STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

CEDRIC LEWIS AND BRANDI SCRIVEN-LEWIS, on behalf of and as parents and natural guardians of TRINITEE RA' MYAH LEWIS, a minor,	)	
Petitioners,	)	
vs.	)	Case No. 09-4812N
FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,	)	
Respondent,	)	
and	)	
ORANGE PARK MEDICAL CENTER, INC.,	)	
Intervenor.	)	

FINAL ORDER

By stipulation of the parties, and pursuant to a November 18, 2010, Order, this cause came on for consideration upon the stipulated record.

APPEARANCES

For Petitioners: Edward V. Ricci, Esquire
Darryl L. Lewis, Esquire
Searcy Denney Scarola Barnhart & Shipley
2139 Palm Beach Lakes Boulevard
West Palm Beach, Florida 33409

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

For Intervenor: Charles Thomas Shad, Esquire
Travase Erickson, Esquire
Saalfield, Shad, Jay, Stokes
& Inclan, P.A.
Post Office Box 41589
Jacksonville, Florida 32203-1589

STATEMENT OF THE ISSUE

Whether Trinitee Ra' Myah Lewis, a minor, qualifies for coverage under the Florida Birth-Related Neurological Injury Compensation Plan.

PRELIMINARY STATEMENT

On September 4, 2009, Cedric Lewis and Brandi Scriven-Lewis, on behalf of and as parents and natural guardians of Trinitee Ra' Myah Lewis (Trinitee), a minor, filed a petition (claim) with the Division of Administrative Hearings (DOAH) entitled "Petition for Benefits Pursuant to Florida Statute Section 706.301, et seq.," seeking a determination of whether Trinitee's injuries are compensable under the Florida Birth-Related Neurological Injury Compensation Plan.

The Petition named Richard L. Bridgewater, M.D., as the "participating physician," who rendered obstetrical services to Brandi Scriven-Lewis in Orange Park Medical Center, Inc., in connection with Trinitee's birth.

DOAH served the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the claim on September 4, 2009, and served Orange Park Medical Center on September 9, 2009. On September 21, 2009, Orange Park Medical Center filed a Petition to Intervene, which was granted by Order of October 1, 2009.

After an extension of time in which to do so, NICA filed, on December 11, 2009, the Response required by section 766.305(4), Florida Statutes, stating that, upon medical advice, Trinitee did not meet the definition of an infant who had suffered a "birth-related neurological injury" as defined by section 766.302(2), in that Trinitee had not suffered an injury which rendered her permanently and substantially mentally and physically impaired.

Repeated attempts to serve Dr. Bridgewater were made until, on February 20, 2010, service was accomplished. Dr. Bridgewater has not sought to intervene in these proceedings.

The case was repeatedly noticed for final hearing on dates convenient to the parties, but, on October 22, 2010, the parties filed a Joint Motion to Submit Stipulated Factual Record and Written Argument in Lieu of a Contested Hearing. After a prehearing conference, that joint motion was granted by an Order for Submission Upon Stipulated Record, entered November 18, 2010.

A prehearing stipulation was filed on February 3, 2011, and ultimately, a stipulated record was filed, in two parts, on February 4, 2011, and February 24, 2011.[1]

The parties were permitted until February 18, 2011, in which to file their proposed final orders. Only Respondent filed a proposed final order, and that proposed final order has been considered.[2]

FINDINGS OF FACT

1. Cedric Lewis and Brandi Scriven-Lewis are the natural parents and guardians of Trinitee Ra' Myah Lewis, a minor.

2. Trinitee was born a live infant on November 11, 2004, at Orange Park Medical Center, Inc., a licensed hospital located in Orange Park, Florida.

3. The physician providing obstetrical services at the time of Trinitee's birth was Richard L. Bridgewater, M.D., and at all times material, Dr. Bridgewater was a participating physician in the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

4. Trinitee is the result of a single gestation, and her birth weight was in excess of 2,500 grams.

5. To address the cause and timing of Trinitee's neurologic impairment, if any, the parties stipulated to medical records related to Mrs. Scriven-Lewis' antepartum course and to

those records associated with Trinitee's birth and subsequent development.

