CLIENT: **Casey Jones**
DATE OF EVALUATION: **June 27, 2005**
DATE REPORT INITIATED: **June 28, 2005**
REPORT FINALIZED: **July 14, 2005**

Casey Jones is an 8-year old Caucasian male seen for evaluation at the Days Inn in Tampa, Florida. Also present and participating in the evaluation is his mother Rosie. Casey and his mother were accompanied to the evaluation by their attorney who observed but did not participate in any way.

Casey was referred for an independent rehabilitation evaluation by Gabby Frida, who is with ABC Insurance Company. The purpose of this evaluation is to assess the extent to which handicapping conditions impede Casey's ability to live independently, handle all activities of daily living, and to assess the disability's impact on his vocational development potential.

Demographic Information:

Client Name: Casey Jones; **Social Security #:** xxx-xx-xxxx; **Address:** 5667 Dotty Blvd. Ocala, FL; **County:** Marion; **Closest Metro Area:** Ocala/Gainesville; **Birthdate:** 10/7/96; **Age:** 8; **Sex:** Male; **Race:** Caucasian; **Marital Status:** Single; **Birthplace:** Tampa, FL then moved to Ocala, FL; **Citizen:** Yes; **Elementary/Secondary Education:** Marion County School System currently. Private school in Marion County; **School:** Currently at Marion County Elementary; **Position/Grade:** Now considered in 1st grade. See developmental levels.; **Bilingual:** No; **Glasses:** Both; **Dominant Hand:** Left (Was right hand dominant. See notes); **Height:** Unsure; **Weight (present):** Unsure; **Weight (pre-injury):** Unsure; **Date of Onset:** 9/23/97.

History: Medical records reveal that Casey developed Strep Pneumococcal Meningitis on 9/23/97 at 11 months of age. He was originally devastated by the meningitis and left initially in a vegetative state with profound deafness. He was not expected to survive. He did survive and gradually improved, but he remained brain damaged.

Loss of Consciousness or Altered State of Consciousness: Yes.

Length of Unconsciousness or of Altered State: Was left initially in vegetative state but improved post shunt placement.

Rehabilitation Program(s) [In/Outpatient Since Injury]: Rosie indicates that no PT, OT or ST was initiated in Tampa Children's Hospital, *''They were expecting him to pass and they did not feel it was necessary.''* He was initially discharged to home on 10/7/97. He was discharged only with hospice care assigned. A hospice nurse came to the home once or twice per week. She would check his vitals. For the most part she seemed to be there for moral support to help with the grieving. She would find out what the needs were and bring prescriptions. This continued until November or about six to eight weeks.

Rosie outlines, *''At that point, Dr. Gi decided that Casey needed a shunt and he was actually responding with more than just a reflex. He felt that he was not going to die right away and he could live for a long period of time like this. Arrangements were made for Dr. Seal to complete a VP shunt placement in November of 1997. Casey responded with gradual improvement to the point where he seemed blind before, but this released pressure off of the cortical nerves so he could see shadows. We used strobes, flashlights and holding books up to stimulate his vision. We got information from websites on different ways to stimulate him. We also stimulated his body, moving his legs and arms. Massaging him from head to toe, and every hour we would physically stimulate him. He would also get constant visual stimulation with disco lights or some other effort would be setup to make sure he was being stimulated throughout the day. On weekends, my mother would come up from Naples and we had friends from Church come out, all to take over sessions so I would not get physically exhausted. I saw gradual but continued improvement.''*

Rosie continues, *''Beginning in January of 1998, we started to get some therapy services, I think through Division of Blind Services. They told me who to call and I did to see what was available to us. Starting in January The School for the Deaf and Blind, Megan Murphee, who still works for us, came out to the house to determine what his and our needs were. She explained our options and what route we wanted to take. At that point, I informed them about research I had done on cochlear implants. I met with Megan in March of 1998, and I started meeting with Rita Yonit who was with Shands who was their cochlear implant specialist in April. That is when they started doing CT scans and found Casey had ocifications. They needed to determine if he had too much ocification. There was one device that provided hearing for those with ocification and it would work with his level. That is the one we got. We met with Dr. Cory*

Freedman. He was the surgeon that implanted the device. We got excellent support from the whole audiological community.''

At this point, I did ask if she had gone over the list of items in Jane Doe's plan required in follow-up to the cochlear implant. She indicated that Jane had gone over the list with her, the audiologist and the specialist at Shands. Nevertheless, she felt a contact with the manufacturer might well have been necessary. She also noted that she is in favor of a bilateral implant. Casey has continued to show ocification/calcification on the right side, but the manufacturer Med-EL has a split array for ocification. She would like to see this implanted. She has not talked with the surgeon about the split array, but she knows he is very pro-bilateral implant. It is possible for the second cochlear implant to be placed and coordinated with the existing array. Dr. Freedman has now done a split array with a shunt patient, and he has found he can just move the shunt out of the way.

Beginning in January of 1998, PT started coming to the house one time per week and this only lasted a month. Each session lasted forty-five minutes. His endurance was limited. At the end of one month, *''I started taking him to Shands and he received his therapies there. This was under Medicaid approval. He began receiving PT and OT the beginning of February to the end of March and it was not until April that ST began. He received two PT and one OT session per week. When ST began, he received it once per week. His endurance was low, so we had to go daily to work the schedule out. He received thirty minute sessions. This continued through 2004. He gradually began to endure more, so the times increased to one hour each session and he learned to endure back to back therapies. Speech had to come before PT so he had the energy left to do the PT, otherwise he would complete PT and just lay his head on the table for ST. We got down to three days per week instead of five. He started going to Oasis Learning Institute from age two to age two and a half. He was at Citrus Park Oral School from age two and a half or September 1999 to April of 2000 when he was age three. He was there on a scholarship. Citrus Park Oral School is in Ocala, Florida. Citrus Park was partly funded by the Early Intervention Program for the State of Florida and the rest was funded by scholarship. At that time, Children's Medical Services also provided his bath seat, some learning tools, a corner seat and feeding chair. We also had quad canes and a few other items that CMS paid for through Shands. He started with a walker, progressed to a quad cane and now he is ambulating but he has to wear an AFO. We anticipate the AFO to be long term.''*

His current therapy schedule is limited to what he gets at school. He is at Marion County Elementary and they are providing him with ST, OT, and PT, and they are doing an English language activity as a supplement to speech. He gets one session of OT for thirty minutes each week. PT is the same at one time per week for thirty minutes. ST is thirty minutes one time per week, but it is supplemented by a one time per week language activity. Mom expresses concern that the speech and language pathologist is not trained on cochlear implants. He is currently not seeing anyone outside the school working on the cochlear implant therapy. Rita Yonit did come out to the house and help mom label items and train her to help teach Casey in follow-up to the implant. Nevertheless, the plan should include cochlear implant therapy/education.

