STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MICHELLE AND CHRIS JOHNSTON, as parents and natural guardians of EMMA JOHNSTON, a minor,	)	
Petitioners,	)	
vs.	)	Case No. 09-1712N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
SOUTHERN BAPTIST HOSPITAL OF FLORIDA, INC., d/b/a BAPTIST MEDICAL CENTER,	)	
Intervenor.	)	

FINAL ORDER

Upon due notice, a final hearing was conducted by Ella Jane P. Davis, an Administrative Law Judge (ALJ) of the Division of Administrative Hearings (DOAH) on October 24 and 25, 2011, in Jacksonville, Florida.

APPEARANCES

For Petitioners: Ronald S. Gilbert, Esquire
Colling, Gilbert, Wright, and Carter, LLC
801 North Orange Avenue
Orlando, Florida 32801

For Respondent: Michael A. Kundid, Esquire
Doran, Sims, Wolfe, Ansay and Kundid
1020 West International Speedway
Boulevard Suite 100
Daytona Beach, Florida 32114

For Intervenor: Earl E. Googe, Jr., Esquire
Smith, Hulsey and Busey
1800 Wachovia Bank Tower
225 Water Street
Jacksonville, Florida 32202

STATEMENT OF THE ISSUE

Whether Emma Johnston, a minor, sustained an injury which is compensable under the Florida Birth-Related Neurological Injury Compensation Plan.

PRELIMINARY STATEMENT

Procedural history

On April 2, 2009, Michelle Johnston and Chris Johnston, individually and on behalf of Emma Johnston (Emma), filed a petition (claim) with the Division of Administrative Hearings (DOAH) to resolve whether Emma qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

DOAH served the Neurological Injury Compensation Association (NICA) with a copy of the claim on April 3, 2009; served Southern Baptist Hospital of Florida, Inc., d/b/a Baptist Medical Center (BMC) on April 6, 2009; and served Evaleen Caccam, M.D., on April 6, 2009. The case file reflects all activity thereafter. Most notable, however, is that upon appropriate motion and

response, a Summary Final Order was entered on June 15, 2010. That Summary Final Order was subsequently vacated by an Order entered on July 13, 2010. Thereafter, on September 3, 2010, BMC was granted Intervenor status, and a motion for intervention on behalf of Dr. Caccam and others was denied without prejudice to filing a new motion. However, there have been no subsequent motions for intervention.

Previously, NICA had filed its response required by section 766.305(4), Florida Statutes, on August 26, 2009, and thereby gave notice that NICA was of the view that the claim was not compensable because the injury to Emma failed to meet the definition of birth-related neurological injury as defined in section 766.302(2). Petitioners had agreed with NICA's determination of non-compensability. Upon intervention, BMC claimed that Emma sustained a birth-related neurological injury as defined in section 766.302(2).

After a period for discovery, the case proceeded to final hearing on October 24 and 25, 2011.

Petitioners, who seek to recover outside the Plan, in circuit court, have consistently declined to invoke the statutory presumption in favor of compensability, as is their prerogative. See § 766.309(1)(a), Fla. Stat., and Bennett v. St. Vincent's Med. Ctr., 71 So. 3d 828 (Fla. 2011).

The record

At final hearing, the parties' Prehearing Stipulation was admitted in evidence as ALJ Exhibit 1. (TR 9-10). Intervenor BMC presented the oral testimony of Thomas Paul Naidich, M.D., Keith Jackson Peevy, M.D., and Ira T. Lott, M.D. Petitioners and NICA presented no oral testimony. Intervenor BMC's Exhibits 1-16, 17A and 17B, 18-24, and 27-31 were admitted in evidence. There is no Intervenor's I-25 or I-26. Petitioners' Exhibits 16-19 and Respondent NICA's Exhibits 1 and 2 were likewise admitted in evidence.[1/]

Post-hearing procedure

The transcript of final hearing was filed on November 8, 2011. Upon stipulations, the parties were granted until December 15, 2011, in which to file their respective proposed final orders. All proposals have been considered.

The parties' respective positions and the burden of proof

Notice is not an issue in this case.

Petitioners and NICA take the position that the claim is not compensable because the injury that Emma sustained was not the result of oxygen deprivation or mechanical injury occurring in the course of "labor, delivery, or resuscitation in the immediate postdelivery period in a hospital" (the statutory period). Petitioners and NICA further take the position that the claim is

not compensable, because Emma did not sustain a permanent and substantial mental impairment. See § 766.302(2), Fla. Stat.

Intervenor BMC takes the position that Emma's injury is compensable, in that she suffered oxygen deprivation to her brain within the statutory period resulting in a permanent and substantial mental impairment.

No party contends that Emma did not suffer a permanent and substantial physical impairment.

As proponents of the issue, the burden of proof as to compensability is upon BMC. Balino v. Dep't of Health and Rehab. Servs., 348 So. 2d 349, 350 (Fla. 1st DCA 1997). Petitioners did not assert the presumption of compensability, which is provided-for by section 766.309(1)(a), and which may be exercised by the Petitioners/claimants only. This presumption is not available to the other parties. See Bennett, supra.

FINDINGS OF FACT

Stipulated and threshold matters

1. Petitioners, Michelle Johnston and Chris Johnston, are the parents and natural guardians of Emma Johnston, a minor.

2. BMC is a Florida-licensed hospital, participating in the NICA plan.

3. Emma was born at BMC on June 6, 2007.

4. Emma was delivered vaginally.

5. Obstetrical services were delivered by Evaleen Caccam, M.D., who was a participating physician in the NICA Plan at all times material.