6. Mrs. Scriven-Lewis' prenatal course was without significant complications.

7. On November 8, 2004, Mrs. Scriven-Lewis was admitted to Orange Park Medical Center to rule out labor and possible rupture of membranes. A vaginal examination at 7:00 p.m.,[3] indicated that she was 1 cm dilated, 50% effaced, and at station -3. The fetal heart rate was baselined in the 120-130's with accelerations. Mrs. Scriven-Lewis was admitted for 23-hour observation for pregnancy-induced hypertension, with a 24-hour urine study in progress. Over time, labor was ruled out, but she was noted to have elevated blood pressure of 160/90 with lower extremity swelling.

8. On November 9, 2004, the fetal heart rate was reactive and reassuring with irregular contractions. A vaginal examination at 10:36 a.m., indicated that Mrs. Scriven-Lewis was 1 cm dilated, 50% effaced, and at station -3. She was diagnosed with mild preeclampsia with borderline thrombocytopenia at term. Also on November 9, 2004, Mrs. Scriven-Lewis' pregnancy-induced hypertension symptoms were stable and another vaginal examination indicated that she was 1.5 cm dilated, 50% effaced, and the baby was at a high station. The baby's fetal heart rate remained reactive and reassuring with contractions that were

spaced. Pitocin was discontinued, and the records indicate that a normal spontaneous vaginal delivery was expected upon onset of active labor. Another vaginal examination was performed at 9:50 p.m., indicating Mrs. Scriven-Lewis was dilated to 1.5 cm, 50% effaced, and at station -2.

9. Mrs. Scriven-Lewis continued to labor on through November 10, 2004. A vaginal examination was performed at 6:54 a.m., with findings indicating she was 2 cm dilated, 70% effaced, and at station -2. The fetal heart rate was reactive and reassuring in the 140's, with good short- and long-term variability with accelerations. Mrs. Scriven-Lewis' membranes were ruptured, and moderate meconium was observed. Pitocin was started, as well as an amnio-infusion, due to decreased amniotic fluid at 3 cm per a sonogram showing fetal weight at eight pounds, two ounces. A normal spontaneous vaginal delivery was still expected at that time.

10. Labor slowly and consistently progressed on November 11, 2004, into the second stage of labor, and pitocin was discontinued. The fetal heart rate was reassuring and a vaginal examination at 7:05 a.m., was at anterior lip, station zero, with some molding. Dr. Bridgewater noted "overall reassuring maternal and fetal status" and believed there was a transition into the second stage of labor.

11. On November 11, 2004, at 8:13 a.m., Mrs. Scriven-Lewis had a low-grade fever of 100 degrees, but the fetal heart rate was reassuring. She had reached complete dilation and effacement and was at station 2+. She was instructed on pushing techniques and was pushing in the correct manner.

12. Mrs. Scriven-Lewis progressed to complete dilation with spontaneous contractions without pitocin. She began pushing with a reassuring fetal heart pattern in the 140-150's. Pitocin was restarted for the second stage of labor to increase the frequency of contractions. However, even with aggressive pushing, she was unable to force the fetus' presenting parts beyond a 2+ station. Subsequently, abdominal, lower extremity and vulvovaginal edema were noted. A fetal assessment was notable for molding and mild caput. The pelvis was adequate, and a vacuum assist was offered for traction and was agreed-upon.

13. A vacuum assist was performed without complications, although there was one pop-off. The molded forehead was delivered at 9:13 a.m., by vacuum-assisted delivery over a midline episiotomy. The elongated forehead was delivered with obvious "turtle sign" to the level of the orbits. A partial McRoberts maneuver was used to deliver the posterior shoulder. When the head was delivered, DeLee catheter suctioning of the

naso-oropharynx was performed on the perineum with some moderate meconium.

14. At 9:14 a.m., the McRoberts corkscrew maneuver was applied with suprapubic pressure without success. When delivery attempts failed, Mrs. Scriven-Lewis' episiotomy was cut to a fourth degree level at 9:15 a.m. The suprapubic pressure paradoxically appeared to have worsened the delivery of the anterior shoulder.

15. At 9:19 a.m., a "stat" cesarean section was called. The shoulder dystocia was reduced at 9:22 a.m., with continued attempts using the McRoberts corkscrew, and Trinitee was delivered in floppy condition. Upon delivery, she was handed off to a neonatologist in attendance.

16. Trinitee's Apgar scores were 0 at one minute, 1 at 5 minutes; 4 at 10 minutes; 4 at 15 minutes; 6 at 20 minutes; and 7 at 25 minutes. Trinitee's cord blood was drawn with a pH of 7.21 with a base excess of -9.1.

