STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

KATIS D'ANGELO AND JEFFREY D'ANGELO, on behalf of and as parents and natural guardians of JEFFREY D'ANGELO, Jr., a minor,

Petitioners,

vs. Case No. 17-0270N

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION,

Respondent,

and

HERNANDO HMA, LLC, d/b/a BAYFRONT HEALTH SPRING HILL; AND LOUIS J. DIEFFENBACH, M.D.,

Intervenors.
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FINAL ORDER

This cause came before the undersigned upon a Joint Motion to Submit Factual Record in Lieu of a Contested Hearing, which was granted on November 26, 2018; a Stipulated Record; and the Proposed Final Orders submitted by Petitioners and Respondent, Florida Birth-Related Neurological Injury Compensation Association (NICA).

STATEMENT OF THE ISSUE

The issue in this case is whether Jeffrey D'Angelo, Jr. (Jeffrey), suffered a birth-related neurological injury as defined by section 766.302(2), Florida Statutes (2014), for which compensation should be awarded under the Florida Birth-Related Neurological Injury Compensation Plan (Plan).

PRELIMINARY STATEMENT

On January 9, 2017, Petitioners filed a Petition for Benefits Pursuant to Florida Statute Section 766.301 et seq. (Petition) with the Division of Administrative Hearings (DOAH) for a determination of compensability under the Plan. The Petition named Louis J. Dieffenbach, M.D. (Dr. Dieffenbach), as the physician who provided obstetric services at the birth of Jeffrey on February 23, 2014, at Bayfront Health Spring Hill Hospital (Bayfront) in Spring Hill, Florida.

On January 19, 2017, DOAH mailed a copy of the Petition to NICA by certified mail. The certified receipt indicates the same was served on January 21, 2017. On January 19, 2017, DOAH also mailed copies of the Petition by certified mail to Dr. Dieffenbach and Bayfront.

On February 20, 2017, Hernando HMA, LLC, d/b/a Bayfront Health Spring Hill's motion to intervene was granted. On February 22, 2017, Dr. Dieffenbach's Motion to Intervene was granted.

On April 19, 2017, NICA filed its Response to the Petition, suggesting that the subject claim was not compensable because Jeffrey had not suffered a birth-related neurological injury and requesting a final hearing to address said issue. The final hearing was originally scheduled for September 12, 2017. After multiple continuances and an Order Denying NICA's Motion for Summary Final Order, the final hearing was ultimately rescheduled for November 28, 2018.

On November 26, 2018, the parties filed a Motion to Submit Stipulated Factual Record in Lieu of Contested Hearing. Said motion was granted on the same date. The parties' Stipulated Record was timely filed on December 7, 2018, and Exhibits A through O were thereby admitted into evidence without objection.

On December 17, 2018, the parties timely filed Proposed Final Orders. On January 4, 2019, however, the undersigned issued an Order requiring the parties to resubmit the proposed final orders with citations to the Stipulated Record. NICA timely resubmitted its Proposed Final Order. The parties' Proposed Final Orders have been considered in preparation of this Final Order.

FINDINGS OF FACT

1. On February 22, 2014, in her 37th week of pregnancy, Petitioner, Katis D'Angelo, had a spontaneous rupture of her membranes. She presented to Bayfront and, at approximately

11:00 p.m., was evaluated in the labor suite. Upon initial examination, her cervix was noted to be "1 cm dilated, 50 percent effaced with the vertex at a -2 station." The fetus's heart tones were normal; however, Mrs. D'Angelo was not having an active labor pattern. Accordingly, Mrs. D'Angelo was admitted to the hospital.

2. Dr. Dieffenbach had been Mrs. D'Angelo's obstetrician throughout her pregnancy and, upon admission to Bayfront, was the primary and attending obstetrician.

3. To assist in the progression of her labor, Dr. Dieffenbach ordered a low dose of Pitocin. Mrs. D'Angelo's labor progressed and her cervix dilated to about five centimeters; however, it "got hung up for about 5 hours." She was reexamined about an hour later with no changes noted. Due to her failure to progress, Dr. Dieffenbach recommended a Cesarean section delivery. Dr. Dieffenbach's Clinical and Operative Notes provide, in pertinent part, as follows:

> CLINICAL NOTE: . . . At this point, cesarean delivery was recommended. Risks were explained and accepted. The labor was dysfunctional. Pitocin was up to about 14 milliunits. The fetal heart tones were in the normal range, but failed to show a great deal of variability. No decelerations were noted. Fluids were changed to D5 and Ringers to see if that would help stimulate the baby.
>
> OPERATIVE NOTE: . . . Uterine incision was extended laterally by stretching. The baby

> was noted to be in a ROT position. The infant was LGA, weighing 7 pounds 14 ounces at 37 weeks. The extraction was difficult. This was a male weighing 7 pounds 14 ounces, 3575 grams. Apgars were 2, 6, and 8. The infant was noted to have cord wrapped around the legs with several loops and also around the abdomen, possibly accounting for the fetal heart rate changes. The nares and orpharynx were suctioned with bulb syringe. Cord was clamped and severed. The infant was given to the nurse for further care at the isolette . . . . Both mother and baby did well. The baby is currently in the NICU, stable.