6. Emma was the result of a single gestation, and her birth weight was in excess of 2,500 grams.

7. Emma is permanently and substantially physically impaired.

The timing and nature of Emma's injury

8. Mrs. Johnston's pregnancy with Emma was essentially uneventful. She suffered gestational diabetes, controlled by diet, and slightly more than average amniotic fluid (mild polyhydramnios), neither of which has been linked to an adverse effect on Emma.

9. Mrs. Johnston had a reassuring non-stress test on May 29, 2007, and she was seen at Faben OB/GYN for a routine appointment on June 5, 2007, at 37 weeks' gestational age. A non-stress test at that time also was reassuring. At approximately 9:30 p.m., that night, Mrs. Johnston experienced a spontaneous rupture of membranes, with light meconium staining.

10. There is no evidence that Emma inhaled meconium below the vocal cords or that she suffered meconium aspiration syndrome.

11. Shortly before 10:30 p.m., June 5, 2007, Mrs. Johnston was admitted to BMC. Fetal monitoring by an external belt was

initiated. The initial nursing assessment recorded that Mrs. Johnston reported normal fetal movement and no problems. For an hour after admission, the fetal heart rate pattern was reactive, with no decelerations.

12. At 12:40 a.m., June 6, 2007, the fetal heart rate decreased to 50 beats per minute, but quickly returned to baseline. Nurses' notes reveal that between 12:40 a.m., and 7:00 a.m., there were variable decelerations in the fetal heart rate and occasional elevations in Mrs. Johnston's blood pressure. Measures to support the fetal heart rate included IV fluids, oxygen, and repositioning the mother.

13. Emma was delivered vaginally at 1:06 p.m., on June 6, 2007, with the nuchal cord looped around her neck one time. Her birth weight was 3,102 grams and her growth was listed as appropriate for her gestational age. However, she was hypotonic (floppy) and not breathing.

14. Apgar scores were two at one minute; three at five minutes; and five at 10 minutes. The barely acceptable "five at 10" score probably was not simultaneous with bag and mask ventilation, as suggested by some of the examination/cross-examination of witnesses, but it clearly occurred after mask ventilation, probably occurred simultaneously with blow-by oxygen, and certainly was achieved only by resuscitative efforts of medical personnel. Emma's respiration continued to fail while

in the delivery room and before her admission to the newborn intensive care unit (NICU) at nine minutes of life. On admission to NICU, Emma was described as cyanotic (blue) and limp, with poor perfusion and no respiratory effort. Also, intubation and mechanical ventilation was accomplished immediately upon admission to the NICU and continued for hours. Thus, it is clear that Emma was not stabilized in the delivery room; that resuscitation was continuous in various forms for hours after birth; that even the depressed Apgar scores were "assisted"; and that there was an extended resuscitative period beyond the delivery room. See Orlando Reg. Healthcare Sys., Inc. v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 997 So. 2d 426 (Fla. 5th DCA 2008).

15. Emma's arterial cord blood gas showed evidence of significant acidosis, with a pH of 7.10, $HC0_3$ of 18, and base excess of minus 13.

16. At 1:33 p.m., an arterial blood gas showed pH of 7.08, $HC0_3$ of 11, and base excess of minus 19. Blood work drawn at 2:03 p.m., showed a lymphocyte count of 11,266K per microliter, and nucleated red blood cells (NRBCs) of 4,726 thousand per microliter. Both readings were elevated, consistent with recent significant stress.

17. At 3:00 p.m., June 6, 2007, Emma was noted to have stiffening of her arms (posturing), suggestive of seizure.

18. At 6:00 p.m., Emma was extubated to room air. She was noted to have a desaturation and apnea. Blow-by oxygen was administrated. Posturing was again noted. Phenobarbital was administrated for seizure, but later discontinued.

19. On June 6, 2007, Emma continued to experience respiratory depression, metabolic acidosis, possible sepsis, possible seizures, hypotension, hypoperfusion, and hypoglycemia.

20. At 1:30 a.m., on June 7, 2007, Emma's calcium was 5.0 (critically low). Measures of her kidney function were also abnormal, with her BUN at 22 (high) and her creatinine at 1.2 (high). At 5:00 a.m., her calcium was 6.3 (critically low), BUN was 20 (high), creatinine was 1.0 (high), AST was 91 (high), and ALT was 99 (high). At 2:46 p.m., the level of lactic acid in her blood remained elevated at 2.8 (high). At 11:05 p.m., her calcium was 6.9 (low).

21. Emma's lab values on June 8, 9, 10, and 11, show values reflective of possible hypoxia.

22. Emma remained in the NICU for 56 days. She suffered feeding difficulties beginning at birth, had difficulty sucking and swallowing, and ultimately required the insertion of a G-tube for feeding.

23. On June 7, 2007, when Emma was 11 hours old, an MRI was performed. BMC's reading radiologist reported that:

> On diffusion weighted images, the cerebral cortex appears more bright than normally seen. It has dark signal on ADC map images. On T2 weighted images, no abnormal signal is seen in the same regions of the cortex. On T1 weighted images, the cortical signal is normal. Significance of these findings is not certain. They probably represent normal variation. Diffuse laminar necrosis or infarct may produce some of the findings but felt to be less likely.
>
> The pituitary gland, corpus callosum and cervicomedullary junction region appear normal.
>
> A focal blooming artifact is seen in the superior portion of the right cerebellar hemisphere on MPGR sequence. No corresponding signal abnormality is seen at this level on T1 weighted images to suggest a hemorrhage. It may represent slow flowing vessel.
>
> Size and configuration of the ventricles and other CSF spaces appear unremarkable considering patient's age.
>
> IMPRESSION
> 1. Signal changes noted in the cerebral cortex are difficult to explain. They may represent normal variation.
> 2. A blooming artifact seen in the cerebellar hemisphere of the right side is probably secondary to slow flowing vessels. (emphasis added).