From the records: Casey has been involved in an aggressive therapy course. He received occupational therapy and physical therapy at Shands Clinic. A therapist from the Florida School for the Deaf and Blind visited the home to teach the family sign language. He received Occupational and Speech therapy at Oasis Learning Institute. Following Cochlear Implantation he attended a Summer Toddler Program at Citrus Park Oral School and was subsequently offered placement in the Toddler Preschool Program starting in September of 1999. Ellen Jansen, Ph.D., stated on 6/7/04 that Casey was still attending speech therapy one time per week at Shands. He continued to receive private speech, physical and occupational therapy including intensive auditory verbal therapy to maximize use of his cochlear implant. He was in a specialized hearing impaired classroom for children with cochlear implants where he was to remain for the upcoming year as a kindergartner. He also was receiving private ST at Shands as well.

Prior Medical History: Significant for Bronchiolitis. Mom quit work to stay home due to Casey's breathing problems.

Otherwise developing normally. Just starting to feed himself. Picking up Cheerios and finger feeding. No other chronic health care issues.

Chief Complaint(s)

Current Disability

Disabling Problems: (By client/family history and report. No physical examination occurred).

Rosie: *''Right hemiparesis, low muscle tone on the right side, chews on the left side only, can't stick his tongue out past his lips and if he tries it goes to the left side.*

I have been told that he does not swallow correctly on the right side according to his pediatrician. He doesn't seem to choke very often, but he does drool on the right intermittently. His right hip seems to rotate out. I don't know if it is because of the low muscle tone, but he even seems to sit cockeyed. He does not seem to pick up his right toes, but drags his foot. For this reason, he requires the AFO. He also has a constant problem with ingrown toenails in the right great toe. I also find he needs the nails on his right hand cut much more often than on the left. I suspect it is because he does not use the right hand as frequently as the left and therefore does not wear them down. Even with the AFO, he trips and falls more frequently. His balance is off and some days are worse than others. Because of the poor balance and weakness on the right, he doesn't catch himself well and he often hits his forehead and ends up with a scab on his forehead. His vision is impaired. The glasses are supposed to help him focus at a faster rate, but his problem is he cannot refocus well when he goes from looking down to looking up. When he holds both hands out in front of him or above his head, he extends the left much farther than the right. He tends to use the right hand/arm as an assist only.'' (On my command, he showed pronation and supination but when asked to pick up a small piece of paper with the right, his hand and arm shook significantly back and forth while he completed the task.)

Rosie continues, *''His left eye is always dilated. His eyes are just not equal. When he looks at you, one eye is slightly off to the side, (strabismus). He may need the strabismus surgery again and they said the same thing about the heel cord lengthening. With his deafness you have the cochlear implant. Because he is only implanted on one side, he does not hear omnidirectional sound. If he takes it off, which he has to do in the rain or to swim, then he hears nothing. He tries very hard to read facial expressions and gestures to get what you mean. He has speech issues for a number of reasons. The deafness, the tongue deal (dysarthria) and the cognitive deficits. These all effect his understanding of receptive and expressive language. He has learning disabilities. This makes him a very slow learner. You can work on the same skill for two years. He has had two excellent teachers, one he had for three years and the aide was with him for four years. Both are moving on this next year. He will have totally new teachers next year. He does not do well with new people or new experiences. He is shy, reserved and becomes very emotional and frightened.''* (At the evaluation this morning he cried for close to an hour when he first encountered me. He did eventually settle down, but he is very sensitive when new demands are placed on him.)

Rosie says, *''I am going to want to volunteer at least one day a week in his class, so I know what to bring home to help him. He can not put together a 23-piece puzzle that my 3-year old niece can put together with little difficulty. He can not learn objects he is not to touch. To teach him about, 'on the table' I would physically have to get on the table. A picture of a boy on the table would not get the concept across. He needs a strong visual aide, repetition, and hands on demonstration. He has a short attention span. He is just getting cognitively aware enough to know there is a difference between him and the kids around him. So now, we get into the whole emotional area. He gets left out. He can't participate in the things his siblings do. His father will put him on his shoulders and carry him a hundred yards if he has to. He can't catch or kick a ball, but he sure wants to do it. He gets frustrated easily if there is something he can not do and he is striving to do it. The whole sharing thing is a problem. He just does not get the concept. We try not to give in to him and continue to educate him, but he just does not get it.''*

Casey has partial complex seizures, which are not under compete control with his medications. He will have breakthrough seizures. His last seizure was in April of 2005. He has had two grand mal seizures, one in February of 2004 and one in April of 2005. Rosie says they thought that he was having petit mal seizures or absence seizures as often as several in a day, but now she is not sure that they were really occurring. She questions this because she has since learned that these types of seizures do not occur post meningitis. Also, the medication he is on does not prevent these types of seizures, but he has not had them since he began the medication.

Rosie notes, *''His teeth are a problem, from all the medications he has been on, they all are weak and they all need to be bonded. I have discussed this with Dr. Rohan and Dr. James. They are waiting for his permanent teeth to come in all the way. He has bad breath all the time. They say because of his swallow, his saliva sits toward the back of his throat.''*

Rosie, *''He still wets the bed. He can go a week without doing so, and then he has done it the last three nights in a row. He refuses pull ups or any special pants because, ''those are for babies''. He has enough going on upstairs to understand that. I want to wake him up to take him to the bathroom, but his neurologist says that is the most likely time for a seizure to occur. I went and bought a TV monitor that allows me to see him in his room. I guess because he is not as mobile, he catches colds more frequently so he needs to use the Nebulizer with Albuterol Sulfate. He also ends up with constipation, which I think is from his immobility. Mineral oil helps and as he gets*

more active it is less of a problem. He is unable to demonstrate fine motor skills at this point such as doing buttons, tying shoes or even getting his shoe on with the AFO. He is zero safety conscious. He will step out into the road, turn on a burner, jump into the pool or go off with a stranger. There is something about big, tall guys. He will run up to them and just give them a hug.''

Casey has some impairment of speech but is definitely intelligible. He is conversational with his parents.

Developmental Delay

Seizure Disorder

Type: Petite mal seizures reported for 1 1/2 years. Partial complex grand mal seizures resulted in Casey experiencing respiratory distress in 2/04. He required intubation and was hospitalized. Casey was started on Trileptal in 2/04 following hospitalization for seizure with respiratory distress that required intubation. EEG was inconsistent and decision was made to place him on the medication even though there was no evidence of seizures during his hospitalization. He did have three episodes of prolonged staring following discharge from the hospital and Trileptal dosage was increased by neurologist (Shands Clinic: 3/9/04).