17. Upon delivery, Trinitee was noted to be limp, pale and apneic. Minimal meconium-stained fluid was aspirated. She was then intubated, and treated with compressions, oxygen and 100 percent ambu [bag]. Due to lack of an auscultated heart rate (heart rate heard via device), three doses of epinephrine were administered at 9:24, 9:25, and 9:27 a.m., in addition to continued oxygen and chest compressions. At 9:28 a.m.,

Trinitee's heart rate was <100, so chest compressions and oxygen were continued. Chest compressions ceased at 9:32 a.m., when there was a regular heart rate of 160, but oxygen continued. At 9:38 a.m., Trinitee had a spontaneous gasp and opened her eyes. Boluses were administered between 9:31 a.m., and 9:42 a.m., for metabolic acidosis. At 9:46 a.m., irregular respirations were noted, and oxygen continued during Trinitee's transport to NICU. Upon arrival in NICU, she was placed on a ventilator.

18. At 11:05 a.m., Dr. Robert D. Garrison from Shands Hospital arrived to evaluate Trinitee. He noted that she had no spontaneous respiratory effort, and had hypotonia, eyelid fasiculations, pink color with adequate skin perfusion and a large boggy scalp in the occiput area. A chest X-ray showed a small right pneumothorax which subsequently resolved. An antibiotics course was started, due to maternal temperature of 100.5 and rupture of membranes at 16 hours. Trinitee was then transferred to Shands' NICU.

19. Trinitee was admitted to Shands NICU at 1:10 p.m., for neonatal depression and respiratory distress. Her physical examination upon admission determined that neurologically she was hypotonic; had a clenched right fist; was tremulous with occasional arching; and was able to move her right arm and lower extremities. However, she could not move her left arm. She also was not alert. While at Shands, Trinitee was treated for

neonatal depression, right pneumothorax, respiratory failure, sepsis, patent ductus arteriosus (a shunt allowing blood to bypass the lungs until they are fully developed), seizures, brachial plexus palsy, cephalohematoma, hypoxic-ischemic encephalopathy and a subdural hematoma.

20. On November 18, 2004, Trinitee was transferred to Baptist-Wolfson's Children's Hospital in guarded condition on room air. She was discharged from Baptist-Wolfson's Children's Hospital on December 8, 2004, after being treated for right phrenic nerve paralysis, murmur, thrush, hematologic surveillance, seizures, and left brachial plexus palsy.

21. Trinitee received follow-up neurological treatment at Nemours Children's Clinic after her discharge from Baptist-Wolfson's Hospital. Upon examination when Trinitee was six weeks of age, Dr. William Turk, neurologist, felt that, considering her early history, Trinitee was doing surprisingly well.

23. On January 17, 2005, at two-and-a-half months of age, Trinitee's brachial plexus injury was thought by the orthopedic clinic physician to be a candidate for exploration and possible repair due to persistent lack of movement of the upper extremity.

24. At three months of age, Trinitee was seizure-free and had a normal EEG, so she was tapered off phenobarbital.

25. A report generated by Dr. Peter Murray, of Nemours' orthopedic clinic, described Trinitee's visit on March 1, 2005, by stating that Trinitee's mother had reported that Trinitee had some increased spontaneous activity with the left upper extremity while lifting from the shoulder in a recumbent position as well as wrist and finger flexion and that the mother had not noted any active elbow flexion. On examination, Dr. Murray noted Trinitee had abduction in that shoulder to about 30 degrees, 15 degrees flexion contracture of the elbow and internal shoulder rotation, but there was no evidence of active external rotation of the shoulder. Trinitee was noted to have full abduction of the shoulder passively as well as external rotation of the shoulder being complete passively. A pin test showed some impaired perception and sensibility in the fingers and dorsum of her left hand and palm, which had improved from her initial sensory examination at one month of age. Nemours has continued to assist in and monitor Trinitee's progress.

26. On May 18, 2005, Trinitee underwent a left brachial plexus acute repair of C5, C6, and C7 nerve roots at Baptist-Wolfson, with bilateral sural nerve grafting. There were no complications.