24. On July 13, 2007, between 5 and 6 weeks of life, Emma underwent another MRI. BMC's Christopher Zaleski, M.D.'s narrative report compared it to the June 7, 2007, MRI. His report reads, in pertinent part:

> There are no areas of restricted diffusion within the brain parenchyma. The midline

structures of the corpus callosum, pituitary gland and cerebellar vermis are within normal limits.

No abnormal bright signal in the distribution of the paranasal sinuses or mastoid air cells. Orbital structures are symmetric and within normal limits.

No mass effect or midline shift. The ventricular system is not dilated. The extra-axial CSF spaces are symmetric in size and are appropriate for the patient's age. Myelination pattern is appropriate for the patient's age as well. No evidence of breakdown products of hemorrhage within the ventricular system or within the brain parenchyma.

No other structural anomalies. Thin section T2 inversion recovery coronal images obtained through the temporal lobes demonstrate symmetry of signal intensity and configuration of the hippocampi.

Axial T1 weighted images demonstrate appropriate distribution of myelination in this patient aged 5 weeks.

CONCLUSION
1. Resolution of scalp soft tissue swelling.
2. Normal myelination with no structural anomaly or intracranial hemorrhage.

25. Emma underwent a third MRI on January 14, 2009, at age 19 months, which was interpreted by the same physician (Dr. Gore) who reviewed her first MRI. He found this MRI to be "unremarkable."

26. In initially denying Emma's parents' claim, NICA relied, in part, upon the opinion of Dr. Donald C. Willis, a board-certified obstetrician with special competence in maternal-

fetal medicine. Dr. Willis reviewed only the narrative reports connected to the MRIs, and did not see or interpret the actual MRI films. He reported to NICA that his records review suggested a birth-related hypoxic injury, but that the MRI failed to demonstrate hypoxic ischemic encephalopathy, and that, therefore, significant hypoxic injury to Emma's brain was unlikely. However, by a later deposition, Dr. Willis testified, in pertinent part, as follows:

> . . . specifically in this case I don't have anything to tell me that when the patient [Mrs. Johnston] was admitted to the hospital the baby had any substantial brain injury at that point. The fetal heart rate tracing had a normal baseline. Reactivity was appropriate.
>
> So when the baby was first placed on the monitor when the mother was admitted to the hospital in labor I don't have anything there to suggest that the baby had any suggested brain injury that had occurred prior to that. (I-29; Willis Depo. pages 38-39).
>
> ***
>
> . . . To be honest with you as I was reading this case I thought this was going to be just a clear abnormal fetal heart rate tracing, baby was born depressed. The cord pH was not quite as acidotic as I was expecting it to be based on all the other information; but, the base deficit was high enough to be consistent with a hypoxic event sufficient to cause severe brain injury.
>
> The hospital course for this baby is fairly characteristic, in my opinion, for a baby that had oxygen deprivation and brain injury during labor and delivery. You have seizures

> and feeding disorders. I have been reviewing these cases for 10 years now and I got used to the findings the babies have in that newborn course when they have significant brain injury, and these are the types of things we see.
>
> But the MRI, you know, kept saying normal. And as you know, without some abnormality on that MRI consistent with oxygen deprivation I just could not say that the baby's brain injury was due to the oxygen deprivation during labor and delivery. Yes, I think the baby had oxygen deprivation during labor and delivery and immediate post delivery period, but it was the normal MRI that kept me from saying that was the reason for the baby's brain injury. (I-29; Willis Depo. pages 43-44). (emphasis added).

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27. Nonetheless, Dr. Willis deferred to a qualified neuroradiologist for interpretation of the actual MRIs.

28. In denying the claim, NICA also initially relied on the opinion of Dr. Michael Duchowny, a pediatric neurologist who examined Emma and reported that, in his opinion, Emma did not suffer oxygen deprivation and damage to her brain during the statutory period because he did not see any structural damage to her brain, and further concluded that her problems must be congenital. This portion of his opinion was not significantly altered in his subsequent two depositions. Dr. Duchowny also only reviewed the MRI narratives, not the MRI films.

29. Keith Jackson Peevy, M.D., practices neonatal-perinatal medicine, as part of a neonatal intensive care unit with up to

100 infants, which involves care of sick newborns and consultation with obstetricians and primatologists about in utero issues. Testifying live at hearing on behalf of Intervenor BMC, Dr. Peevy concluded that Mrs. Johnston's gestational diabetes, mild polyhydramnios, and light meconium staining was immaterial to Emma's situation. According to him, Emma's abnormal lab values at birth (cord blood gas, arterial blood gas, NRBCs, calcium, and lymphocytes) were consistent with oxygen deprivation during labor and delivery, and he concluded that Emma suffered hypoxic ischemic encephalopathy (HIE) between her mother's hospital admission in labor and her birth. While Dr. Peevy relied on the fetal monitor strips to conclude that Emma's HIE occurred as a result of oxygen deprivation during labor, he conceded that the fetal monitor strips did not demonstrate, and therefore he could not conclude that, there had been a sentinel event of hypoxia during labor. He further concluded that it is more probable than not that Emma suffered subtle, but protracted, hypoxic ischemic injury in the period between her mother's hospital admission and her delivery, an opinion echoed by another witness, Dr. Pinshaw (see Finding of Fact 38).