4. Jeffrey was born at 1:52 p.m., on February 23, 2014. At delivery, he was noted to be "depressed." At one minute of life, Jeffrey's Apgar score was a 2.[1/] A Neonatal Intensive Care Unit (NICU) Registered Nurse (RN) was requested to provide assistance in the operating room and the RN arrived within four minutes.

5. Due to his depressed state, resuscitative efforts were required in the first several minutes of life. These efforts included positive pressure ventilation (for five minutes), oxygen, and chest compressions for 30 seconds. It appears the resuscitative efforts were administered by the respiratory therapist and operating room nurse prior to the NICU RN's arrival.[2/]

6. The NICU RN documented that, upon arrival, Jeffrey had poor color and tone. By his tenth minute of life, Jeffrey had responded well to the oxygen, his color had improved, and he had

spontaneously cried. At 2:10 p.m., Jeffrey was transitioned and admitted to the Bayfront NICU.

7. At the NICU, Jeffrey was noted to have decreased tone, facial bruising, petechiae, and a low blood glucose level. He was noted to have a strong suck (for feeding), however, he had desaturations during feeding attempts, with a recorded apnea. At 3:45 p.m., Jeffrey was noted to have a significant apneic episode (ceased breathing for more than 15 seconds), he became cyanotic, and "very aggressive stimulation was needed," in addition to mask oxygen. At that time, his oxygen saturation level was low at 58. At approximately 7:00 p.m., Jeffrey was placed on a nasal cannula for oxygen (vapotherm 2 LPM 23%).

8. Jeffrey had several additional apneic episodes during his first day of life. On three occasions, the apnea lasted for more than 15 seconds, he became cyanotic, and required gentle or vigorous stimulation. Due to these incidents, on February 24, 2014, an echoencephalograph (EEG) was performed. The EEG finding and impression were as follows:

> FINDING:
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> Transcranial head ultrasound was performed with gray scale imaging via anterior fontanelle. This demonstrates normal brain parenchymal echogenicity. There is a normal germinal matrix and cord plexus. There is no hydrocephalus or intraparenchymal hemorrhage.

> Impression:
>
> 1. Normal transcranial head ultrasound as above.

9. Jeffrey remained at the Bayfront NICU until March 5, 2014. During his NICU stay, he had a cranial ultrasound which was interpreted as normal; he was noted as having frequent arching and possible posturing; and continued to have poor feeding coordination. On March 5, 2014, he was transferred to All Children's Hospital to obtain a brain MRI, neurology consultation, and a speech therapy consultation.

10. On March 6, 2014, the brain MRI was conducted. The MRI was interpreted as showing a brain with normal signal intensity, including gray and white matter on multiple sequences. Ultimately, Jeffrey was discharged from All Children's Hospital after approximately three days.[3/]

11. Following his discharge, Jeffrey exhibited developmental delays. When Jeffrey was approximately nine months old, he was evaluated by Elizabeth Barkoudah, M.D., the attending physician for the Neurodevelopmental Disabilities Department at Children's Hospital in Boston, Massachusetts. Her report documents his post discharge history as follows:

> Concerns with Jeffrey were first noted in the neonatal period given low tone. This has prompted him to be seen by various specialties in Florida including Neurology, Neurosurgery, Physiatry, Genetics, Ophthalmology and Neuro-opthalmology. He

> has had a head ultrasound at 5 months of age which showed increased frontal lobe fluid. A brain MRI was repeated at 7 months of age including a cervical MRI. Again this showed the increased fluid. He was seen by Neurosurgery who did not feel that shunting was needed. His cervical MRI showed some narrowing with persistent SCF flow around the spinal cord. This MRI was obtained after papillodema was found on his examination. This examination was recommended due to "choppy visual tracking." Over time it was felt that this was not truly papilledema and is simply elevated optic nerves. Visual assessment at the time showed weaknesses left more than right.
>
> In regards to evaluations, he has also been seen by Genetics who has obtained a chromosomal microarray which was unremarkable. He had thyroid testing and CPK levels which were normal. He has been seen by Physiatry who recommended ongoing therapy. They have provided him with a Benik trunk brace which now he only uses with exercises. He has been receiving Early Interventions services including PT two times per week, OT one time per week and speech therapy one time per week.

12. Dr. Barkoudah's impression was that Jeffrey's low muscle tone was "likely central in origin and related to his gross motor delays." She did not recommend any further assessments. Dr. Barkoudah opined in her report that the average age for diagnosis of cerebral palsy is two years of age, and, therefore, Jeffrey did not currently meet the diagnostic requirement.

13. At approximately 13 months of age, Jeffrey was referred to Radhakrishna K. Rao, M.D., D.C.H., M.S., at Bay

Regional & International Institute of Neurology, for a neurological evaluation. After conducting an examination of Jeffrey, Dr. Rao's report documented his clinical impression as follows:

> Patient has a complex medico-neurological condition of severe complexity. Patient had difficult neonatal period as described above. Developmentally child is making progress at a slower pace without any regression. In my opinion, the loose umbilical cord wrapped around his legs and abdomen may have contributed to initially for persistent transverse lie and later descent for normal vaginal birth. This also might have contributed for respiratory depression and low Apgar score resulting in intermittent hypoxia. This appears to be the reason for his development of generalized hypotonia, gross motor and fine motor developmental delay and hypotonic cerebral palsy.