27. Thereafter, Trinitee received occupational therapies during her hospital course which continued after her discharge.

28. Therapy included weight-bearing exercises for the left upper extremity and positioning of the left wrist. On August 9, 2005, an occupational therapy evaluation determined that Trinitee had bilateral upper extremity passive range of motion within normal limits. Her left upper extremity active range of motion was severely limited at the shoulder, elbow, wrist, and hand, but her fine motor skills were considered age appropriate, given her limited left upper extremity use.

29. Trinitee's August 12, 2005, physical therapy evaluation by "Pediatric Therapy Works!" found that her left arm was floppy with no intentional movement noted, but that with total body movement, the tone increased in the left upper extremity. Hereafter, the term "left upper extremity" includes the left arm and hand, unless stated otherwise.

30. By August 2005, Trinitee was tolerant of weight-bearing exercises to her left upper extremity, and with taping, she was noted to extend her thumb and first two fingers while keeping her wrist in neutral. She was also noted to accept more weight bearing to the left upper extremity and was more tolerant to challenges. At a September 21, 2005, neurology visit, Trinitee's mother reported to Dr. Turk some modest improvement in Trinitee's left arm function and some increased shoulder abduction and finger flexion.

31. At ten months of age, Trinitee was seizure-free and making reasonable progress developmentally. At that point, she was discharged by Drs. Turk and Usmani-urishi, but continued upon a follow-up consultation nine months later.

32. Trinitee brought her wrist to neutral and her first three fingers into extension in October and November 2005. Mrs. Scriven-Lewis also reported to Dr. Murray on October 4, 2005, that Trinitee had no overall change in her left upper extremity except for some mild early forward flexion of the left shoulder. Physical examination was absent for biceps flexion and any left shoulder elevation. Some adduction of the left arm across the chest was noted. Her occupational therapy records indicate that in October and November 2005, Trinitee had improved tonus of the left upper extremity holding weight bearing with minimal elbow assist once her hand was positioned. She also showed good shoulder extension while reaching to activate musical toys.

33. In December 2005, Trinitee's occupational therapist reported that Trinitee showed increased tone in her left upper extremity distally. She also kept her left extremity wrist in neutral with tape. At the same time, Trinitee was noted to have increased distal tone in the left upper extremity and had increased active grasp to hold a toy.

34. In January 2006, Trinitee grasped beads with the fingers of her left hand extended, and achieved 80 degrees shoulder flexion to place the beads over her mother's head.

35. In February 2006, Trinitee had movement of the left upper extremity 70-80 degrees actively in shoulder flexion to manipulate toys on a table. Active movement of the thumb and first and second fingers was also noted. Trinitee's February 21, 2006, re-evaluation by Caterina A. Tsombanidis, her physical therapist, indicated that Trinitee was using her left hand to assist occasionally to keep objects in place and manipulate objects. She was able to move the first three fingers involving radial and median nerves and raised her left upper extremity in shoulder flexion to 70 degrees actively and about 60 degrees abduction. She was able to prop up on elbows in prone position and to bear weight on bilateral extended upper extremities, especially on the left side. At that time, Trinitee's physical therapist's treatment note indicated that Trinitee had a partial range of motion and active range of motion to the left upper extremity while playing the "so big game" and that she was able to pick up three rings and place them into her left hand spontaneously.

36. The occupational therapy re-evaluation on February 20, 2006, found that Trinitee's left upper extremity's passive range of motion was within normal limits with active range of motion

improved to 80 degrees left shoulder flexion and 20 degrees elbow and wrist flexion, and that her left hand finger extension could grasp a toy. She fully bore weight on her left upper extremity when given an assist for elbow extension. When crawling, she only bore weight on her right upper extremity (right arm).

37. Physical therapy notes in March 2006, indicate that Trinitee continued to improve being able to lift her left upper extremity to 60 degrees to reach for a toy. Trinitee was also able to lift that upper extremity while sitting, to place it on a table actively 70 degrees in shoulder abduction and flexion. Active movement was noted at wrist, improving slightly, moving to neutral. In March 2006, Trinitee was noted by the occupational therapist to bring her left shoulder to 90 degrees actively and to place her hand on the table independently. She also had partial and active range of motion to the left upper extremity while on a ball to increase spontaneous movement, and she used her left upper extremity in two-handed play.