Breakthrough Seizures: Yes.

Last Seizure: April 2005.

Surgeries

Performed: Shunt placement was accomplished in November of 1997.
Underwent left Cochlear device implantation on 9/9/98.
Strabismus surgery was accomplished in January of 1999.
Approximately the middle of 1999, tubes were placed in his ears for repeat otitis media. Tubes have since fallen out.
Casey underwent right hamstring and heel cord tendon lengthening in early 3/2002.

Anticipated: Left Cochlear implantation anticipated. Also mother indicates repeat of strabismus surgery has been discussed and repeat of heel cord lengthening.

Therapy/Education

Present Therapy Schedule / School Program: His current therapy schedule is limited to what he gets at school. He

is at Marion County Elementary and they are providing him with ST, OT, and PT, and they are doing an English language activity as a supplement to speech. He gets one session of OT for thirty minutes each week. PT is the same at one time per week for thirty minutes. ST is thirty minutes one time per week, but it is supplemented by a one time per week language activity.

Daily Care

Current Attendant and / or Nursing Care: Mother cares for Casey.

Bowel/Bladder Program: He is basically potty trained, but he does experience nocturnal enuresis.

Anticipated Treatments: Physical therapy, speech therapy, shunt revisions if necessary. Repeat Cord lengthening, additional cochlear implant and repeat strabismus surgery. Mom has been told that shunt revisions are highly probable but they have been fortunate up to this point. Mom notes that the cochlear implant manufacturer mentioned some concern about Botox injections with the implant and of course they have to do special MRI's with the implant.

From the records: Family was interested in bilateral cochlear implantation (Shands Clinic 5/25/04). Being considered for bilateral cochlear implant. Would likely need ongoing intensive language therapy, as well as a highly structured and individualized educational program that incorporated multisensory and manipulative activities to facilitate learning and long-term retention (Ellen Jansen, Ph.D., 6/7/04).
Parents would like Casey to have hippotherapy and aqua therapy as he gets burned out with ''*work*'' of therapy (Plaintiff Life Care Planner).

Psychosocial Issues

Patient: Casey is a very happy child. He laughs, smiles, and mimics his mother's words. He does show low frustration tolerance, cries and gets upset when exposed to strange or new circumstances. He tolerates going back to Shands, but he gets very upset going into Tampa Children's Hospital because of his memories of surgery and treatment.

Family, Emotional Impact on Spouse/Children: The other children have been included in discussions about Casey. They feel an, ''*ownership of Casey. Thus far they feel willing to set aside their own goals or desires for Casey. Yet they are wanting their independence. For example people will invite Andrew over and not Casey. People are afraid of Casey and Andrew wants to go, but doesn't want to hurt*

Casey's feelings.'' For Mom and Dad, *''It gets tough sometimes but we are doing well. Our marriage is strong. We did go through a difficult time. I was resentful that he could go to work and leave me home to deal with neurologist and therapies and just get a summary later. From his perspective it is his first born son. We worked through it. We do okay as long as we just deal with the here and now. If we think of the long term, it becomes very overwhelming. We did see a marriage counselor through our church pastor at one point. Not a licensed counselor. I've come to the conclusion that the key is to have God in the proper perspective.''*

Physical Limitations

Loss of Tactile Sensation: Right side hemiparesis. Uses left hand for everything and uses the right hand for assist primarily. He can be encouraged to use the right with assistance.

Reach: He can demonstrate bilateral reach, but with right side limitations as noted in chief complaints. He lacks full extension, full supination/pronation, significantly reduced strength and uses primarily for assist.

Lift: He has bilateral lift, but he is very shaky with his right and uses right primarily for assist to left.

Prehensile/Grip: Bilateral grip but weak on right. Awkward and significantly less coordinated.

Sitting: He can sit. He tends to sit at an angle favoring the left. His right shoulder tends to hang lower than the left. He is checked regularly for scoliosis and Dr. Ulrich and Dr. Gi have indicated he is in a high risk category of scoliosis.

Standing: Currently stands and ambulates with AFO on right.

Walking/Gait: Observed ambulation and even running, albeit awkwardly, with his AFO and no other aides.

Bend/Twist: He can bend from waist and twist, but shows clear right side hemiparesis and balance deficits.

Kneel: Not functional for repetition but can do. He favors left but mother notes he can get to hands and knees.

Stoop/Squat: Yes.

Climb: Yes but with handrail and he can not alternate steps. He must lead with the left and pull the right up behind.

Balance: Poor balance due to right sided hemiparesis. He is able to stand on his left foot in PT as of this evaluation.

Breathing: Normal except for when he has colds. He is at higher risk for colds.

Headaches: He does not complain of headaches.

Vision: He has strabismus, both eyes.

Hearing: Has cochlear implant. Can hear most sounds.

Driving: Not a likely candidate.

Physical Stamina (average daily need for rest or reclining): Up from 6 AM to 8:30 PM. Rarely naps.

Environmental Influences

Problems on exposure to:

Air Conditioning: No.
Heat: The moisture from summer humidity gets to the implant. They had to get a dry and store kit.
Cold: Tends to get sick very easily and he wets the bed more frequently.
Wet/Humid: Yes. See above note on implant.
Sudden Changes: Yes.
Fumes: No.
Noise: Yes. Disturbing with implant. Too much stimulation and he gets overwhelmed.
Stress: Yes. He can get overwhelmed and over stimulated easily.

Present Medical Treatment

Doctors	Specialty	Frequency	Last Seen
Dr. Ulrich	Pediatrician	1X month	

PRN but averages one time per month.

Dr. Gi	Neurologist	2X/year	

Shands Clinic			
Dr. Davis	Ophthalmologist	1X year	
Shands Clinic			
Dr. Roderick	Orthopedist	2X/year	1 year ago
They fit him for his AFO			
Drs. Rohan and James	Dentist	1X/year	
One time per year for cleaning. Then allow for bonding of adult teeth.			

Therapist	**Therapy**	**Facility**	**Frequency**
Kara Natane	Programs Cochlear Implant	Shands	3X year

Medication	**Strength**	**Frequency**	**Tablets**	**Purpose**	**Prescribed By**
Trileptal	300/150mg	2/day	60	Anti-convulsant	Gi
Albuterol		PRN Average 2 X / year for 3-4 days		Respiratory treatment	
Lamictal	25mg/50mg	2/day	60	Anti-convulsant	Gi

Additional Medications/Notes: Lamictal dosage is being gradually increased until it reaches 75mg in the morning and 75mg in the evening by the end of August 2005.

Over-the-Counter Medication(s): Mineral Oil to help with painful bowel movements.
Drugstore: Walgreen's
Assistive Devices: Uses right AFO for assistance with ambulating.