14. Dr. Rao recommended an additional EEG to document any underlying neuronal dysfunction and seizure activity. An EEG was conducted several days later and was interpreted as within normal limits for Jeffrey's age, and there was no definite seizure activity seen.

15. Jeffrey presented to Dr. Rao again on April 21, 2015. On this occasion, among other medical concerns, Dr. Rao diagnosed Jeffrey with hypotonic cerebral palsy. Jeffrey continued to treat with Dr. Rao through August 2015.

16. On June 21, 2017, Jeffrey (at age three years, four months) presented to the neurology clinic at All Children's

Hospital for follow-up of his history of hypotonia and global development delay. According to the clinical note, he had been diagnosed previously with congenital hypotonia, and had developmental delays including expressive speech delays. It was further documented that Jeffrey has a history of abnormal signal intensities on brain MRI.

17. The clinical note described Jeffrey's developmental delays as follows:

> Parents relate today that he is making steady for developmental progress, although slowly. Parents are very involved with a home regimen of multiple therapies which they engage in with him on a daily basis. Presently, he is able to walk independently. He continues to be unsteady and falls frequently. He is not able to stoop to pick up an object and then stand back up alone without holding onto something. He is not yet running. He can pick up a Cheerio or small object with a pincer grasp: not able to yet hold onto a crayon and scribble. Expressive language reveals approximately 15-20 independent words, although these are inconsistent. He knows (approximately) 8 signs and uses these appropriately. He is not able to identify pictures in books; does not know body parts. He waves "bye bye" and initiates some activities. He is not potty trained. He wears glasses and does vision therapy. Developmental level at this time by Denver Developmental Assessment is gross motor: (approximately) 15 mo.; fine motor/adaptive: (approximately) 10 mo.; language: (approximately) 15 mo.; personal/social: (approximately) 15 mo.

18. The All Children's clinical note again documented Jeffrey as having congenital hypotonia and concluded that he is

globally delayed, but making slow gains with "a lot of intervention/therapy."

19. As indicated in the preceding paragraphs, Petitioners have commendably sought advice, treatment, and evaluations from multiple health care providers and specialists in an effort to care for Jeffrey. At the time of Mrs. D'Angelo's deposition on September 17, 2018, Jeffrey was four years, seven months old. Mrs. D'Angelo credibly testified about a "day in the life" of Jeffrey, his development, and his limitations.

20. Jeffrey is currently receiving multiple therapies on a daily basis at Petitioners' home. Mrs. D'Angelo credibly testified that Jeffrey receives physical therapy once per week, occupational therapy twice per week, speech therapy three times per week, music therapy twice per week, and Applied Behavioral Analysis therapy for 40 hours per week. His various therapies essentially begin at 8:00 a.m., and continue throughout the day until 5:00 p.m.

21. Mrs. D'Angelo explained that, in physical therapy, the primary goal at this time is for Jeffrey to be able to transition stairs. Over the last 4.5 years of physical therapy, there has been some slight improvement in that 1) he no longer has to wear a medical helmet; 2) he no longer has a walker; 3) his leg braces were previously from the knee down and now they are only ankle braces; 4) and he can walk independently

indoors with adult supervision with mats on the floor to protect him from falls. At this time, he does not walk independently without the mats due to the potential fall risk.

22. Concerning his occupational therapy goals, Mrs. D'Angelo credibly testified that they are working on his prewriting skills. The team is working on his ability to draw a line. At present, he does not have the ability to independently hold a pencil or a crayon correctly. Mrs. D'Angelo explained that he continues to require speech therapy, as he is functioning at a one-year-old level. Although Jeffrey may be able to say 20-25 words, they are approximations. Essentially, he can say "mom," "dad," and "hi" clearly.

23. Mrs. D'Angelo further credibly testified concerning other limitations. Jeffrey wears diapers and is not potty-trained. He can follow very limited one-task directions, but rarely two-step directions. Jeffrey cannot and does not play with other children. While he can use a "sippy cup," he cannot use an open cup to drink and cannot use utensils to feed himself.

24. In April 2018, Jeffrey was diagnosed with an undisputedly rare genetic disorder referred to as CHAMP 1. The undersigned finds that there was insufficient evidence presented by the parties concerning this disorder to make any findings as

to whether Jeffrey's impairments are caused by genetic or congenital abnormality.

25. NICA retained Donald C. Willis, M.D., an obstetrician specializing in maternal-fetal medicine, to review the medical records of Jeffrey and Mrs. D'Angelo, and opine as to whether there was an injury to his brain or spinal cord that occurred in the course of labor, delivery, or resuscitation in the immediate postdelivery period due to oxygen deprivation or mechanical injury. Dr. Willis made the following findings and expressed the following opinions in a report, dated March 27, 2017:

> I have reviewed [the] medical records for the above individual. The mother, Katis D'Angelo was a 25 year old G1 with a history of successful treatment for preterm labor at 32 weeks. Prenatal course was otherwise without complications.
>
> The Mother was admitted at 37 weeks gestational age with spontaneous rupture of the membranes. Her cervix was dilated 1 cm. She was not in labor. Pitocin induction of labor was initiated for rupture of membranes.
>
> The fetal heart rate (FHR) monitor tracing was reviewed. There was no fetal distress. Cesarean section was done for failure to progress. Birth weight was 3,575 grams (7 lbs 14 oz's). Extraction of the fetal head during Cesarean section was described as difficult. Several loops of umbilical cord were around the body of the fetus.
>
> Apgar scores were 2/6/8. Positive pressure ventilation was given for 5 minutes and chest compressions for 30 seconds. The baby

was taken to the NICU for evaluation and management.