38. In April 2006, Trinitee used a hand-over-hand assist with her left-hand shoulder flexion to 90 degrees to make an art project. Trinitee was subsequently removed from the occupational schedule due to poor attendance. As of April 4, 2006, her mother reported her as actively using her shoulder, and a physical examination by Dr. Murray at Nemours found

Trinitee with active shoulder abduction and forward flexion to approximately 80 degrees, and forward flexion to approximately 70 degrees, respectively. During ambulation, she was noted to carry the elbow at approximately 60 degrees of flexion, but also would extend the elbow during ambulation, and she was seen to have digital and wrist extension to neutral.

39. An April 2006 physical therapy note indicated that Trinitee was extending her upper extremity nicely on the left side and was reaching with increased skill, as well as having increased movement of the wrist in neutral position with manipulation of activities. Trinitee was more active with activities of her left upper extremity when her right upper extremity movement was limited. She was also found to flex her trunk to the right to increase her left upper extremity movement when lifting above 90 degrees.

40. As of June 2006, Trinitee continued to show increased functional ability with the left upper extremity, by grabbing, attempting to throw, and using her left upper extremity to put objects into a container. She also had increased range of motion, active 90-110% with a tendency to extend backwards to increase her range of motion with activities. Despite her improvement, she was discharged from "Pediatric Therapy Works!" on August 30, 2006, for non-compliance with its attendance policy and a less than 50% attendance rate.

41. By age two, neurologically, Trinitee was making good progress, including talking, putting words together, and understanding what was being said to her, and her parents felt that she was quite intelligent. Since she was seizure-free and developmentally making progress, Trinitee was not scheduled for any follow-up appointments with Dr. Murray at that time.

42. On January 16, 2007, at age two, during a follow-up evaluation, Mrs. Scriven-Lewis reported that Trinitee was continuing to make progress in her left upper extremity function. A physical examination determined that Trinitee was undergoing continued recovery of her left upper extremity brachial plexus reconstruction with forward flexion of the left shoulder to 90 degrees, abduction to 90 degrees, biceps flexion to 90 degrees, wrist extension to -10 degrees, and digital extension to neutral.

43. On July 10, 2007, Trinitee's mother reported no complaints regarding her progress. At that time, her essentially routine physical examination by Dr. Murray revealed that Trinitee had excellent biceps flexion at 3+/5, extended the wrist to neutral, and extended her index finger to beyond neutral. Forward flexion and abduction of the shoulder were both to 90 degrees, with passive forward flexion of her left shoulder to 170 degrees and external rotation to 90 degrees in abduction. A Hoffer latissimus transfer was discussed with

Mrs. Scriven-Lewis, and Trinitee was to return to the clinic again in November 2007.

44. On May 9, 2008, "after a long hiatus," Mrs. Scriven-Lewis indicated that Trinitee's left upper extremity was working well but that she had concerns about Trinitee's left shoulder animation. Physical examination revealed abduction of the left arm to approximately 80 degrees, forward flexion to approximately 80 degrees with the shoulder in the internally rotated position. Biceps strength was found to be excellent at 4/5, and Trinitee was able to extend her wrist to neutral with digital extension and good grasp and release. Her left shoulder could be passively externally rotated to 45 degrees in the adducted position and 80 degrees in the abducted position. At that point in time, Mrs. Scriven-Lewis agreed to have Trinitee undergo a left shoulder Hoffer latissimus transfer.

45. Trinitee returned for an orthopedic visit to Nemours and Dr. Murray on November 20, 2009. At that visit, her mother indicated that Trinitee's left upper extremity was working well, but that Trinitee could not raise her arm above her head or put her hand behind her head. It also was reported that Trinitee was doing well in kindergarten. Examination revealed passive range of motion of the left shoulder was forward flexion 170 degrees, external rotation in abduction 80 degrees, and external rotation in adduction 80 degrees. Forward flexion of the

shoulder was 80 degrees and also for abduction. Left elbow range of motion was 30/130 with strength at 4/5. Left wrist extension was to 120 degrees, but Trinitee was unable to touch the back of her head, due to loss of internal rotation of the left shoulder. A latissimus transfer was discussed to augment Trinitee's left shoulder external rotation.

46. On December 18, 2009, due to lack of wrist extension and lack of shoulder external rotation, Trinitee underwent, at Nemours, a left wrist flexor carpi ulnaris to extensor carpi radialis brevis tendon transfer; a left latissimus dorsi and left teres major tendon transfer to left supraspinatus tendon and a one-and-a-half shoulder spica cast application without complications. She was five years old at the time. At her surgical follow-up visit on February 3, 2010, Trinitee showed evidence of early range of motion of the shoulder in abduction and external rotation, both at 90 degrees. By March 5, 2010, she was able to touch the back of her head and needed to wear her brace only at night.