Medical Summary

Date of Medical Summary: 10/19/00

Casey is now a four-year-old Caucasian male who developed Strep Pneumococcal Meningitis on 9/23/97 at 11 months of age. He was originally devastated by the meningitis and left in a vegetative state with profound deafness. He gradually improved, but he remains with neurological impairments.

TAMPA CHILDREN'S HOSPITAL: 10/7/96 - 10/9/96; 11/12/97 - 11/13/97; 1/6/98; 8/27/98; 9/8/98 - 9/9/98; 10/5/98; 1/7/99; 4/5/99; 2/16/00 - 2/17/00

10/7/96 - 10/9/96: Casey was born a healthy term male weighing 8lbs. 14oz on 10/7/96.

11/12/97 - 11/13/97: Admitted for placement of right coronal ventriculoperitoneal shunt due to post meningitis hydrocephalus. Discharged home with referral for Children's Medical Services.

1/6/98: Seen for vomiting and lethargy. Head CT ruled out shunt malfunction. Diagnosis: Viral Illness. Discharged home.

8/27/98: Outpatient CT scan of the internal auditory canal without contrast only, axial as well as coronal projections to determine appropriateness for Cochlear Implant. Impression was: Intracochlear ossifications, most marked on the right.

9/8/98 - 9/9/98: Underwent left Cochlear device implantation.

10/5/98: Underwent bilateral myringotomy with insertion of ventilation tubes and culture and sensitivity of left ear fluid due to chronic mucoid otitis media. Discharged home.

1/7/99: Admitted for eye surgery to both eyes due to exotropia. Underwent recession of right and left lateral rectus muscles.

4/5/99: Seen in ER. Parents reported, he fell face first on concrete. He immediately started vomiting, but did not have loss of consciousness. He was observed and discharged with a diagnosis of closed head injury.

2/16/00 - 2/17/00: Seen for symptoms of vomiting, diarrhea, low grade temperature and irritability. Diagnosis was gastroenteritis and dehydration. He was treated and discharged home.

OCALA FAMILY PRACTICE, LUNA STACEY, M.D.: 10/7/96 - 11/8/97

10/7/96 - 5/19/97: Seen for series of well child visits and typical child related illnesses.

9/23/97: Phone call by mom (8:54 AM) Stated she needed to get in ASAP. Casey had stomach virus, vomiting. Not keeping anything down. Fever down to 101, was 102.8. She was not sure if he was urinating, diaper was barely wet. No tears, lethargic.

9/23/97: (Doctor's report) Seen in office (11:00 am). Mom reported vomiting for 24 hours. Two episodes of diarrhea last 24 hours. Did have wet diaper that AM, but much less. Was willing to drink. Low grade fever 102.8 previous night. Has had cough and cold for 24 hours. Last emesis 5 AM-tolerated Tylenol at 8 AM. Temperature was 100.4, Casey looked ill, not toxic. He was given Phenegren and Pedialyte in the office and voided while there. Instructions were to continue medications at home, no fruit juices, and return if fever persists. Note that Casey looked more alert, mom felt he was improved.

9/23/97: Phone Nurse History Sheet (9:30 PM). Note states: Seen today-stomach flu. At that time, talked about him not crawling and not sitting up since yesterday. Told weak from virus-given Pedialyte and Phenergan suppository in office, voided okay. Mom worried-tried to sit him up-unable to hold head up-doesn't move head side to side-whimpers but doesn't cry. Dr. Lindell notified. Instructions were to take him to Ocala General ER.

9/24/97: Office notified that Casey was hospitalized previous night with diagnosis of meningitis. He was intubated and in PICU.

10/12/97: Status post meningitis, in persistent vegetative state. Parents doing feedings at home only for supportive care. Casey was moaning a lot when touched, slept constantly. He showed no purposeful movement, skin breakdown had started. Assessment: Persistent vegetative state. Otitis Media. Otitis was not discussed with parents, as they remained committed to non-use of antibiotics.

10/20/97: Seen for follow-up. Possible seizure activity. Assessment: Persistent vegetative state, Oral thrush, Possible seizures. Provided extensive support for family. Advised to continue medications. He was started on Klonopin for possible seizures per discussion with Dr. Gi.

10/27/97: Remained in vegetative state. Family support was continued and refills for medication were given.

10/28/97: Mom called office to report Casey was sucking and swallowing from bottle. Wanted to know if that was good sign. Her phone call was returned. She was advised to keep using the bottle, but cautioned that it was not necessarily an improving sign.

11/3/97: Mom reported in last 48-72 hours, Casey has increased intake. He took 16 ounces from sippy cup and appeared to purposefully place left hand on cup. Left hand opened with palmar stimulation. Moaning less, more like

crying. Was awake all day, napped 2 hours. Was opening eyes. Assessment was: Recovery? Pneumococcal Meningitis. Dr. Gi would see Casey within the next two weeks. A head CT and possible EEG with evaluation were planned.

11/8/97: T/C. Mom reported small amount of vomiting. Advised to reduce amount of Pediasure and call back if vomiting gets worse.

SHANDS CLINIC: 10/29/97 - 2/26/99

10/29/97: Dr. Gi Pediatric Neurologist - T/C with Mrs. Jones. She reported no change in status except his recent ability to suck from a bottle. She was informed that the ability to suck is a primitive reflex often preserved in neurologically devastated individuals. He reiterated that Casey's prognosis was poor and that he would probably persist in a vegetative state for the rest of his life.

11/7/97: Seen by Dr. Gi Three issues identified. First, suspected intermittent seizures, which were treated with Klonopin. Casey had not received Klonopin for 10 days and there were no seizures. Second, was his nutritional status. He began one week ago sucking from a bottle and then progressed to drinking out of a sippy cup. No coughing, gagging or vomiting was noted by parents. He did appear to cry when hungry and was content after feeding. The third issue was his neurological status. Decreased use of his right side was noted. He slept through the night and was awake during the day. At times, he was irritable and agitated. He appeared to hold the cup with his left hand. He was not receiving therapies at that time.

CT scan showed probable obstructive hydrocephalus. On exam, Casey sucked and swallowed. He had decreased muscle bulk. His eyes were open and he had random search movements without any clear ability to fix or follow. He did not respond when a bell was rung.

Dr. Gi summarized that Casey was initially expected not to survive, but it now appeared evident that he would. He made certain small progress, but he would continue to be profoundly handicapped throughout his life. His parents were eager to start planning for his future. He advised them that would include PT and institution of anticonvulsants should his seizures reoccur. He solicited Dr. Seal's thoughts regarding the CT scan and the need for placement of a ventricular peritoneal shunt. Follow up in two months was recommended.