NICU evaluation noted overall reduced motor activity and a rapid respiratory rate. X-ray showed bilateral vascular markings, compatible with transient tachypnea vs pneumonia. Several episodes of apnea occurred. Capillary blood gas at 5 hours of age was normal with a pH of 7.36. Antibiotics were started and continued for 7 days. Blood cultures were negative.

Initial platelet count was low at 84,000. A short tongue frenulum, Ankyloglossia was present. This birth defect was later surgical[ly] corrected.

Orogastric tube feedings were required for poor feeding coordination. Frequent body arching and posturing episodes developed. EEG on DOL 2 was normal. Head ultrasound was also normal. The baby was transferred to All Children's Hospital due to possible seizure activity and poor feeding.

Genetic testing, including microarray studies were negative.

The child continue[d] to have hypotonia after hospital discharge. Neurology evaluation for hypotonia and motor developmental delay was done with the impression of a "complex medico-neurological condition of severe complexity." EEG at about one year of age was normal. Sleep studies suggested upper airway obstruction. MRI found mild cervical spine narrowing, but no brain injury.

There was no apparent obstetrical event that resulted in loss of oxygen or mechanical trauma to the baby's brain or spinal cord that resulted in injury during labor, delivery and the immediate post delivery period.

26. Dr. Willis's findings and opinions were confirmed and verified in an affidavit dated September 1, 2017. At his deposition, Dr. Willis testified, in pertinent part, as follows:

> Q. Okay. What is your opinion as to whether or not Jeffrey D'Angelo suffered a birth-related neurological injury?
>
> A. I do not believe that there was any apparent obstetrical event that resulted in loss of oxygen or mechanical trauma to the baby's brain during labor, delivery, or the immediate post-delivery period.
>
> * * *
>
> Q. Would you briefly summarize your findings and basis for your opinion?
>
> A. Yes.
>
> Q. And refer to the report if necessary.
>
> A. Yeah. The mother was admitted to the hospital at 37 weeks gestational age with spontaneous rupture of the membranes. Labor was induced. She progressed to about 5 centimeters dilation and then had failure to dilate after that point.
>
> Cesarean section was then done for failure to dilate. And the – let me back up a moment. I did see the fetal heart rate tracings. And there was a nice set of fetal heart rate tracings during labor. I reviewed those. The fetal heart rate tracing did not show anything to me that suggested fetal distress during labor. It appeared to be a reassuring fetal heart rate pattern. Delivery was done by Cesarean section. Delivery was stated to be complicated or difficult because the umbilical cord was around the baby's body.

> And the – and the delivery was stated to be difficult.
>
> When the baby was born, it was depressed. Apgar scores were 2 at 1 minute, 6 at 5 minutes, and 8 at 10 minutes. The baby did require positive-pressure ventilation for approximately 5 minutes. And chest compressions were approximately 30 seconds. The baby was taken to the neonatal intensive care unit. Chest x-ray showed – had some bilateral vascular markings which were compatible with transient tachypnea of the newborn.
>
> Shortly after birth the baby had some episodes of apnea. A capillary blood gas was done about 5 hours after birth, and it was normal. The pH was 7.36. EEG was done on day of life two, which was normal. Head ultrasound was also normal. The baby was transferred to All Children's Hospital because – from what I gather from the records because they wanted to do an MRI. The MRI was done about two weeks after birth and was – and was normal.

27. With respect to Jeffrey's Apgar scores, Dr. Willis testified, in relevant part, as follows:

> Q. What did those Apgar scores mean or indicate to you in the context of your review of this case?
>
> A. Right. Well, usually we say that the one Apgar – the 1-minute Apgar score tells you what resuscitation is required. So Apgar score of 2 would be a low Apgar score. And that would mean that some resuscitation would be required after birth. The 5-minute Apgar score tells you a little bit more about what the baby's acid base status, oxygen deprivation status would be. And that was 6. We consider the Apgar to be low if it is below 7. So the 5-minute Apgar was slightly lower than expected. By 10 minutes

it was 8. So that would be within normal limits' score for an Apgar.

28. With respect to the diagnostic studies performed during the newborn period, Dr. Willis testified, in relevant part, as follows:

Q. What is the purpose of an EEG?

A. Purpose of the EEG is to determine if there's any electrical brain injury.

Q. Okay, and that's a diagnostic study to determine if the brain is functioning properly?

A. Correct.

Q. And in this case on the second day of life an EEG was done and it was read as normal?

A. Correct.

Q. If J.D. in this case had suffered oxygen deprivation significant enough to cause brain damage in the course of labor and delivery, would you expect an EEG on day of life two to be normal?

A. No. You would expect some abnormalities in that EEG.

Q. So this EEG, correct me if I am wrong, would be inconsistent with . . . J.D. having suffered oxygen deprivation significant enough to cause brain injury at the time of labor and delivery in this case?