30. Ira T. Lott, M.D., is a board-certified pediatric neurologist, with special competence in child neurology, who testified on Intervenor's behalf, and who also, upon a records review, was unable to pinpoint a sentinel event during labor,

delivery, or resuscitation in the immediate postdelivery period when oxygen deprivation to Emma's brain had occurred. Nonetheless, he concluded that Emma had suffered substantial permanent neurological injury due to oxygen deprivation during labor and delivery, based upon the fetal monitoring strips, Apgar scores, lab results (especially the acidosis), EEGs, and seizure activity.

31. Intervenor BMC also presented at hearing the live testimony of Thomas Paul Naidich, M.D., a board-certified pediatric neuroradiologist. Dr. Naidich is the Director of Neuroradiology at Mount Sinai Medical Center and the Albert Einstein School of Medicine, where he is vice-chairman of radiology for academic affairs, professor of radiology and neurosurgery, and endowed chair for research in neuroscience and neuroimaging. He is a founding member and past-president of the American Society of Pediatrics and Neuroradiology and helps administer board certification examinations for radiologists and neuroradiologists. Dr. Naidich compared Emma's three MRI films with those of healthy babies of similar age. He testified that, in his expert opinion, and contrary to the reports of all BMC personnel who contemporaneously reviewed her MRIs, Emma had suffered progressive hypoxic ischemic brain damage as evidenced by the abnormal brightness seen initially on the MRI taken the day after her birth. (See Finding of Fact 23.)

32. In Dr. Naidich's opinion, based on the type of damage to Emma's brain, the damage to her brain had occurred during "the perinatal period," which period he considered to be in the course of labor and/or delivery. That said, Dr. Naidich also was unable to point to any indication of fetal distress on the fetal monitor strips or to any sentinel hypoxic event identifiable by any means, including MRI, which had occurred during labor, delivery, or resuscitation in the immediate postdelivery period. Nonetheless, he noted that MRIs do not necessarily pinpoint, in time, hypoxic events, ischemic damage, or even births.

33. The early MRIs were, at best, inconclusive, and Dr. Naidich's testimony is persuasive to the effect that Emma's brain suffered injury at some point at or around birth. However, in addition to Dr. Naidich's testimony, the undersigned attributes considerable weight to the reassuring stress test the morning before labor began and to the several records, as explained by various witnesses, which show no signs of fetal damage or of maternal symptoms preceding Mrs. Johnston's admission to the hospital and the commencement of labor, and to the encephalograms (EEGs) and other tests described hereafter which likewise suggest that, more likely than not, an hypoxic brain injury occurred during labor, delivery, or resuscitation.

34. Indeed, Emma had undergone an EEG on June 7, 2007, the second day of life. It was abnormal and compatible with a

diffuse multifocal encephalopathy, which could be caused by hypoxia or hypoperfusion (abnormally low blood flow). Later that day, Dr. Islam, a pediatric neurologist, suggested that Emma could have an underlying infectious, metabolic or hypoxic injury. However, records show the EEG on June 12, 2007, was "suggestive of an immature or dismature state, most likely seen secondary to global hypoxia, ischemia, infection, metabolic abnormalities or other global insults."

35. Evidence further persuasive to a finding that Emma suffered oxygen deprivation during labor, delivery, and/or the immediate postdelivery resuscitative period is the evidence that on June 14, 2007, Dr. Anthony Perszyk from the Genetics service of Nemours Children's Clinic examined and tested Emma, reviewed her MRIs, and concluded that the MRIs showed "diffuse hypodensity suggesting hypoxic ischemic changes, acute more likely but subacute possible," and was unable to identify a genetic or metabolic cause for Emma's problems.

36. A chromosome analysis also has disclosed no genetic disorder.

37. Emma was subsequently seen at the Genetics Clinic at Nemours by Laura Marin, M.D., on March 20, 2008, and May 16, 2008. Testing and extensive inquiry into family history did not identify a specific genetic or metabolic problem.

38. Alan Pinshaw is a board-certified obstetrician-gynecologist,[2/] with a 40-year career in all phases of pregnancy, labor, and delivery. He is a Harvard Medical School professor, teaching obstetrics and gynecology to residents and medical students. Dr. Pinshaw testified by deposition, and among the witnesses, most clearly explained what probably happened to Emma. He found no abnormalities to have occurred during Mrs. Johnston's pregnancy to account for Emma's condition, observing that the non-stress tests showed that the baby was in good condition at those points in time and receiving adequate oxygenation; the meconium staining, polyhydramnios, and gestational diabetes were not significant; and the initial fetal heart tracings were initially reassuring. Although Dr. Pinshaw gave prenatal acquisition of Emma's condition a one percent chance, he believed prenatal acquisition of it to be improbable and not within a reasonable medical probability.

39. In Dr. Pinshaw's opinion, the later deep, persistent decelerations and fetal tachycardia observed on the fetal heart rate monitor strips demonstrated that the baby was "stressed" and was attempting to compensate for the decelerations. The decreased beat-to-beat variability on the fetal heart rate monitor strips was another adverse sign. Together, these factors evidenced decreased oxygenation to the baby during labor. Based upon the subsequent course of labor, delivery, and particularly

Emma's condition at birth and her worsening condition immediately thereafter, plus the EEG evidence, it was Dr. Pinshaw's view that Emma's situation is consistent with her having suffered an hypoxic brain injury during the statutory period.