An addendum to that report states that Dr. Seal agreed with the diagnosis of probable obstructive hydrocephalus and recommended monitoring and repeat scan. A second addendum

notes that another CT was performed on 11/11/97 due to increased vomiting and irritability. Dr. Seal saw Casey in his office. Placement of a ventricular shunt was scheduled for 11/12/97.

2/4/98: Seen by Dr. Davis Pediatric Ophthalmology. Mother reported Casey had no vision for two months following meningitis, but that it had slowly improved since shunt placement. Impression: Cortical visual impairment without ocular or optic nerve disease found. Follow up in two years.

2/13/98: Seen by Dr. Gi Pediatric Neurology. Casey had done remarkably well since his last visit. He was improving socially and would laugh and smile. He recognized his parents. His physical skills improved, he had improved head control and better use of his right arm. He could not sit independently, but was able to bear weight. He was on no medications and questions regarding possible seizures were denied. He had degree of cortical visual impairment. His hearing remained of concern, as parents noted no response to noises.

Although Casey was improving Dr. Gi felt that he would likely have lifelong impairments, but would expect steady improvement. Concerns persisted for his vision, hearing and right body development. Vigilance for seizures would continue. He requested follow-up in six months and referred the parents to the Shands Cerebral Palsy program.

2/16/98: Audiologic evaluation. Impression: Behavioral observation, parental report and auditory brain responses (ABR) were consistent with very severe sensorineural hearing loss for each ear. Bilateral middle ear stiffness. Recommendations included 1) Otologic examination/possible treatment by Dr. Ulrich (PCP) of possible conductive component. 2) Right earmold impression taken for diagnostic hearing aid fitting. 3) Return to clinic for continued behavioral testing and ENT consultation/medical clearance for amplification.

3/4/98: Otolaryngology Clinic, Dr. Lofton, Initial Evaluation. Audiologic testing revealed profound neurosensory loss. Flat responses by tympanometry. Impression was: Severe Meningitis, secondary neurosensory hearing loss, recurrent but not chronic otitis or effusion at that point, hopefully resolving. He was cleared for a hearing aid trial. A CT scan of the temporal bone was advised to look at cochlear fibrosis. Medication course was to continue and reevaluation was suggested.

3/24/98 - 6/24/96: Continued visits to ENT and Audiology Clinic.

4/23/98: CT Internal Auditory Canals performed at Ocala General Medical Center. Scan revealed a small sclerotic cochlea on the right, a small amount of soft tissue around the stapes on the left without evidence of osseous erosion. No other complications of meningitis were visible.

6/24/98: Otolaryngology Clinic. Seen for Cochlear Implant consultation. Parents had some reservations and requested that sessions be scheduled to evaluate Casey for implants.

6/30/98- 8/20/98: Seen by Otolaryngology, Audiology, Speech and Language Pathology, Neurology and Neurocognitive specialists for evaluations to determine appropriateness of cochlear implants. An evaluation by Dr. Freedman, Neurologist documented continuing ossification of the cochleae. Therefore, a decision regarding implantation had to be made as soon as possible.

8/28/98: Casey was recommended for cochlear implantation. The procedure was scheduled for 9/9/98.

9/17/98: Seen in Cochlear Implant Clinic status post cochlear implants. He appeared to be recovering well. He was engaged in therapy, interacted well with environment and with his toys, did a nice job with turn taking with eye contact and responded well to the particular therapy setting.

9/18/98: Seen in Otolaryngology Clinic. Mom reported he was pulling on ear. Assessment: Fluid in left ear, likely secondary to his surgery.

9/23/98: Seen in Cochlear Implant Clinic for speech, language and aural rehabilitation. Demonstrated an increased awareness of listening tasks and structure tasks.

9/30/98: Otolaryngology Clinic. Fluid in left ear. Assessment: Serous otitis, right ear. Plan was to proceed with the placement of tubes.

10/6/98 - 2/4/99: Seen in Cochlear Implant Clinic for speech, language and aural rehabilitation. He continued to demonstrate excellent progress. Wearing time was at 100% of his waking hours. He demonstrated a stimulus response to environmental and speech information and was beginning to imitate with a verbal response to auditory only information. He also demonstrated the beginnings of first words and using voicing to get attention and request actions and objects.

1/19/99: Seen in Otolaryngology Clinic. Impression: 1) Right Otorrhea 2) Eustachian tube dysfunction-bilateral ventilating tubes in place and patent. 3) Cochlear implants.

2/1/99: Follow-up in Otolaryngology Clinic. Otorrhea resolved. Eustachian tube dysfunction, stable. Ventilating tube in place and patent.

2/18/99: Seen in Ophthalmology Clinic for follow-up status postoperative recession of both lateral rectus muscles on 1/7/99. Impression was: intermittent exotropia, improved but still present. Close monitoring recommended, but further surgery was not indicated.

Physical Therapy: 11/8/97 - 2/26/99
Initial evaluation indicated that Casey was beginning to eat by mouth. He became irritable with attempts to hold his head erect. He had complete passive range of motion throughout all extremities with some tightness at the end of range in his right extremities. With upper chest support, he could bring his head to a neutral position. Casey attended therapy weekly and made slow but steady progress. The last monthly summary note dated 2/26/99 indicated that Casey was crawling and ambulatory with a walker. He was resistant about walking on his own. All ranges continued appropriate.

Occupational Therapy: 12/3/97 - 1/29/99
Initial evaluation indicated Casey was functioning at a 2-month level with delays in fine and gross motor, cognition, and visual perceptual skills. The degree to which Casey was able to see and hear was questionable. Treatment consisted of fine motor skills, bilateral hand use, ADL's and visual motor skills. Casey made steady progress in OT. He was able to sit, demonstrated improved UE. He did have a definite left hand preference. It was decided on 1/29/99 to decrease his sessions to monthly, due to him being more interested in engaging in activities at home. Parents were provided with a home program.

HOSPICE OF OCALA: 10/6/97 - 11/10/97
Provided care and assistance following discharge from hospital. Services were discontinued as Casey became stabilized and somewhat improved.

ULRICH, JACOB M.D.: 11/21/97 - 2/15/00
Casey's pediatrician. Oversaw and coordinated care and therapy. Treated Casey for a number of minor childhood illnesses.

SEAL, DOMINIC, M.D.: 11/11/97; 6/25/98

11/11/97: Seen for irritability and vomiting for past three days. A CT scan the previous week showed marked dilated ventricles, which appeared to look like they had pressure effect. Concern was for possible hydrocephalus. Impression

was probable post meningitis hydrocephalus. Parents wished to proceed with VP shunting.

6/25/98: Casey has made remarkable progress since VP shunt placement. Shunt was intact to palpation and pumping normally. Would check follow-up CT scan to make sure shunt will function as an adequate baseline. If so, follow-up would be on yearly basis.