47. Trinitee currently attends Discovery Point Child Development Center. The medical evaluation completed by Suncoast Pediatric Care dated March 3, 2009, indicates that "This child may participate fully in school activities including physical education." Additionally, her Individual Child Profile for the fall checkpoint date of October 16, 2009, indicates that

she does not often use her left arm, but, nonetheless, she has balance while moving, climbs up and down, pedals and steers a tricycle, and can throw, kick, and catch, with increasing control. She also uses tools for writing and drawing to make basic strokes and some recognizable objects. In all other areas of her development, she met the goal for the fall checkpoint date.

48. Regarding Trinitee's general development, Mrs. Scriven-Lewis indicated on the Oak Hill Hospital Rehabilitation Center Pediatric/Adolescent Intake Form, filled out when Trinitee was five years old, that Trinitee held her head up between 3-6 months; stood at 1-2 years; was bowel-trained at 2-3 years; sat unsupported at 1-2 years; walked unaided at 1-2 years; and fed herself with a spoon at 12 months. According to her mother, Trinitee's favorite activities at age five included playing, riding her bike, and coloring. With regard to communication skills, her mother represented that Trinitee did not have difficulty expressing her thoughts, feelings, and needs to other people, either verbally or non-verbally; that her primary form of communication is verbal; and that her speech is a little slurred, but her voice is normal. Trinitee also appeared to understand speech normally for her age. She did not repeat questions. She did not have any issues with coughing, choking while swallowing, or with chewing and

swallowing. She had not had any issues regarding her ability to read or write. For recreational activities, Trinitee rode her bike, colored, painted and played on a swing and with cards.

49. On March 2, 2010, Trinitee was five years and three-plus months of age, and took a Preschool Language Scale-3 test. Her auditory comprehension score indicated that she was at the age equivalent of five years and eight months old. Her expressive comprehension score indicated that she was at the equivalent age of five years and 11 months old. Her total language score indicated that she was at the age equivalent of five years and seven months old. Her March 2, 2010, Oak Hill Rehabilitation Services Outpatient Pediatric Assessment for speech therapy indicated, in the clinical findings, that Trinitee had an auditory comprehension age equivalent of five years eight months, and that she had an expressive language score of five years, 11 months. However, she obtained an articulation (speaking, pronunciation, enunciation) score of only three years, 11 months.

50. On September 30, 2010, Trinitee was discharged from therapy because she stopped coming in.

51. Pertinent to this case, coverage is afforded by the Birth-Related Neurological Injury Compensation Plan for infants who suffer a "birth-related neurological injury," defined as an "injury to the brain or spinal cord of a live infant . . .

caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired." § 766.302(2), Fla. Stat.

52. Based on the parties' stipulations, the issue to be resolved herein is whether the record supports the conclusion that, more likely than not, any injury that Trinitee may have sustained during the statutory period resulted in a permanent and substantial mental and physical impairment as required for coverage under the Plan. See § 766.302(2), Fla. Stat.

53. NICA's position is that Trinitee has a substantial motor impairment because she has brachial plexus palsy, but that her injury does not arise from damage to the brain or spinal cord. In addition, it is NICA's position that Trinitee does not have any permanent or substantial mental impairment

54. Among the items in evidence is a report of Donald C. Willis, M.D., an expert in maternal-fetal obstetrics, who concluded that there had been an obstetrical event (shoulder dystocia), that caused loss of oxygen to the brain and mechanical trauma to the spinal nerve roots. He was unable to comment as to the severity of the injuries. Apparently, Dr. Willis' conclusion was based solely on a records review, because his report does not mention an examination of Trinitee.

