brain injury caused by oxygen deprivation or mechanical injury during labor, delivery, or resuscitation in the immediate postdelivery period.[10] In so concluding, Dr. Willis observed Elizabeth was not depressed at birth; her Agpar scores were normal (8 at one minute, and 9 at five minutes); she did not require any significant resuscitation (only stimulation and bulb-suctioning); and her newborn course was without incident until seizures were noted at 16 hours after birth.

26. As for the subgaleal hemorrhage (the bleed between the skull and the scalp) Elizabeth was shown to have suffered (on the CT scan of September 18, 2004), Dr. Willis agreed it was likely related to the vacuum-assisted delivery. As for the cause of the periventricular hemorrhage (brain injury/stroke) Elizabeth was shown to have suffered (on the MRI of September 22, 2004), Dr. Willis voiced no opinion, and deferred to the expertise of a pediatric neurologist. As for Petitioners' theory of the case, that a subgaleal hemorrhage can

progress to cause bleeding within the brain as a result of hypovolemia, Dr. Willis agreed. However, he did not see evidence in this case to suggest such a causative connection. Dr. Willis expressed his opinion, as follows:

> Q. Tell me why you don't think, if you don't think, that her brain injury is related to the vacuum extraction?
>
> A. Well, subgaleal hemorrhage is between the skull and the skin on the outside of the skull, and that's very common with vacuum extractions.
>
> But the only way that that can cause a brain injury that I'm aware of is that if so much hemorrhage occurs into that hematoma that the baby becomes hypovolemic and has a stroke due to hypovolemia and low blood pressure related to blood loss. I am not aware that this child had a subgaleal hematoma that was to that extent.

(Exhibit 18, pp. 17 and 18). See also Exhibit 18, p. 35.

27. Dr. Duchowny evaluated Elizabeth on September 10, 2008. Based on his evaluation, as well as his review of the medical records, Dr. Duchowny was of the opinion that Elizabeth's impairments were likely the result of a meningoencephalitis (an "inflammation of the brain and meninges"[11]), resulting from a viral infection, albeit not HSV, as opposed to a brain injury caused by oxygen deprivation or mechanical injury occurring during labor or delivery. Dr. Duchowny was also of the opinion that Elizabeth was neither

substantially mentally nor substantially physically impaired. (Exhibits 15 and 19).

28. Dr. Duchowny described the results of his evaluation, and the bases for his opinions, as follows:

> Q. . . . During that examination did you obtain any medical history from Elizabeth's family?
>
> A. Yes.
>
> Q. What was the history that you obtained?
>
> A. I was able to speak to Elizabeth's mother, who was the person, the caretaker, bringing Elizabeth to my office; and she first talked about Elizabeth's seizures, which began shortly after birth, at age sixteen hours; and continued with a total of five seizures during her life. The seizures, although infrequent, were prolonged, and her mother indicated that they lasted between three and five hours, all of which, obviously, resulted in hospitalizations. They were terminated with rescue Diastat in order to stop the status epilepticus.
>
> All of Elizabeth's seizures began on the right side of her body but then would generalize to involve both arms and both legs, and most recently Elizabeth has been treated which Trileptal, which apparently has brought the seizures under control.
>
> Her mother then went on to describe mild weakness on the right side of Elizabeth's body. She commented that Elizabeth had trouble with fine motor coordination, particularly a pincer grasp, and as a result was a left hander. However, Elizabeth's overall motoric ability was good. She didn't have any specific limitations to her motor abilities, and she was fully

functional for her age, which at that time was three years.

On a positive note, her mother indicated that her mental development was going well, that there were no delays in her acquisition of speech and language, and that she was in the New Dimensions Preschool Program where she was attending a regular classroom.

There has never been any regression of Elizabeth's abilities, and at the time that I evaluated Elizabeth in September, she did not have an ongoing need for either physical or occupational therapy.

Otherwise, things were good; she was healthy. She was under the care of Dr. Harry Abrams at Nemours Children's Hospital. She continued to have abnormal EEGs, and her mother commented that her MRI scan of the brain revealed damage, primarily on the left side of her brain.

Q. What information, if any, did you obtain regarding her birth?

A. Well, again, this was information from Elizabeth's mother, and she told me that Elizabeth was born after a term gestation at St. Luke's Hospital. It was a natural delivery, but with the assistance of a vacuum for the extraction. Elizabeth weighed seven pounds, eleven ounces. She breathed well. She was not a jaundice baby, but that she remained in the NICU at St. Luke's Hospital for a treatment of suspected infection with the herpes simplex virus; so essentially, a herpes simplex encephalitis concern.

Q. Thank you.

Did you obtain any information with respect to Elizabeth's growth and development?

A. Yes. Elizabeth rolled over and sat at six months and then was able to stand at age ten months. She was walking on her own by age thirteen months and began talking in single words between a year and age eighteen months.