A. Correct.

* * *

Q. And then you mentioned that an MRI was done at approximately 2 weeks of age?

A. Correct.

Q. And are you referring to the MRI that was dated March 6, 2014?

A. Correct.

Q. And what did that MRI reflect?

A. That MRI was read as normal. So nothing on that MRI that suggested hypoxic or ischemic brain injury. And I felt that was very important in my – in my final disposition of this case because the delivery was somewhat difficult. And the baby was depressed at birth and required resuscitation. So that made me somewhat concerned about oxygen deprivation at birth. However, if the baby has oxygen deprivation at birth enough to cause brain injury, then the EEG will be abnormal and for sure the MRI at two weeks is going to show abnormalities.

With a normal MRI at two weeks after birth, it really confirms that there was no oxygen deprivation during labor or delivery or the immediate post delivery period that was substantial enough to cause identifiable brain injury.

Q. Okay. Is it fair to say, just to follow up on that MRI at two weeks, that the findings on that MRI are inconsistent with J.D. in this case having suffered oxygen deprivation significant enough to cause brain injury at the time of labor and delivery?

Q. Correct.

29. Dr. Willis's findings and opinion that there was not a brain injury caused by oxygen deprivation or mechanical injury

in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital are credited.

30. NICA also retained Laufey Y. Sigurdardottir, M.D., a pediatric neurologist, to review Jeffrey's medical records, conduct an independent medical examination (IME), and opine as to whether he suffers from a permanent and substantial mental and physical impairment as a result of a birth-related neurological injury. Dr. Sigurdardottir reviewed Jeffrey's medical records and performed an IME on March 29, 2017. Dr. Sigurdardottir made the following findings and summarized her evaluation as follows:

> Pregnancy and Birth Summary: Jeffrey was born at 37 weeks 3 days to a 25-year-old G1, P0 serology negative mother after normal, noncomplicated, pregnancy. She did have premature labor at 32 weeks that resolved and then spontaneous rupture of membranes at 11 p.m. on 02/22/2014. Jeffrey's mother presented shortly before midnight to Bayfront Health Labor and Delivery Ward, was found to have 1 cm cervical dilation and was admitted. She was not felt to be in active labor at that time. Labor was augmented with Pitocin but an emergent C-section was performed at 1 p.m. on 02/23/2014 due to failure to progress and arrested of fetal head. Fetal heart rate strips are available for our review and no fetal heart decelerations are noted. During the Cesarean section, the infant was found to be in a ROT position and large for gestational age. The extraction was difficult. The umbilical cord was noted to be wrapped around the legs with several loops and also around the abdomen. The infant was depressed at birth with Apgars of 2, 6 and 8

at 1,5 and 10 minutes. The infant was delivered at 1352 on 02/23/2014 weighing 3570g, length 51 cm and head circumference of 33cm. The infant did receive chest compressions for 30 seconds and positive pressure ventilation. Infant was noted to have respiratory distress and was admitted to Bayfront NICU for further evaluation. Infant had initial exam on admission suggestive of perinatal depression. His neurologic examination on admission revealed decreased muscle tone, decreased motor activity, symmetric Moro reflex, response to stimuli and no tremor. The infant had recovery of neurologic status apart from continued hypotonia and difficulty feeding. Infant was worked up with labs including a capillary blood gas at 5 hours of life showing a pH of 7.36 and a base excess of -0.6. PCo2 was 48. Initial creatinine measurement was 1 and had a steady decline after that. AST and ALT were found to be normal. Initial platelets were found to be 84,000 with recovery to 165,000 by 6 a.m. on 02/24/201[4]. EEG performed on day of life 2 was found to be normal with no indication of a lowered seizure threshold and no abnormality on background activity. Head ultrasound was also performed and found to be normal. Infant had transient tachypnea, tongue ankyloglossia, possible sepsis and was treated with antibiotics. Nutritional status was found to include initial low blood glucose and episodes of arching with feeding. The patient did require partial gavage feeding prior to discharge. Discharge was on 03/05/201[4].

Developmental and Medical History: Jeffrey continued to exhibit delays in neurologic development. Per parents' report, he had poor feeding abilities, was found to have low muscle tone and required therapies, occupational, physical, and speech therapy, from a very early age. He sat around 14 months, crawled at 15 months and walked unassisted at 22 months. He has had

significant language delays, although at this time he has 20-25 words. He has been found to have apraxia of speech. The patient has had ophthalmologic abnormality including a downward eye deviation that the parents report and was seen at Boston Children's Hospital at the age of 9 months for a second opinion of the underlying etiology for his delays. He has had genetic workup including microarray and Prader-Willi has also been ruled out. Patient has had multiple neuro radiologic evaluations of brain and spinal cord. The initial MRI was performed on 03/06/2014 and found to have a brain that seems normal in signal intensity including gray and white matter on multiple sequences. Vascular structures appear grossly normal. The second evaluation is a brain ultrasound on 07/29/2014 which shows mild increased CSF fluid spaces. A second MRI was performed in September 2014 and showed increased bifrontal temporal extraaxial convexity, effusion and mild ventricular dilation as compared to study from 03/06/2014. This was considered to be suggestive of a communicating hydrocephaly with impaired drainage at the level of the arachnoid granulations. An MRI of the cervical spine was also performed and showed mild C3-C5 spinal canal stenosis. A follow up MRI was then performed on 01/26/2015 with no interval change in the spinal stenosis at C3-C5 and no significant change in appearance of the extraaxial fluid or ventricular size. A 3rd follow up MRI then performed in May 2015 which showed possible increased in kyphosis of cervical region but no clear change in ventricular size and possible decrease in amount of extraaxial CSF spaces. Final MRI was then performed on July 2016 which continues to show mild bilateral and lateral ventricular dilation and bifrontal temporal convexity, extraaxial fluid. This was deemed to be stable. In the final MRI there are noted small foci of bifrontal white matter increased FLAIR signal without associated mass effect.