55. In contrast, Dr. Michael S. Duchowny, a board-certified pediatric neurologist, examined Trinitee. According to Dr. Duchowny, Trinitee has a substantial motor impairment because she has a brachial plexus palsy. However, it was also Dr. Duchowny's opinion that Trinitee's brachial plexus palsy resulted from a peripheral nerve injury and was not the result of damage to the brain or spinal cord. While the foregoing condition was characterized by Dr. Duchowny as permanent, and he described Trinitee's palsy as "permanent," and "moderate to severe," it was also Dr. Duchowny's opinion that Trinitee did not have any permanent or substantial mental impairment. In particular, Dr. Duchowny testified, in pertinent part, as follows:

* * *

> A: . . . I thought that Trinitee did have a substantial motor impairment because she had a brachial plexus palsy, which involved multiple cervical and probably high thoracic segments of her brachial plexus, so this was a severe motor impairment.
>
> However, the motor impairment resulted from damage to the brachial plexus, which is outside the spinal cord and, therefore, outside the central nervous system. So even though there was a substantial impairment and permanent motor impairment, it did not arise from damage to the central nervous system, either the brain or spinal cord.
>
> I also thought that Trinitee did have a speech dysarthria, which was highly [likely] to be developmentally based, but overall,

her examination showed no findings that suggested a substantial or permanent mental impairment.

* * *

My opinion, I do not believe that Trinitee's motor impairment is a result of an injury to the brain or spinal cord.

* * *

. . . I believe that she had neither a permanent nor substantial mental impairment.

* * *

I didn't find any evidence of brain damage in Trintee.

* * *

Q: Well, based on your understanding of what is required in order for a child to receive compensation through NICA, did Trinitee Lewis sustain such an injury with respect to her physical impairment?

A: I'm sorry, I need to qualify my previous answer. I don't think she met any of the criteria because her physical impairment is due to an injury outside the central nervous system, so she doesn't meet criteria on that basis.

Q: Doctor, if you would, help me understand that again briefly.

When you say her injury was outside the central nervous system, where in your opinion was the injury?

A: The nerve root in the brachial plexus.

Q: And the nerve root in your opinion then does not connect to the central nervous system?

A: It connects, but is part of the peripheral nervous system.

* * *

Q: Doctor, this will be a somewhat broad question, but I'm going to rely on you to fill in the details.

If you would please give me in as minute details as possible all the reasons you believe that Trinitee Lewis does not qualify for having a mental impairment that would provide her with compensation under NICA.

* * *

A: The examination doesn't reveal findings one would expect to see with a substantial mental impairment. In order to have a substantial mental impairment, one would anticipate that the child would have severe mental problems, probably be mentally retarded; and on the examination that I performed, it is clear that Trinitee was not mentally retarded. So, you know, I think that was fairly evident from the examination, and that would suggest that she was not eligible for NICA on that basis.

* * *

Q: . . . Doctor, do you have an opinion as to whether or not that speech dysarthria will be permanent or is that is [sic] something that will subside with time?

A: I think it will improve with time. I don't know where it will ultimately end up. I think she will be better as time goes on.

56. While it is clear that Trinitee had a difficult delivery and permanent and substantial motor (physical) impairment, given the record, it must be resolved that Trinitee

(1) did not suffer an injury to the brain or spinal cord; and (2) does not suffer from permanent and substantial mental impairment.

CONCLUSIONS OF LAW

57. The Division of Administrative Hearings has jurisdiction over the parties to, and the subject matter of, these proceedings. §§ 766.301-766.316, Fla. Stat.

58. 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.

59. 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.

60. 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.

61. In discharging this responsibility, the Administrative Law Judge must make the following determination based upon available evidence:

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

> resuscitation in the immediate postdelivery period in a hospital.

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

62. 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.

63. Here, the proof failed to support a conclusion that, more likely than not, Trinitee has permanent and substantial mental impairment. The record also demonstrates that her infirmities, although acquired during the statutory period, were not caused by an injury to the brain or spinal cord, irrespective of the timing or cause. Consequently, given the provisions of section 766.302(2), Trinitee does not qualify for

coverage under the 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).

CONCLUSION

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

The claim for compensation filed by Cedric Lewis and Brandi Scriven-Lewis, on behalf of and as natural guardians of Trinitee Ra' Myah Lewis, a minor, is dismissed with prejudice.

DONE AND ORDERED this 30th day of March, 2011, 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 30th day of March, 2011.