40. Specifically, Dr. Pinshaw testified:

> . . . Firstly, during every labor, there's a decrease in oxygen delivery during uterine contractions. That -- that is normal physiology. There will be reduced oxygen delivery to the fetus during uterine contractions. And before the next uterine contraction occurs, there is recovery of that relative oxygen deprivation so that you go back to baseline; you don't incur an oxygen debt.
>
> It's only when with recurrent small oxygen debts that are not paid back that you incur an overall oxygen deprivation resulting in the formation of the acid products that I was talking about in a baby being born in an oxygen-deprived state or in a -- hypoxic state. But it is quite normal for many episodes of oxygen deprivation. That's quite normal during labor. But the point is, is this oxygen debt or this oxygen deprivation corrected after the uterine contraction, and under normal circumstances it is.
>
> So if you're asking me whether during these variable decelerations there was relative hypoxia, the answer's yes, you would expect it. But if you look at the fetal heart rate tracing thereafter, it starts to look -- look fairly reassuring, suggestive of the fact that whatever hypoxia did occur during that variable deceleration is temporary.
>
> Later in this fetal heart rate tracing, the baby loses that ability to recover to a fetal heart rate tracing that is normal. And

> the fetal heart rate tracing at that point exhibits a tachycardia, fetal tachycardia, which is not normal, so you can conclude that the baby at that stage has hypoxia. (I-18; I-28; P-19, pages 66-67).
>
> ***
>
> . . . you have a series of variable decelerations, and it's during those variable decelerations that there's decreased oxygen delivery, which eventually, in my opinion, outstrips the ability of the baby to compensate to a normal fetal heart rate tracing, and it develops a tachycardia.
>
> ***
>
> . . . There's a debt that's accumulated and, in a healthy situation, paid off immediately, so that you restore the oxygen status. But too many variables, too -- if they're too long or too deep or too many, it gets beyond the ability of the fetus to compensate, and that's when you'll get a tachycardia. And that's what eventually, in my opinion, happens in this case. (I-18; I-28; P-19, pages 70-71).

41. Having considered and weighed all the testimony and exhibits, it is found that Dr. Pinshaw's explanation is credible and fits all of the facts as established by the other credible competent evidence.

42. Finally, the credible, competent evidence as a whole supports a finding that Emma's brain suffered injury from oxygen deprivation occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in the hospital.

Permanent and substantial mental impairment

43. In initially denying the claim, NICA relied on the opinion of Dr. Duchowny, who examined Emma on August 5, 2009, when she was two years old. At that time, Dr. Duchowny rendered an opinion by contemporaneous letter. The portion thereof addressing Emma's mental status reads:

> In SUMMARY, Emma's neurological examination reveals evidence of cognitive delay together with generalized hypotonia and congenital nystagmus and an alternating esotropia. [cross-eye] In addition, Emma demonstrates somatic abnormalities including epicanthal folds and a high arched palate. These findings are consistent with a diagnosis of hypotonia ataxic cerebral palsy.

44. Thereafter, Dr. Duchowny was deposed, on November 12, 2009, and testified in pertinent part:

> Q: Following your examination and review of the records that were provided you, did you formulate an opinion as to whether or not Emma Johnston has permanent and substantial mental or cognitive impairment.
>
> A: [Dr. Duchowny] I think that is more difficult to say. She clearly is delayed with respect to her speech. But in truth, I think it is too soon to say that she has a permanent and substantial cognitive impairment. I guess I'm stopping short of saying that ultimately it will be substantial.
>
> Q: Okay. At what age would you anticipate that you would be able to reach an opinion that a cognitive impairment is both permanent and substantial, if it ultimately is such?

> A: The best time would be age six. You could probably come close to that by age four. But to be definitive, age six years. (emphasis added). (I-30; Depo. page 24).

45. Dr. Trevor Resnick, another board-certified pediatric neurologist and a colleague of Dr. Duchowny, examined Emma on December 10, 2010, when she was three and a half-years-old. Dr. Resnick prepared a December 14, 2010, letter opinion largely directed to Emma's physical impairments. However, by this letter opinion, dated December 14, 2010, and stipulated in evidence (Intervenor's Exhibit 17A), Dr. Resnick stated, in relationship to Emma's mental status:

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> PHYSICAL EXAMINATION: Emma was interactive and demonstrated good eye contact during the examination. . . . Head shape was normal. . . .
>
> NEUROLOGICAL EXAMINATION: She was alert during the evaluation. She smiled interactively occasionally. She did not make sounds or say any words. She did not demonstrate any comprehension. . . .
>
> ASSESSMENT: Emma's neurological status is characterized by marked and diffuse hypotonia, cognitive impairment and nystagmus. She also has a high arched plate and epicanthic folds. Her neurological deficits are permanent in nature. (I-17A).

46. Hypotonia (floppiness) and nystagmus (rapid eye movement) have not been shown to be prognosticators of mental

impairment, nor are a high-arched palate and epicanthic folds (extra creases in the eyelid) significant in assessing cognition.

47. At the request for greater detail from Intervenor's counsel, Dr. Resnick issued the same letter later the same day with a little more detail, and included an opinion with regard to permanency and substantiality of Emma's mental and physical impairments. This item was designated Exhibit I-17B. Dr. Resnick was never deposed and did not testify at hearing.

48. Dr. Willis had no independent opinion on the impairment issue.

49. Dr. Naidich conceded that he was not qualified to render any opinion with regard to whether or not Emma had suffered a permanent and substantial impairment, mental or physical.

50. Dr. Pinshaw also had no opinion as to whether or not Emma had suffered a permanent and substantial impairment.

51. Dr. Peevy first stated that he had no independent opinion as to whether or not Emma had suffered a permanent and substantial impairment, mental or physical, but upon cross-examination, he conceded that, to the extent that he had such an opinion, that opinion was not based upon any examination or tests of his own and that he had merely accepted the opinions of Drs. Duchowny and Resnick.

52. Dr. Lott also stated that he had no independent opinion on the impairment issue, but had relied on the opinions of Drs. Duchowny, Willis, and Resnick.