FLORIDA DIVISION OF BLIND SERVICES: 12/26/97 - 6/13/99
Assisted family in learning more about hearing impairments, cochlear implants, and arranged communication with other families with impaired children. Also gave referral to The School for the Deaf and Blind. It was determined that Casey was eligible for SSI, Medicaid and Children's Medical Services. Additionally, he was an IEP client and would be having OT, PT and Speech Assessment at Oasis Learning Institute.

THE SCHOOL FOR THE DEAF AND BLIND: 4/9/98 - 12/18/99
At onset of program Casey was functioning at 14 months old cognitively and 10 months motorically. The family began sessions to learn sign language. Casey made good communication progress and was scheduled for Cochlear implantation on September 9. Status post Cochlear implantation, Casey progressed steadily. At time of discharge, he was at a 32-months level for receptive language and 26-months for expressive. Casey began attending school during morning hours at Citrus Park Oral School for the deaf.

OASIS LEARNING INSTITUTE: 4/1/98 - 8/98

Occupational Therapy: Initial evaluation revealed Casey had delayed fine motor skills, delayed ability to access toys in the sitting position and decreased ability to engage in play requiring bilateral hand use. Direct OT was recommended at a frequency of 1-2 times weekly. Casey attended therapy until August. He left current rehab to attend therapy at Shands.

Speech Therapy: Initial evaluation demonstrated a delay in the development of receptive and functional expressive language skills. Casey was to participate in a treatment program 1-2 times weekly for 30-minute sessions. A home program of skills/activities was implemented with the family to assist carryover of communication skills. Progress notes indicated last session took place on 6/17/98. At that time, Casey was tolerating oral stimulation to face, cheek, tongue and eyes. He would chew, and was making isolated sounds. Therapy was discontinued as Casey was scheduled to have Cochlear Implantation.

QUICK CARE WALK-IN CLINIC: 1/16/99; 3/13/99

1/16/99: Seen for complaints of fever and drainage from left ear. Diagnosis was otitis media.

3/13/99: Seen and treated for conjunctivitis.

EARLY INTERVENTION PROGRAM: 2/5/98 - 5/25/99
Multidisciplinary program designed to evaluate children diagnosed with developmental delays. The Bayley Scales were administered. Casey was reported to be functioning at a 4-month level mentally and a 5-month level motorically. He was noted to use his left hand only and to have peripheral vision. ST evaluation revealed his receptive and expressive language below the 5-month level. Shands Clinic OT/PT reports were reviewed. Casey was also evaluated by Dr. Meyer whose overall impression was: S/P bacterial meningitis-VP shunt in place; severe global developmental delay with significant scatter of skills, right hemiparesis, vision impairment-deafness? The clinic team recommended OT/PT/ST 2-3 times weekly and return to the clinic in 6 months. On 5/25/99, a developmental evaluation revealed Casey was doing well with self-feeding with only an 8-month delay in self-help skills. He was socially and academically delayed, testing at the 10-month level. His motor and communication skills were at the 12-month level. He could not walk independently. Recommendation was for cognitive skills to be assessed with non-language based assessment tool. From a speech therapy standpoint, he still had a severe language disorder due to his profound hearing loss and the fact that he was only 8 months status post Cochlear implant. Progress notes indicated, he had improved hand use, was able to take off his shoes and socks and dressed himself with assistance. He was working on standing alone for 20 seconds and walking independently and moving from his hands to his knees to independent sitting.

Casey's parents requested a referral to Citrus Park Oral School for speech therapy. Casey was to attend the 1999 Summer Program there.

CITRUS PARK ORAL SCHOOL: 7/7/99 - 2/25/00
Casey participated in the 1999 Summer Toddler Program. He attended the program 2 days per week, 2 hours per day for 4 weeks on a trial basis to determine if it was an appropriate educational setting to meet his needs. He made progress in the classroom and in therapy and was offered a placement in the Toddler Preschool Program three days per week. His IEP was scheduled for October 1999, after his 3rd birthday. Testing was to be completed in September in order to develop auditory, speech, language goals for the academic year based on testing results.

DEPOSTION OF ROSIE JONES: 1/21/00
Casey's mother. Lives in a mobile home with husband and three children (pgs.6-7). Prior to meningitis, Casey was able to stand, let go of tables. He said Momma, and identified his father when pointed at (pg. 46). She was advised by Dr. Luna that Phenergan administered at office would make him lethargic and not to be alarmed if Casey slept all day (pg. 52). At 9PM she picked Casey up and his head fell to one side, he could not hold it up (pg. 61). Dr. Luna's office was notified and she was instructed to take Casey to Tampa Children's Hospital ER (pg. 68). He was diagnosed with meningitis. Shortly thereafter, he began bleeding internally and was placed on a ventilator. The Jones's were advised that he did not have enough brain there to keep him breathing or swallowing. Decision was made to remove the endotracheal tube the following Monday to see if Casey would remain breathing on his own. He was not expected to survive (pgs. 73-74). He was discharged home and hospice care was arranged. Hospice care was terminated due to Casey's improved status.

Casey attends Citrus Park Oral School for the hearing impaired on scholarship. Similar schools in the public school system are not appropriate for him. He worked with a therapist from The School for the Deaf and Blind one time per week at his home. He was also going to Shands Clinic one day per week. He received speech therapy 4 times weekly, 3 days at Citrus Park and 1 day at Shands (pgs. 118-120). Cognitively, he is missing about 30% of his brain mass so no one is certain how much development he will have before he stops developing. He has strabismus in his eye. He had surgery for that, but it has come back. He has hemiparesis on the right side. He can not work his right hand very well. He can not walk. When he stands, he stands on his ankle bone. He has no swallowing ability on his right side of his mouth. At some levels, he is on a twelve-month level. Socially he is almost at his level (pgs. 122-124). With the Cochlear implant, he can hear most things (p.124). He progressed remarkably from January to June of 1998. Dr. Gi said do not be surprised if he can never get more than a low-income job. They do not know if he will ever walk. He is not potty-trained. He can not dress himself. He says a few words, no sentences. He mimics everything Rosie says. He can feed himself if his food is cut into small pieces. He can pick things up with his left hand only. He does not have full range of motion to his right leg. He communicates by pointing to what he wants. He laughs, gives hugs and kisses and is able to play at a 12-month level. He can wave bye-bye (pgs. 125-128).

The Jones's receive Medicaid coverage (pg. 137). Casey currently treats with Jocob Ulrich, M.D., pediatrician. He sees Casey once a month in the warmer weather, more often in the cold weather due to breathing problems (pre-existing).