At the time I saw her she had not yet been toilet trained, but she received all of her immunizations and had no known allergies to medications. She had undergone surgery on two occasions for the ear tubes and, of course, there were the multiple hospitalizations for the recurrent bouts of status epilepticus.

Q. Did you perform a physical examination of Elizabeth?

A. Yes.

Q. What were your findings upon that examination?

A. When I saw her, she was actually quite cooperative so, socially, she was very appropriate for her age. She seemed appropriately nourished and developed. Her weight was recorded at thirty-five pounds. There was no abnormalities of her skin, neck and she had no abnormal aspects of her body which suggested a malformation. I noted that her spine was normal. Her head growth was good. She had a head circumference of 49.1 centimeters, which for age three years is within standard percentiles. There were no abnormalities of her heart, her lungs, her abdomen, and her extremities or her peripheral pulses.

Q. Did you also perform a neurological examination of Elizabeth?

A. Yes. And once again, in terms of her social abilities, she actually was quite good for her age and she was appropriately verbal at her age level. She answered

questions, she provided decent verbal content. I thought her speech sounds had a very mild disarticulation, but she knew her colors. She was able to identify parts of her body, and she was able to draw with a pencil using her left hand. No drooling was noted.

Examination of her cranial nerves was essentially normal, and her motor examination revealed a well developed, age appropriate amount of muscle strength, bulk of her muscle and muscle tone. I was unable to detect any specific focal weakness, although, again, there was a difference in terms of her fine motor coordination. Even though she used both hands cooperatively, she clearly preferred her left hand, although I was able to demonstrate a pincer grasp bilaterally and reasonably good manual dexterity.

Where I did think there was asymmetry had to do with her walking where her left arm would swing in a more prominent fashion on the left compared to the right. Also, there was a tendency actually for both feet to turn in, but this was more prominent, again, on the right side.

I thought that Elizabeth's sensory examination was normal and that her gait was appropriate in terms of coordination, despite the asymmetric arm swing.

Her deep tendon reflexes were normal and symmetric on both sides of the body, in other words, both arms and legs; and her plantar response, which is a reflex response to stroking the bottom of the feet, was normal. There were no abnormalities of her neurovascular examination, meaning that there were no asymmetries when a stethoscope was placed on her neck, head or over her eyes. The bones of her skull were closed, which was appropriate.

Q. Okay. Thank you.

Based upon your review of the medical records and documents which you identified earlier, and based upon your examination of Elizabeth and the findings from that examination, were you able to form an opinion as to the nature and extent of Elizabeth's neurological delays or developmental delays, if any, and the etiology of those delays?

A. Well, there were some findings on the neurological exam with respect to Elizabeth's motor coordination, and my impression was that these findings were, at best, mild. I would characterize them really as very mild.

Q. Specifically, what are those findings?

A. The asymmetric arm swing, the establishment of handedness on the left and slightly decreased -- well, really, minimal, minimal change in dexterity. Really, the arm swing and the handedness.

Q. And those delays that you've identified and, as I understand it, it's your opinion that you would characterize those as mild?

A. Yes.

Q. What functional impact, if any, do those mild delays have on Elizabeth based upon your examination of her when you saw her?

A. Well, at present I would have predicted that there would be no compromise to her functionality, and that appeared to be the case.

Q. With respect to her cognitive development, what were you able to conclude based upon your review of the medical records and your examination of her?

A. My examination revealed normal cognitive development; in other words, a level of mental function, which was at age level. So I was, again, not surprised that she was in a regular class at the New Dimensions Preschool.

Based upon your review of the medical records, were you able to form an opinion as to the etiology of any of those neurological problems that were identified?

A. Well, from a review of the records, I think that there was a strong indication that Elizabeth had had some kind of meningoencephalitis in the first week of life, and I believe that her findings on neurological examination today are related to the previous bout of meningoencephalitis.

Q. Do you have an opinion as to whether or not Elizabeth suffers from a substantial mental impairment?

A. I do, and that is that I do not believe that Elizabeth has a substantial mental impairment.

Q. Do you have an opinion as to whether or not Elizabeth suffers from a substantial physical impairment?

A. I do not believe that Elizabeth has a substantial physical impairment either.

* * *

Q. . . . You mentioned the motor findings that you described as, at best, mild, or very mild, and you listed the asymmetrical arm swing, and the handedness on the left and the minimal loss of dexterity.

I think your findings also included abnormalities in the gait, is that correct?

> A. Yes, that's true. There was a toe-in position bilaterally, but I didn't see that as a functional problem. She did that, but it didn't seem to contribute to any disability at all . . . .

(Exhibit 19, pp. 7-16).