53. To one degree or another, any opinion by Drs. Peevy and Lott, as to whether or not Emma has a mental impairment and whether or not Emma's mental impairment, if any, rises to the level of being permanent and substantial, was dependent upon Intervenor's Exhibit 17B, the second letter-opinion of Dr. Trevor Resnick. Dr. Resnick's second letter was objected-to and admitted over objection as is appropriate in chapter 120 proceedings, but it has not been considered as evidence for purposes of making a finding of fact, and the following findings of fact reflect that situation.[3/]

54. On March 29, 2011, Dr. Duchowny was deposed a second time. At that date, in reliance on Exhibit I-17B, he testified substantially differently than he had in his previous deposition. Accordingly, that altered testimony of Dr. Duchowny also may not be used for a finding of fact.[4/]

55. The undersigned has carefully perused the record for any objective evidence of Emma's mental state at the present time. Such evidence is slim. The record as a whole reveals that her head size at birth and at various stages of growth has been measured and found to be within normal limits. In other words, she is not microcephalic, and her head may be expected to grow to

accommodate her brain as her brain grows. She has a high arched palate, her eyelids have epicanthal folds, and she has nystagmus, but up to 30 percent of the normal population may have one or more of these variations.

56. There is no anecdotal evidence from parents or teachers in this record by which one might assess the ability or lack of ability to learn.

57. The stipulated paper record is extensive but mostly directed to physical improvement strategies. It reveals that Emma has undergone occupational therapy, speech therapy, and physical therapy, but precisely what these therapies entailed and how successful or unsuccessful they were is not clear. There also do not seem to be any standardized test results.

58. Reports in evidence suggest that at least up until her third year, Emma was meeting her developmental milestones, but meeting them late. There is evidence that she is sometimes hysterical when in groups of people or with her brother. There is evidence that she has developmental delays, but there is no clear assessment of the degree or nature of those delays.

59. A July 19, 2011, report by David Childers, M.D., of the University of Florida Developmental Pediatric Program states Emma had no communication at age four and was only able to smile or cry to express emotions. However, his report adds that she is making only slow progress with the help of speech therapy,

physical therapy, and occupational therapy, so apparently at that time, at least, she was making some progress. There is no qualified expert opinion to the effect that Emma cannot translate her cognitive capabilities into adequate learning or social development. Emma has cerebral palsy but many children with cerebral palsy are capable of learning.[5/]

60. Given the foregoing and the absence of any presumption of permanent and substantial mental impairment, Intervenors have failed to meet their burden to establish that Emma's mental impairment is permanent and substantial.

CONCLUSIONS OF LAW

61. The Division of Administrative Hearings has jurisdiction of the parties and subject matter of this cause. §§ 766.301-766.316, Fla. Stat.

62. 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 after January 1, 1989. § 766.303(1), Fla. Stat.

63. 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 submit relevant written information relating to the issue of whether the injury is a birth-related neurological injury." § 766.305(4), Fla. Stat.

64. 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.

65. In discharging this responsibility, the ALJ must make the following determinations based upon all 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. 766.302(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.

66. An award may be sustained only if the ALJ 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.

67. 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 an 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.

68. Both the brain injury and the oxygen deprivation that renders the child permanently and substantially mentally and physically impaired must occur during the statutory period. See § 766.302(2), Fla. Stat. See also Bennett v. St. Vincent's Med.

Ctr., Inc., 71 So. 3d 828 (Fla. 2011); Nagy v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 813 So. 2d 155 (Fla. 4th DCA 2002). Cf. Orlando Reg. Healthcare Sys., Inc. v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 997 So. 2d 426 (Fla. 5th DCA 2008).

69. Herein, the parties have stipulated that a physician participating in NICA delivered services in the statutory period, and that Emma is permanently and substantially physically impaired. Given the evidence, it is not reasonably debatable that Emma suffered oxygen deprivation to her brain in the statutory period described in section 766.302(2). Still, inasmuch as both physical and mental impairments are required to establish compensability, the ALJ must address whether or not that oxygen deprivation during the statutory period has produced in Emma a permanent and substantial mental impairment. Fla. Birth-Related Neurological Injury Comp. Ass'n. v. Fla. Div. of Admin. Hearings, 686 So. 2d 1349, 1356 (Fla. 1997); Masterton v. Fla. Birth-Related Neurological Injury Comp. Ass'n. Case 08-6032N (Fla. DOAH FO Jan. 29, 2010) (Corrected Final Order).

70. Herein, Petitioners declined to take advantage of the rebuttable presumption found at section 766.309(1)(a), and as the proponent of the issue, the burden rested on Intervenor to demonstrate that Emma suffered a "birth-related neurological injury." § 766.309(1)(a), Fla. Stat. See also Balino v. Dep't

of Health and Rehab. Servs., 348 So. 2d 349, 350 (Fla. 1st DCA 1997)("[T]he burden of proof, apart from statute, is on the party asserting the affirmative of an issue before an administrative tribunal.").

71. Herein, the proof supported a finding of brain injury by oxygen deprivation during the statutory period, and the parties stipulated that Emma was permanently and substantially physically impaired, but the proof fell short of establishing that Emma has sustained a permanent and substantial mental impairment. Consequently, given the provisions of section 766.302(2), Emma does not qualify for coverage under the NICA Plan. See also §§ 766.309(1) and 766.31(1), Fla. Stat. Humana of Fla., 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 construed to include only those subjects clearly embraced within its terms."), approved, Fla. Birth-Related Neurological Injury Comp. Ass'n v. McKaughan, 668 So. 2d 974, 979 (Fla. 1996).