Jeffrey has been treated with vigorous therapy, both with therapy providers as well as with his parents and has undergone hyperbaric oxygen therapy. Parents feel that he continues to be significantly delayed as compared to his peers. But now he is more responsive to them. He has been evaluated for possible autism and found to be negative for such symptoms on 3 occasions, as per parents' report.

* * *

Physical Examination: Jeffrey is 17.7 kg, 91.4 cm and his head circumference is 51 cm. This places his growth parameters to be at the 95th percentile for weight, at the 13th percentile for length and his head circumference to be at the 59th percentile. His general exam is as follows: Head and Neck: There are no obvious dysmorphic features, although mouth tends to be open. He does have conjugate eye movement. Lungs: Clear to auscultation. Cardiovascular exam reveals first and second heart tones, no noted heart murmurs, no rhythm abnormalities. Abdomen is soft, no hepatosplenomegaly. GU normal. Musculoskeletal: He does have some increased joint laxity. Skin is without abnormal markings. Neurologic Examination: Mental status: The patient is interactive with his parents often needing multiple requests to comply with their requests for him. He does wave bye-bye. He does clap and does have occasional words that are difficult for this examiner to understand. His eye contact seems at times to be poor. No repetitive behavior is noted. Cranial nerves: His pupils are equal, reactive to light. He has full visual fields. Extraocular movements are conjugate. His facial expression is somewhat diminished. His hearing seems intact to voice. Motor exam reveals generalized hypotonia with some increased joint laxity, but full strength. Reflexes are difficult to elicit but

present. Balance and coordination is delayed for age, although fine motor skills assessment is not performed.

Summary: Jeffrey is a 3-year 1-month-old boy with motor and speech delays from birth. There is documented fetal depression but no clear documented fetal heart rate disturbance after the onset of active labor. His current status is improved from early in life and he is now able to ambulate without support and has started speaking in single words. There are no signs of autistic features.

Result as to question 1: Jeffrey is not found to have a substantial physical impairment at this time. He is found to have a substantial language impairment at this time.

Result as to question 2: In review of available documents, although having neurologic depression requiring some resuscitation at birth, there is no clear acute hypoxic event, and fetal heart rate strips were relatively benign. MRI performed in the neonatal period, EEG performed in the neonatal period did not support an acute encephalopathy. No laboratory evidence of multisystem hypoxic changes were noted in postnatal period.

Result as to question 3: The prognosis for full motor and mental recovery is guarded but his life expectancy is full.

Due to absence of evidence of hypoxic event during active labor, absence of secondary findings supportive of a hypoxic encephalopathy (MRI, laboratory or EEG) and his ongoing motor and cognitive progress, I do not feel that he should be included in the NICA program. (JE I, P. 1-3).

31. Dr. Sigurdardottir confirmed and verified her opinions in an affidavit dated August 31, 2017. Dr. Sigurdardottir also

testified, in relevant part, during her deposition on February 14, 2018, as follows:

> Q. And what were your conclusions to those questions (asked by NICA)?
>
> A. The conclusions are the following: Jeffrey is not found to have a substantial physical impairment at this time. He is found to have a substantial language impairment at this time. That is question one. So question one, he does not fulfill the criteria having both a substantial physical impairment and mental impairment.
>
> Result of the question two, that although having neurologic depression requiring some resuscitation at birth there is no clear precipitating acute hypoxic event that we can establish with the available records that we have, including fetal heart restrict, as well as in the neonatal post natal period there was no evidence of multi-system organ failure that often goes along with hypoxic ischemic events. So there was an MRI performed within the first two weeks, an EEG that was performed in a neonatal period, and then no laboratory evidence of multisystem hypoxic injury.

32. On cross examination by Mr. D'Angelo, Dr. Sigurdardottir further explained her opinions and analysis as follows:

> Q. So what do you personally think was just the resuscitation he needed at birth likely? And I understand we're not dealing in terms of absolutes, but was the likely cause of my son's injury due to low amounts of oxygen at birth?
>
> A. Well, I would say it's clear he had neurologic depression at birth. Then, we start looking for signs that would indicate

> that that would happen, such as the fetal heart rate [t]racing, that was benign. There was nothing in that that indicated there was lack of oxygen. And then after birth, even though he had neurologic depression, we did not have any of the hard evidence that he had significant hypoxic ischemic encephalopathy, is what we call it, and that's when you have other systems involved, like the liver test becomes abnormal, the creatine continues to rise, his active base balance at the age of five hours looked fairly good, did not show a metabolic acidosis. And then an MRI that was performed, I believe, on day of life 10 or 11, that did not show any abnormality at that point that indicated an acute ischemic injury. So we have little that supports it from all of the laboratory results that we have and the fetal heart rate [tracing].

33. Dr. Sigurdardottir's findings and opinion that Jeffrey has a substantial language impairment is undisputed and credited. Her opinion that Jeffrey does not have a substantial physical impairment is not credited for the reasons discussed below in the Conclusions of Law. Dr. Sigurdardottir's opinion that there is evidence of fetal depression, but insignificant evidence (at birth) to establish significant hypoxic ischemic encephalopathy is supported by the evidence and is credited.