29. When, as here, the medical condition is not readily observable, issues of causation are essentially medical questions, requiring expert medical evidence. See, e.g., Vero Beach Care Center v. Ricks, 476 So. 2d 262, 264 (Fla. 1st DCA 1985)("[L]ay testimony is legally insufficient to support a finding of causation where the medical condition involved is not readily observable."); Ackley v. General Parcel Service, 646 So. 2d 242, 245 (Fla. 1st DCA 1994)("The determination of the cause of a non-observable medical condition, such as a psychiatric illness, is essentially a medical question."); 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 causal connection."). Here, the opinions of Doctors Willis and Duchowny were logical, consistent with the record, not controverted, and not shown to lack credibility. Consequently, it must be resolved that the cause of Elizabeth's impairments was most likely a meningoencephalitis, as opposed to a "birth-related neurological injury," and, regardless of the

etiology of her impairments, she is not permanently and substantially mentally and physically impaired. See Thomas v. Salvation Army, 562 So. 2d 746, 749 (Fla. 1st DCA 1990)("In evaluating medical evidence, a judge of compensation claims may not reject uncontroverted medical testimony without a reasonable explanation.").

CONCLUSIONS OF LAW

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

31. 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.

32. 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 within five years of the infant's birth. §§ 766.302(3), 766.303(2), 766.305(1), and 766.313, Fla. Stat. The Florida Birth-Related Neurological Injury Compensation Association, which administers the Plan, has "45 days from the date of service of a complete claim . . . in which to file a response to the petition and to submit relevant

written information relating to the issue of whether the injury is a birth-related neurological injury." § 766.305(3), Fla. Stat.

33. 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.

34. In discharging this responsibility, the administrative law judge must make the following determination based upon the available evidence:

> (a) Whether the injury claimed is a birth-related neurological injury. If the claimant has demonstrated, to the satisfaction of the administrative law judge, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically impaired, a rebuttable presumption shall arise that the injury is a birth-related neurological injury as defined in s. 766.303(2).
>
> (b) Whether obstetrical services were delivered by a participating physician in the course of labor, delivery, or

> resuscitation in the immediate post-delivery period in a hospital; or by a certified nurse midwife in a teaching hospital supervised by a participating physician in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital.

§ 766.309(1), Fla. Stat. An award may be sustained only if the administrative law judge concludes that the "infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at birth." § 766.31(1), Fla. Stat.

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

> injury to the brain or spinal cord of a live infant weighing at least 2,500 grams 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.

36. As the proponents of the issue, the burden rested on Petitioners to demonstrate that Elizabeth suffered a "birth-related neurological injury." See § 766.309(1)(a), Fla. Stat. See also Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349, 350 (Fla. 1st DCA 1977)("[T]he burden

of proof, apart from statute, is on the party asserting the affirmative issue before an administrative tribunal.").

37. Here, the proof failed to demonstrate that Elizabeth suffered "an injury to the brain . . . caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period" or that Elizabeth was "permanently and substantially mentally and physically impaired." Consequently, given the provisions of Section 766.302(2), Florida Statutes, Elizabeth does not qualify for coverage under the Plan. See also Humana of Florida, Inc. v. McKaughan, 652 So. 2d 852, 859 (Fla. 2d DCA 1995)("[B]ecause 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. McKaughan, 668 So. 2d 974, 979 (Fla. 1996); Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings, 686 So. 2d 1349 (Fla. 1997)(The Plan is written in the conjunctive and can only be interpreted to require both substantial mental and substantial physical impairment.).

38. Where, as here, the administrative law judge determines that ". . . the injury alleged is not a birth-related neurological injury . . . he [is required to] enter an order [to

such effect] and . . . cause a copy of such order to be sent immediately to the parties by registered or certified mail." § 766.309(2), Fla. Stat. Such an order constitutes final agency action subject to appellate court review. § 766.311(1), Fla. Stat.

## CONCLUSION

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

ORDERED that the claim for compensation filed by April D. Adams and Jeffrey Floyd Adams, individually and on behalf of and as parents and natural guardians of Elizabeth Ann Adams, a minor, is dismissed with prejudice.

DONE AND ORDERED this 24th day of April, 2009, in Tallahassee, Leon County, Florida.

WILLIAM J. KENDRICK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of April, 2009.

## ENDNOTES

1/ The petition also alleged that the physician who provided obstetrical services at Elizabeth's birth (Michelle McLanahan, M.D.) and the hospital at which her birth occurred (St. Luke's Hospital) failed to comply with the notice provisions of the Plan. However, the parties subsequently stipulated the physician and hospital provided adequate notice of their participation in the Plan. (Amended Pre-hearing Stipulation, Admitted Facts, paragraph 9).