72. It may be "intuitive" that with her severe physical impairments, Emma's intellect is not "normal," but these proceedings require proof of the impairment, if any, and the measure of an impairment under the Plan is not how a normal child behaves or competes, but rather, whether his mental and physical injuries are "substantial," a benchmark far below the norm.[6/]

"Intuition" is insufficient, and affirmative proof of substantial mental impairment is required. See also Bennett, supra.

73. The Legislature has expressed its intent in section 766.301(2), 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. (emphasis added).

74. Given the Legislature's intent to restrict no-fault coverage under the Plan to "a limited class of catastrophic injuries," it is concluded that the word "substantially," as used in the statutory phrase "permanently and substantially mentally and physically impaired," denotes a "catastrophic" mental and physical injury, as opposed to one that might be described as "mild" or "moderate."

75. Applying the foregoing standards to the facts of this case, it must be concluded that Intervenor has not borne its burden to show that Emma is permanently and substantially mentally impaired. Therefore, she cannot be said to have suffered a "birth-related neurological injury" as defined by statute.

CONCLUSION

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

ORDERED that the claim for compensation filed by Michelle Johnston and Chris Johnston, on behalf of and as parents and natural guardians of Emma Johnston, a minor, is hereby dismissed with prejudice.

DONE AND ORDERED this 27th day of April, 2012, in Tallahassee, Leon County, Florida.

ELLA JANE P. DAVIS
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 27th day of April, 2012.

ENDNOTES

1/ Many exhibits in evidence are somewhat duplicative or redundant of the live testimony and are more fully described as: ALJ Exhibit 1: The Prehearing Stipulation -- interlineated by ALJ to conform to the parties' oral representations at hearing; I-1: Obstetrical Records of Michelle (Ballard) Johnston from Faben OB/GYN, Inc., A00001-000150; I-2: 6/5/07 Baptist Medical Center (BMC) Delivery Admission Records of Michelle Johnston, Including Fetal Monitoring Strips; I-3: 6/6/07 to 7/22/07 BMC Visit List for Emma Johnston (single page); I-4: Seven

photographs of Emma; I-5: 6/6/07 to 7/22/07 BMC Birth Records on Emma Johnston B000244-000834, B000835-0001399; I-6: Two BMC Radiology Records (CDs) and Studies/CVs-MRI June 2007, July 2007, January 2009; I-7: Genetic Consultation Report prepared by Dr. Persyk B000898-900; I-8: 7/31/07 to 12/22/10 Medical Reports of Baptist Pediatrics C000001-C000349; I-9: 7/5/07 to 9/9/10 Medical Records of Children's Clinic C000243-348; I-10: 2/23/10 to 6/1/10 Medical Records of New Heights of Northeast Florida C000350-357; I-11: 6/7/07 to 2/11/10 Medical Records of Dr. Monica Islam C000358-399; I-12: 8/6/09 to 1/28/11 Medical Records of Florida School for the Deaf & Blind C000400-615; I-13: 11/8/07 to 7/11/08 Medical Records of A+ Children's Therapy, Inc., C000616-627; I-14: 8/6/07 to 2/11/11 Medical Records of Early Steps C000628-935; I-15: 7/17/08 to 8/18/10 Medical Records of PhysioPower, Inc., LLC C000936-1200; I-16: 10/12/10 to 2/28/11 Therapeutic Learning Center C001201-1252; I-17A: Medical Records and Reports Regarding Examination of Emma Johnston by Dr. Trevor Resnick 12/14/2010 (2 pages); I-17B: Letter of Dr. Trevor Resnick 12/14/2010; I-18: Documents attached to the video depositions of Dr. Alan Pinshaw including his report (11 pages); I-19: Documents attached to the deposition of Dr. Michael Duchowny 11/12/2009 (8 pages & 4-page report); I-20: Documents attached to the deposition of Dr. Donald C. Willis and report; I-21: CV of Dr. Alan Pinshaw (4 pages); I-22: CV of Dr. Ira Lott (22 pages); I-23: CV of Dr. Thomas Naidich (65 pages); I-24: CV of Dr. Keith Peavy (17 pages); I-25: None; I-26: None; I-27: University of Florida Pediatric Multispecialty Center reports; (Composite) I-28: Pinshaw Deposition Video; I-29: Deposition of Dr. Willis (Intervenor's designations); I-30: 11/12/2009 Deposition of Dr. Duchowny (Intervenor's designations); I-31: 3/21/2011 Deposition of Dr. Duchowny (Intervenor's designations); P-16: 10/13/09 Deposition of Dr. Willis (Petitioners' designations); P-17: 11/12/09 Deposition of Dr. Duchowny (Petitioners' designations); P-18: 3/29/11 Deposition of Dr. Duchowny (Petitioners' designations); P-19: 3/15/11 Deposition of Dr. Pinshaw (Petitioners' designations); R/NICA-1: CV of Dr. Duchowny; R/NICA-2: CV of Dr. Willis.

2/ Dr. Pinshaw testified by video deposition (I-18; I-28) and via transcribed deposition designations of Petitioners (P-19).

3/ The arguments for and against admission of I-17B (a second letter-opinion of Dr. Trevor Resnick dated the same day as his letter-opinion designated and admitted without objection as I-17A), are set out at TR 309-403. This second letter-report was not admitted by stipulation; is not sworn testimony; and

Dr. Resnick did not testify live or by deposition. Therefore, Exhibit I-17B is "hearsay."

Despite being hearsay, the second report was subject to being admitted pursuant to section 120.57(1), which provides, in pertinent part:

> (c) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence, but it shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.

Admitting the second Resnick report under the foregoing statutory authority peculiar to this type of administrative proceeding does not convert the second Resnick report (Exhibit I-17B) from hearsay to reliable evidence for purposes of a finding of fact. Likewise, the consideration and reliance of several physicians upon the second Resnick report does not convert the second Resnick report from hearsay to reliable evidence.