34. Petitioners submitted a notarized statement from Jeffrey Huber in support of their position that Jeffrey sustained a birth-related neurological injury. It appears that Mr. Huber was the respiratory therapist in the operating room at the time of delivery. Mr. Huber's statement provides, inter

alia, that Jeffrey had a "lack of ventilation for longer than 2 minutes." Although Mr. Huber's statement has been considered, it constitutes hearsay and cannot support independently any finding of fact.

35. Additionally, Dr. Willis and Dr. Sigurdardottir, the only qualified medical experts who have testified in this matter, both represented that Mr. Huber's statement was duly considered by them and did not change any of their opinions and ultimate conclusions. Specifically, Dr. Willis testified, in relevant part, as follows:

> Q. Did that report [and] statement from Mr. [H]uber have any impact on your ultimate opinions and conclusions?
>
> A. No. No, it did not. Most of the things that he – that he talked about in there were part of the medical records. The fact that the baby required resuscitation, required chest compressions was all in the medical records. So nothing new there. He does not state exactly what his position is, but I assume from what I've read he must be somehow involved with respiratory therapy. So nothing new as far as what was in the medical records in his report.

CONCLUSIONS OF LAW

36. DOAH has jurisdiction over the parties to and the subject matter of these proceedings. §§ 766.301-766.316, Fla. Stat.

37. The Plan was established by the Legislature "for the purpose of providing compensation, irrespective of fault, for

birth-related neurological injury claims" relating to births occurring on or after January 1, 1989. § 766.303(1), Fla. Stat.

38. 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 DOAH. §§ 766.302(3), 766.303(2), and 766.305(1), Fla. Stat. NICA, which administers the Plan, has "45 days from the date of service of a complete claim . . . in which to file a response to the petition and to submit relevant written information relating to the issue of whether the injury is a birth-related neurological injury." § 766.305(4), Fla. Stat.

39. If NICA determines that the injury alleged is a claim that 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 (ALJ) to whom the claim has been assigned. § 766.305(7), Fla. Stat. If, on the other hand, NICA disputes the claims, as here, the dispute must be resolved by the assigned ALJ in accordance with the provisions of chapter 120, Florida Statutes. §§ 766.304, 766.309, and 766.31, Fla. Stat.

40. In discharging this responsibility, the ALJ is required to make the following threshold determinations based upon the available evidence:

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

§ 766.309(1), Fla. Stat.

41. The term "birth-related neurological injury" is defined in section 766.302(2) as follows:

> "Birth-related neurological injury" means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired.

42. In Bennett v. St. Vincent's Medical Center, Inc., 71 So. 3d 828, 837 (Fla. 2011), the court summarized the determination of a birth-related neurological injury as follows:

> Thus, based on the language of the statute, a birth-related neurological injury has four components: (1) an injury to the brain or spinal cord; (2) which is caused by oxygen deprivation or mechanical injury; (3) during labor, delivery, or resuscitation in the immediate postdelivery period; and (4) which renders the infant permanently and substantially impaired.

43. As set forth above, section 766.309(1)(a) provides for a rebuttable presumption. Where, as here, the claimants are seeking benefits under the Plan, to obtain the rebuttable presumption they do not have to establish that the incident occurred during labor, delivery, or resuscitation in the immediate postdelivery period, assuming the other statutory prerequisites have been met. Bennett, 71 So. 3d at 844. The statutory presumption is the type described in section 90.302(1), Florida Statutes, also known as the "bursting bubble" presumption. Id. at 846.

44. Here, the evidence establishes that Jeffrey was a single gestation, born in a hospital, and weighed over 2,500 grams at birth. Based on the medical records and testimony, the better evidence supports the conclusion that he has suffered an injury to his brain caused by oxygen deprivation. It appears to

be undisputed from the medical records that Jeffrey has been diagnosed with cerebral palsy.[4/]

45. Prior to addressing whether Jeffrey is "permanently and substantially mentally and physically impaired," it is noteworthy that "the legislature chose not to define the terms used in the test for NICA qualification." Adventist, 865 So. 2d at 568. These terms are to be given their ordinary meaning. Id. In Adventist, the Fifth Circuit provided the following limited directive:

> The legislature left the application of the terms they used to the administrative law judges designated by statute to hear these claims and to apply the expertise they develop in carrying out this task to determine from the evidence adduced in each case whether the test for NICA is met.
>
> * * *
>
> In cases such as the one before us, the ALJ, as fact finder, brings his own background, training, experience and expertise to the task of weighing and evaluating very sophisticated evidence. The child's advocate likewise brings his own communication and strategic skills to the fact-finding process; and finally, the evidence in each case will vary in its power to persuade. This will be especially true in cases where the opinions of experts are considered.

Id. at 568-69.

46. Petitioners contend that Jeffrey is permanently and substantially mentally impaired. NICA concedes, in its proposed

final order that Jeffrey has a permanent and substantial mental impairment. The undersigned concurs and concludes that Jeffrey is permanently and substantially mentally impaired.