2/ The parties' stipulated record is identified by their Amended Notice of Filing Stipulated Record (Exhibits 1-26), attached to their Amended Pre-hearing Stipulation, filed March 12, 2009; Notice of Filing Supplement to Stipulated Record (Exhibit 27), filed March 19, 2009; and Notice of Filing Supplement to Stipulated Record (Exhibit 28), filed March 27, 2009.

3/ 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 Elizabeth suffered an injury to the spinal cord that rendered her permanently and substantially mentally and physically impaired. Consequently, that alternative need not be addressed.

4/ A "hemorrhage" is "the escape of blood from the vessels; bleeding." Dorland's Illustrated Medical Dictionary, 28th Edition, 1994. See also Exhibit 18, pp. 17 and 18.

5/ A "hematoma" is "a localized collection of blood, usually clotted, in an organ, space, or tissue, due to a break in the wall of a blood vessel." Dorland's Illustrated Medical Dictionary, 28th Edition, 1994. See also Exhibit 18, pp. 17 and 18.

6/ Petitioners note that their "argument is contrary to the ruling of the Fourth District Court of Appeal on closely similar facts in Nagy v. Florida Birth-Related Neurological Injury Compensation Ass'n, 813 So. 2d 155 (Fla. 4th DCA 2002)," but "respectfully submit that Nagy is wrongly decided." (Petitioners' Memorandum Regarding Final Order, pp. 5 and 6).

Notably, in Nagy, the court concluded the child did not suffer a "birth-related neurological injury." In doing so, the court reasoned:

> Because the initial injury was to something other than the baby's brain or spinal cord, by definition, it is not a "birth-related neurological injury" written section 766.302(2). The fact that the subgaleal bleeding ultimately led to cerebral hypoxia and hypovolemia, and this loss of oxygenated blood in turn damaged the brain sometime before death occurred 14 hours from birth, simply means that the deprivation and injury to the brain did not occur during labor or delivery [, or immediately afterward]. The fact that a brain injury from oxygen deprivation could be traced back to a mechanical injury outside the brain resulting in subgaleal hemorrhaging does not satisfy the requirement that the oxygen deprivation or mechanical injury to the brain occur during labor or delivery [or immediately afterward].

Nagy, 813 So. 2d at 160

Here, contrary to Petitioners' suggestion, the facts are not "closely similar" to the facts in Nagy. In Nagy, the proof clearly demonstrated that the subgaleal bleed continued

unabated, resulting in hypovolemia, ischema, cardiogenic shock, brain injury, and death. Here, as discussed infra, the record does not support a conclusion that the subgaleal bleed resulted in hypovolemia and brain injury. (See e.g., Exhibit 18, pp. 17, 18, and 35). Moreover, if it did, Nagy would apply, and foreclose recovery.

7/ Vaginal examination at 11:06 p.m., revealed the cervix at 6.5 centimeters, effacement at 75 percent, and the fetus at -1 station; at 1:00 a.m., September 17, 2004, the cervix at 10 centimeters (complete), effacement at 100 percent (complete) and the fetus at 0 station; and at 4:33 a.m., the cervix complete and the fetus at +2 station.

8/ An Apgar score is a numerical expression of the condition of a newborn infant, and reflects the sum points gained on assessment of heart rate, respiratory effort, muscle tone, reflex irritability, and color, with each category being assigned a score ranging from the lowest score of 0 to a maximum of 2. (Dorland's Illustrated Medical Dictionary, 28th Edition 1994; Exhibit 1). Here, at one minute, Elizabeth's Apgar score totaled 8, with heart rate, respirator effort, and reflex irritability being graded at 2 each, and muscle tone and color being graded at 1 each. At five minutes, Elizabeth's Apgar score totaled 9, with heart rate, respiratory effort, muscle tone, reflex irritability being graded at 2 each, and color being graded at 1.

9/ "Acrocyanosis' is "a condition marked by symmetrical cyanosis of the extremities, with persistent uneven blue or red discoloration of the skin of the digits, wrists, and ankles and with profuse sweating and coldness of the digits." Dorland's Illustrated Medical Dictionary, 28th Edition, 1994.

10/ 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.

§ 766.301(2), Fla. Stat.

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."

When not defined, "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]ccuring 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.

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 as written, the oxygen deprivation or mechanical injury to the brain must take place during labor, or delivery, or immediately afterward."). 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)("[B]ecause 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).

Under the facts of this case, resuscitation in the immediate postdelivery period ended not later than the five-minute Apgar, by which time Elizabeth had been stimulated and bulb-suctioned.

(Exhibits 18, pp. 19 and 20). Thereafter, Elizabeth required no further intervention until 16 hours of life when she showed evidence of seizure activity. Elizabeth's brain injury likely post-dated her "resuscitation in the immediate postdelivery period."

11/ See "meningoencephalitis," Dorland's Illustrated Medical Dictionary, 28th Edition, 1994.

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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.