Casey has a lot of pain when he has a bowel movement. He takes mineral oil daily to help with that. She thinks his taste buds have been affected, but he does eat a lot. He also sees Rita Yonit, speech therapist. He sees Dr. Gi, his neurologist, once per year. He sees an ophthalmologist, Dr. Davis, every six months. He sees Kara Nutane at Shands once every two months. She does the programming on his Cochlear implant. Dr. Gi said that now that Casey is more mobile, it looks like he will have a normal life expectancy (pgs. 142-148). His shunt will have to be replaced if he falls, bangs it or gets blockage or infection.

The Jones's receive social security benefit of $450 - $500 monthly. The amount is based on Chris's monthly income (pg. 170).

Casey's doctors do not know if Casey will be able to walk in the future with braces or therapy (pg. 179).

DEPOSITION OF CHRIS JONES: 3/6/00
Casey's father. Employed through Software Intelligence, a contracting computer information technology business. His yearly salary is $28,111 (pgs. 5-6). Casey was walking with a walker. He was utilizing the Cochlear implant and could hear pretty much everything. He has about a 20-word vocabulary. He did not know how much his brain was processing and how much the Cochlear implant was playing a part. His vision seemed okay. Developmentally, he was below his level. Socially he may be up to a three-year old level. Physically, he was still a one-year old. Cognitively, he was probably at about a one-year old level. Due to his shunt, he should not play any contact sports (pPgs. 147 - 151). Before the meningitis, Casey was able to pull up on furniture and scale along it. He was not at the point where he was letting go yet, and he would crawl and play chase.

Records Reviewed:

Tampa Children's Hospital: 10/7/96-10/9/96; 11/12/97 - 11/13/97; 1/6/98; 8/27/98; 9/8/98 - 9/9/98; 10/5/98; 1/7/99; 4/5/99; 2/16/00 - 2/17/00
Citrus Park Oral School: 7/7/99 - 2/25/00
Quick Care Walk-in Clinic: 1/16/99; 3/13/99
Florida Division of Blind Services: 12/26/97 - 6/13/99
The School for the Deaf and Blind: 4/9/98 - 12/18/99
Hospice of Ocala: 10/6/97 - 11/10/97
Ocala Family Practice: 10/7/96 - 11/8/97
Shands Clinic: 10/29/97 - 2/26/99
Photographs
Seal, Dominic M.D.: 11/11/97; 6/25/98

Oasis Learning Institute: 4/1/98 - 8/31/98
Early Intervention Program: 2/5/98 - 5/25/99
Ulrich, Jacob, M.D.: 11/21/97 - 2/15/00

Depositions Reviewed:

Rosie Jones: 1/21/00
Chris Jones: 3/6/00

ADDENDUM: 8/19/04

SHANDS CLINIC: 3/15/00 - 5/25/04

Shands Clinic: 3/15/00
(Cochlear Implant Clinic) Training session. Casey was demonstrating wonderful progress with the implant. He demonstrated some nice cognitive skills in his ability to match colors, shapes and objects. He was very successful in both closed and open set speech/auditory perceptual skills.

Shands Clinic: 3/22/00
(Cochlear Implant Clinic) Casey continued to demonstrate excellent progress with discrimination ability with the cochlear implant demonstrated by responses to sound and speech production.

Shands Clinic: 4/13/00
(Cochlear Implant Clinic) Eighteen-month post initial stimulation of cochlear implant programming session. Casey had made excellent progress with the cochlear implant and the development of spoken language had been surprisingly achieved sooner than expected.

Shands Clinic: 10/2/00
(Cochlear Implant Clinic) Progress Report. Casey was S/P right cochlear implantation on 9/8/98. He made excellent progress with his implant with 2 years of use. He had responded to both programming sessions and to the rehabilitation. He wore the implant during all waking hours and appeared to enjoy the sound he received through the implant.

The following measures were administered to document progress with the implant:

- Infant-Toddler Meaningful Auditory Integration Scale (IT-MAIS)
- The Early Speech Perception (ESP) Test, Low Verbal
- Glendonald Auditory Screening Procedure-Words (GASP Words)
- Multisyllabic Lexical Neighborhood Test (MLNT)
- Ling 6 Sound Test
- Communication Skills Checklist

- Spontaneous Speech/Language Sample

Results indicated that Casey demonstrated the ability to make progress with the cochlear implant for learning to listen to support spoken language. He bonded well with the implant and was very concerned when the implant stops working. He continued to develop language and concepts on a regular basis. He had strong auditory skills with the implant. It continued to be important for him to receive intensive, individual therapy to facilitate increased expressive and receptive language. A small classroom with children of similar linguistic ability where spoken language was used throughout would benefit him. Primary goals of his classroom placement should be developmental language and basic concept development through listening. Continued rehabilitation and programming recommended at a minimum of 2 one-hour sessions weekly.

Shands Clinic: 11/15/00
(Cochlear Implant Clinic) Seen for replacement of external pieces to implant.

Shands Clinic: 11/17/00
(Cochlear Implant Clinic) Seen for fitting of a replacement CisPro Plus body processor.

Shands Clinic: 11/17/00 - 1/19/01
(Cochlear Implant Clinic) Participated in training sessions for cochlear implant. He was seen twice weekly. He continued to demonstrate excellent progress and listening skills during sessions. He was beginning to increase his ability to use auditory only information for learning new information. He had been able over the last week to learn the use of possessives as well as contractions when provided with auditory only information.

Shands Clinic: 6/6/01
(Cochlear Implant Clinic) Casey used CIS PRO + processor during treatment. Mother reported she was alternating both the TEMPO and CIS PRO with no difficulties.

Shands Clinic: 4/22/02
(Orthopedic Clinic/Dr. Roderick) No new complaints. He was six weeks S/P tendo-achilles lengthening and heel cord lengthening in right leg. Examination out of cast revealed a popliteal angle of approximately 0 degrees on the right and dorsiflexion to 30 degrees with the knee extended. Advised to return to therapy and swimming.

Shands Clinic: 7/18/02
(Department of Communication Sciences) Psychophysical evaluation. Integrity test. E11 & E12 measured high values with both deactivated for some time due to partial

insertion. Minimum and maximum level could not be assessed, as Casey would not allow placement of processor connected to DPI and computer at the ear site. He hesitated in entering the programming environment and was very protective of his processor to touch. He cried for 1 1/2 hours and would not participate in activities.

Shands Clinic: 8/27/02
(Department of Communication Sciences) Integrity test = All functioning with exception of E11 and E12. Casey had progressively become resistant to programming his cochlear implant. His behavior had also escalated negatively when his implant became nonfunctional. His behavior included pulling coil and processor off, crying, covering ears and resisting placement. Verbal discussions, modeling and reasoning had been unsuccessful.