47. Petitioners further aver that Jeffrey sustained a brain injury caused by oxygen deprivation and that he was thereby rendered permanently and substantially physically impaired. Under the Plan, a "physical impairment" relates to the infant's "motor abnormalities" or impairment of his "physical functions." Matteini v. Fla. Birth-Related Neurological, 946 So. 2d 1092, 1095 (Fla. 5th DCA. 2006). In support of this contention, Petitioners testified as to their daily observations of Jeffrey's physical impairments and limitations, as set forth in the above Findings of Fact.

48. On behalf of NICA, Dr. Sigurdardottir examined Jeffrey on March 29, 2017. The motor examination revealed generalized hypotonia with some increased joint laxity, but full strength. She further found his reflexes difficult to elicit, but present. Additionally, she found that his balance and coordination were delayed for his age; however, she did not perform a fine motor skill assessment. As noted in the Findings of Fact, Dr. Sigurdardottir concluded that Jeffrey did not have a substantial physical impairment and that his prognosis for full motor recovery was "guarded."

49. While it is without question that Dr. Siguardottir possesses the requisite education, training, skill, and background to credibly opine on the issues presented, her opinion on whether Jeffrey has sustained a substantial physical impairment is of limited value here. In her deposition, Dr. Siguardottir explained that she utilizes the NICA statute's reference to "catastrophic injuries" as a reference or benchmark in formulating her opinion as to whether a particular examinee has sustained a substantial physical impairment. For all that appears, she also utilizes a qualitative approach in reaching said opinion, often referencing Jeffrey in relation to where he exists, developmentally, on a continuum of other examinees previously determined entitled to compensation under the Plan.

50. Dr. Siguardottir was examined concerning the findings contained in the most recent examination contained in the Stipulated Record. This examination was conducted on June 21, 2017 (when Jeffrey was four years, three months old), at All Children's Hospital. The findings of that examination document that Jeffrey's gross motor skills were equivalent to a 15-month old; his fine motor skills were that of a 10-month old; his muscle tone was low throughout; and his coordination was developmentally delayed. Dr. Siguardottir opined that Jeffrey, a 4.25-year-old, is "somewhere between two and three years delayed," but that, "those developmental numbers are much higher

than the developmental age equivalence that we are typically seeing in the NICA program."

51. Dr. Siguardottir's reference to catastrophic injuries appears to originate from section 766.301(2), which sets forth the legislative intent of the NICA program, 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.

52. As discussed above, the NICA statute does not statutorily define the terms used to determine NICA qualification. While section 766.301(2) documents legislative intent, it does not set forth the standard for compensation eligibility. The phrase "substantial physical impairment" is to be given its ordinary meaning. Without question, there will be infants whose substantial physical impairments are catastrophic; however, it does not follow that a physical impairment must be catastrophic to be considered substantial. As Dr. Siguardottir appears to have utilized a heightened standard beyond that required by section 766.302(2) in reaching her opinion on substantial physical impairment, the same is not credited in this matter.

53. Having considered the entirety of the Stipulated Record, the undersigned concludes that Petitioners have met their burden of showing that Jeffrey is substantially and

permanently physically impaired. Accordingly, the undersigned concludes that Jeffrey sustained a brain injury caused by oxygen deprivation that rendered Jeffrey permanently and substantially mentally and physically impaired. Accordingly, Petitioners are entitled to the rebuttable presumption the injury is a birth-related neurological injury as defined in section 766.303(2).

54. While Petitioners are entitled to the rebuttable presumption, that does not end the inquiry. It is undisputed that, at the time of Jeffrey's birth, there was an incident of oxygen deprivation that required resuscitation in the immediate postdelivery period in the hospital. The medical records further document that Jeffrey had several additional apneic episodes on his first day of life. Additionally, the medical records from Dr. Rao provide some evidence of a potential causative link between Jeffrey's depressed state at birth and his ensuing physical and mental impairments. The undersigned finds, however, that the better evidence was presented by NICA's credible medical expert witnesses who uniformly testified that, despite his depressed state at birth, there was not an injury to Jeffrey's brain caused by oxygen deprivation during labor, delivery, or resuscitation in the immediate postdelivery period. Accordingly, it is concluded that Jeffrey did not sustain a birth-related neurological injury, and, therefore, is not entitled to compensation under the Plan.

CONCLUSION

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that the Petition is dismissed with prejudice.

DONE AND ORDERED this 6th day of February, 2019, in Tallahassee, Leon County, Florida.

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Filed with the Clerk of the
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ENDNOTES

[1/] An Apgar score is a numerical expression of the condition of the newborn and reflects the sum total of points gained on an assessment of heart rate, respiratory effort, muscle tone, reflex irritability, and color. See Bennett v. St. Vincent's Med. Ctr., Inc., 71 So. 3d 828, 848 n.2 (Fla. 2011).

[2/] The discharge summary from Bayfront provides that "[i]nfant received PPV x 5 min, oxygen, and chest compressions for 30 seconds per RT notes." The respiratory therapy records, however, are not included in the Stipulated Record.

[3/] The Stipulated Record does not include all of the records from Jeffrey's admission at All Children's Hospital. The results from the MRI of March 6, 2014, are not included.

[4/] Although the Stipulated Record lacks a clear definition of cerebral palsy, it is understood that cerebral palsy refers to a group of motor disorders caused by an injury to the developing brain. See Adventist Health Sys./Sunbelt, Inc. v. Fla. Birth-Related Neurological Injury, 865 So. 2d 561, 563 (Fla. 5th DCA 2004).

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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).