ENDNOTES

1/ The stipulated record is composed of 2406 Bates stamped pages, housed in five notebooks, designated as follows: Jt. Ex. A: Medical records, including fetal heart monitor strips, from Orange Park Medical Center, Inc., for Brandi Scriven-Lewis dated June 30, 2004-November 13, 2004 (Bates 1-777); Jt. Ex. B: Medical records, Orange Park Medical Center, Inc., for Trinitee Lewis dated November 11, 2004 (Bates 778-831); Jt. Ex. C: Medical records from Shands-Jacksonville for Trinitee Lewis 11/11/04-11/18/04 (Bates 832-1063); Jt. Ex. D: Medical records from Baptist-Wolfson's Children's Hospital for Trinitee Lewis 11/18/04-12/8/04, updated 5/18/05-5/19/05, 5/24/05, 12/18-19/09 (Bates 1064-1655); Jt. Ex. E: Medical records from Nemours Children's Hospital for Trinitee Lewis 12/16/04-10/4/04, updated medical records 11/18/04-3/5/10; Jt. Ex. F: Medical records from Rehab Kinetics for Trinitee Lewis 1/17/05-7/6/05 (Bates 1963-1991); Jt. Ex. G: Records from Pediatric Associates at Argyle for Trinitee Lewis, dated December 9, 2004 (Bates 1992-2011); Jt. Ex. H: Medical records from Pediatric Therapy Works! for Trinitee Lewis 8/9/05-8/30/06 and additional records 9/12/05-7/17/06 (Bates 2012-2065); Jt. Ex. I: Medical records from Carol Tietz, OT (Pediatric Therapy Works!) for Trinitee Lewis 8/9/05-12/20/06 (Bates 2066-2083); Jt. Ex. J: Medical records from Oak Hill Hospital for Trinitee Lewis dated 7/4/07 (Bates 2084-2102); Jt. Ex. K: Medical records from Dr. Rizwan Qureshi for Trinitee Lewis 11/18/05-3/2/07 and updated medical records 1/13/05-8/23/10 (Bates 2103-2164); Jt. Ex. L: School records from Discovery Point Child Development Center for Trinitee Lewis 10/16/09-1/10/10 (Bates 2165-2178); Jt. Ex. M: Donald C. Willis, M.D.'s report dated November 9, 2009 (Bates 2179-2180); Jt. Ex. N: Michael S. Duchowny, M.D.'s report dated 12/2/09 (Bates 2181-2184); Jt. Ex. O: Deposition of Michael S. Duchowny, M.D., of 11/15/2010, and Exhibits 1-2 thereof (Bates 2185-2271); Jt. Ex. P: Petitioners' Response to Respondent's First Set of Interrogatories dated 3/10/2010 (Bates 2272-2281); Jt. Ex. Q: Intervenor Orange Park Medical Center, Inc.'s Verified Responses to Respondent's Interrogatories dated 1/12/2011 (Bates 2282-2289).

2/ Respondent's proposal was filed on February 18, 2011, and the stipulated record was completed on February 24, 2011, with

the filing of Jt. Exs. R and S, which exhibits all parties agreed in writing had inadvertently not been transmitted earlier, with the rest of the stipulated record on February 4, 2011.

3/ All military or universal times have been converted to standard times. It is noted that some times as recorded in the medical records are inconsistent and/or contradictory. Wherever possible, they have been reconciled by the undersigned.

COPIES FURNISHED:
(Via Certified Mail)

Kenney Shipley, Executive Director
Florida Birth Related Neurological
Injury Compensation Association
2360 Christopher Place, Suite 1
Tallahassee, Florida 32308
(Certified Mail No. 7010 1670 0000 3097 0775)

Edward V. Ricci, Esquire
Darryl L. Lewis, Esquire
Searcy Denney Scarola Barnhart & Shipley
2139 Palm Beach Lakes Boulevard
West Palm Beach, Florida 33409
(Certified Mail No. 7010 1670 0000 3097 0782)

Charles Thomas Shad, Esquire
Travase Erickson, Esquire
Saalfield, Shad, Jay, Stokes & Inclan, P.A.
Post Office Box 41589
Jacksonville, Florida 32203-1589
(Certified Mail No. 7010 1670 0000 3097 0799)

M. Mark Bajalia, Esquire
Brennan, Manna & Diamond
800 West Monroe Street
Jacksonville, Florida 32202
(Certified Mail No. 7010 1670 0000 3097 0805)

Richard L. Bridgewater, M.D.
16782 Northwest 67th Avenue
Hialeah, Florida 33015
(Certified Mail No. 7010 1670 0000 3097 0812)

Amy Rice, Acting Investigation Manager
Consumer Services Unit
Department of Health
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275
(Certified Mail No. 7010 1670 0000 3097 0829)

Elizabeth Dudek, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(Certified Mail No. 7010 1670 0000 3097 0836)

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.