Finally, the opinions of the several physicians (Peevy, Lott, and Duchowny), who relied upon the second Resnick report, may not provide a conduit for consideration of Dr. Resnick's opinion on permanent and substantial mental impairment. Although experts can base an opinion on evidence that is not otherwise admissible (in this case, Dr. Resnick's second letter-report) those experts' reliance is not sufficient to transform Dr. Resnick's second letter-report into substantive evidence.

The great impediment to consideration of Dr. Resnick's second letter-report (I-17B), or any opinion arising from it, is that Dr. Resnick did not testify at trial and therefore, could not be cross-examined. Likewise, he was never deposed. Accordingly, neither I-17B nor the opinions based on I-17B can support a finding of fact. See Linn v. Fossum, 946 So. 2d 452 (Fla. 2006); McKeithan v. HCA Health Servs. of Fla., Inc., 879 So. 2d 47 (Fla. 4th DCA 2004); McElroy v. Perry, 753 So. 2d 121 (Fla. 2d DCA 2000).

For all of the foregoing reasons, the second unsworn letter of Dr. Resnick, (Exhibit I-17B) can neither directly nor indirectly constitute the type of evidence upon which a finding of fact can be made to the effect that Emma has sustained a permanent and substantial mental impairment. All findings of

fact herein with regard to permanent and substantial mental impairment are based upon other evidence.

4/ To the extent that Dr. Duchowny's second deposition opinion was based on Dr. Resnick's second letter (I-17B), it may not form the basis of a finding of fact. See n.3. Moreover, inasmuch as Dr. Duchowny previously testified that no determination as to permanency of mental impairment can reasonably be made until a child is approximately six years of age, (see Finding of Fact 44) his later reliance on Dr. Resnick's permanency determination made when Emma was only three and-a-half years of age is not credible.

5/ "Under the Plan, a 'physical impairment' relates to the infant's impairment of his 'motor abnormalities or physical functions,' which along with the brain injury, significantly affects the infant's mental capabilities so that the infant will not be able to translate his cognitive capabilities into adequate learning or social development in a normal manner." Matteini v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 946 So. 2d 1092, 1095 (Fla. 5th DCA 2006). See also Fla. Birth-Related Neurological Injury Comp. Ass'n v. Fla Div. of Admin. Hearings, 686 So. 2d 1349, 1356 (Fla. 1997).

"Under the Plan, a 'birth-related neurological injury' is an injury to the brain or spinal cord of an infant caused by oxygen deprivation or mechanical injury during labor or delivery, which renders the infant both 'permanently and substantially mentally and physically impaired.' § 766.302(2), Fla. Stat. (2005). . . . [T]he ALJ was required to determine whether Sierra's [the child's] brain injury was the likely cause of her current impairments and whether Sierra is substantially and permanently physically and mentally impaired." Matteini v. Fla. Birth-Related Neurological, 946 So. 2d 1092, 1094 (Fla. 5th DCA 2006).

See Adventist Health Sys./Sunbelt, Inc. v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 865 So. 2d 561 (Fla. 5th DCA 2004), explaining that under the Plan, "the identification of a substantial mental impairment may include not only significant cognitive deficiencies but can include, in a proper case, additional circumstances such as significant barriers to learning and social development"; that parental observations are useful; that cerebral palsy is generally understood to be a group of motor physical disorders; and that the statute is written in the conjunctive and can only be interpreted to require permanent and substantial impairment that has both physical and mental elements.

6/ See McNally v. Fla. Birth-Related Neurological Injury Comp. Ass'n, DOAH Case No. 09-5623 (FO March 7, 2012).

COPIES FURNISHED:
(Via certified mail)

Ronald S. Gilbert, Esquire
Colling, Gilbert, Wright and Carter, LLC
Suite 830
801 North Orange Avenue
Orlando, Florida 32801
(Certified Mail No. 7011 1570 0001 1540 5482)

Michael A. Kundid, Esquire
Doran, Sims, Wolfe, Ansay and Kundid
1020 West International Speedway
Boulevard Suite 100
Daytona Beach, Florida 32114
(Certified Mail No. 7011 1570 0001 1540 5499)

Earl E. Googe, Jr., Esquire
Smith, Hulsey and Busey
1800 Wachovia Bank Tower
225 Water Street
Jacksonville, Florida 32202
(Certified Mail No. 7011 1570 0001 1540 5505)

Evaleen H. Caccam, M.D.
836 Prudential Drive, Suite 1506
Jacksonville, Florida 32207
(Certified Mail No. 7011 1570 0001 1540 5512)

Kenney Shipley, Executive Director
Florida Birth Related Neurological
Injury Compensation Association
2360 Christopher Place, Suite 1
Tallahassee, Florida 32308
(Certified Mail No. 7011 1570 0001 1540 5529)

Amie Rice, Investigation Manager
Consumer Services Unit
Department of Health
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275
(Certified Mail No. 7011 1570 0001 1540 5536)

Elizabeth Dudek, Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(Certified Mail No. 7011 1570 0001 1540 5543)

NOTICE OF RIGHT TO JUDICIAL REVIEW

Review of a final order of an administrative law judge shall be by appeal to the District Court of Appeal pursuant to section 766.311(1), Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original notice of administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy, accompanied by filing fees prescribed by law, with the clerk of the appropriate District Court of Appeal. See § 766.311(1), Fla. Stat., and Fla. Birth-Related Neurological Injury Comp. Ass'n v. Carreras, 598 So. 2d 299 (Fla. 1st DCA 1992).