Shands Clinic: 8/29/02
(Department of Communication Sciences) Casey was seen for third consecutive day for programming and behavioral management. Prior to this week, he had become fearful and resistant to programming, and nonfunctional cochlear implant system. His previous two sessions had been successful and goals were achieved.

He entered the programming session with slight crying but no resistance. He sat and did not put his hands over his ears. He quickly engaged in cleaning the processor, placing coil on head and engaged in conditioned play. Concepts of on/off, soft/loud and responding appropriately to DIB programming signal was achieved. He repeated all the goals again with the beige TEMPO system. Casey was smiling and seemed to enjoy the session.

Shands Clinic: 5/28/03
(Department of Communication Sciences) Casey returned for cochlear implant aural rehabilitation session. He continued to receive good benefit for speech information with his cochlear implant and demonstrated progress for auditory, speech and language skills.

Shands Clinic: 7/29/03
(Department of Communication Sciences) Follow up visit for broken prongs in processor. Upgraded to new software and both processors with MAP #6 in all programs.

Shands Clinic: 9/25/03
(Department of Communication Sciences) Interim session with a reduction in comprehending auditory information noticed by family, teachers and speech therapist. Difficulty was noted with comprehension and periods of stillness and blank appearance on face. Cochlear implant was stable and mapping

was appropriate. Advised mother to speak with primary care physician regarding follow up neurological consultation.

Shands Clinic: 12/8/03
(Department of Communication Sciences) Interim follow up. Casey was using implant daily with functional spoken language skills. Recently, his mother reported poorer performance and attention. Speech therapist and audiologist noted periods of gazing and inattentiveness. Family contacted neurology for follow up to rule out seizure activity. New MAP was created and Casey had good detection and recognition ability.

Shands Clinic: 10/17/03
(Neurology Clinic/Dr. Gi) Neurological evaluation for possible seizures. For the past year, parents reported what they characterized as ''blank out spells.'' They consisted of a stare straight ahead which would interrupt ongoing activities. They were brief in duration, lasting no more than 5 to 15 seconds and he returned to baseline thereafter. They were witnessed by both parents and teachers. Frequency was variable. The events occurred without any facial distortion, eye deviation, eye flutter or other automatic type movements.

Casey had EEG on 10/9/03 and study was reviewed. He concurred with the interpretation that there were prominent left central sharp generalized discharges or activation with hyperventilation.

Casey attended a hearing-impaired program at Marion County Elementary. He was felt to be functioning at a 3-4 year level. He had right hemiparesis. On examination, he had evidence of right spastic hemiparesis as walked with a circumductive gait. His left pupil was larger and less reactive than the right.

Impression: Right hemiparesis and mild to moderate cognitive delay. Historically, his spells were suspicious for absence-type seizures; however; that type of epilepsy was not commonly seen in children who have history such as Casey, and his EEG was not consistent with that type of epilepsy, so he did not initiate a medication at this time. Other concerns would be complex partial-type seizures, which would be more likely in view of his EEG and past medical history. Other concerns would be that the events were predominantly behavioral in origin. Decision was made to continue observation. Script for Diastat issued in the event of prolonged seizure.

Shands Clinic: 2/20/04
(Ophthalmology Clinic/Dr. Davis) Casey was S/P strabismus surgery in 11/99 and was doing well with that. He was

writing letters backwards and had difficulty naming colors. Impression:

- Strabismus, with good postoperative alignment
- Excessive hyperopia, with mild anisometropia
- Possible specific learning disability

Spectacle of +1.75 sphere on the right and +2.00 sphere on the left for full time wear (or at least academics) prescribed. Follow up with Dr. Jansen recommended as he was now at the age where special education testing would possibly be indicated.

Shands Clinic: 3/9/04
(Neurology Clinic/Dr. Gi) Mother reported Casey was taking Trileptal 150mg/300 mg, which was started three weeks earlier. The day after starting the Trileptal, he had three episodes of prolonged staring reported by his teacher. The spells were noted to be 10 to 30 seconds in duration. After the seizures, he would be a little slow to return to normal focusing abilities. Another concern since starting Trileptal was that Casey was more emotional than usual and his balance was not quite as good. The concerns seemed to be improving, the longer he was on the medication. He was in a special learning disabled program at school related to his hearing impairment and developmental delay.

Impression: Casey was recently hospitalized after a seizure that required intubation. His mother stated the seizure was associated with respiratory distress. He did have probable brief complex partial events last week on his dose of Trileptal.

Mother was advised that Trileptal needed to be increased to 225 mg-300mg as Casey did have seizures on current dose.

Shands Clinic: 5/25/04
(Department of Communication Sciences) Annual evaluation completed with unaided audiogram performed. No residual hearing at either ear present. Good performance with cochlear implant. Telemetry stable. Created new MAP with increased M levels globally by 3 keystrokes. New MAP in all positions in both processors. Family was interested in potential bilateral implantation. CT ordered by Dr. Freedman to assess patency of right cochlea for implantation.

TAMPA CHILDREN'S HOSPITAL: 5/1/02
PT progress report. Casey was 5.6 years of age and had been relatively healthy since last evaluation. He underwent right hamstring and heel cord tendon lengthening surgery in early 3/02. He was in short leg cast. Cochlear implant was

functioning well. He continued to show progress with his speech and language and his ability to follow directions. He also showed improvement in his passive hamstring length secondary to the surgery. However, he did demonstrate more functional gait deviations secondary to increased length on right hamstring and underlying weakness of that same muscle. He ambulated with his short leg cast on and his right hip externally rotated and abducted with minimal right hip active flexion with knee flexion. He also continued to demonstrate:

- Gait deviations secondary to hemiplegia
- Limited right hamstring and heel cord active ROM
- Asymmetric balance and coordination
- Delayed balance reactions
- Generalized gross motor delay (functioning at 28-29 month level with right ankle cast applied according to Peabody Motor Scales; raw score 210).

Continued therapy 1X/week recommended.

ULRICH, JACOB, MD: 4/28/03 - 6/25/04

Ulrich, Jacob, M.D.: 4/28/03
Pediatric evaluation. Mother reported cough. Diagnosed with asthma and tonsillopharyngitis.

Ulrich, Jacob, M.D.: 4/29/03
Mother reported significant improvement in asthma symptoms.

Ulrich, Jacob, M.D.: 9/25/03
Mother reported staring spells for past 1-2 months. No tonic-clonic activity was noted. Diagnosed with tonsillopharyngitis and possible seizures. Augmentin prescribed and referral to neurologist issued.

Ulrich, Jacob, M.D.: 6/25/04
Regular check-up. No acute problems.

TAMPA CHILDREN'S HOSPITAL: 2/21/04 - 2/23/04 (Discharge Summary Only)
Admitted for muscle twitching and activities similar to seizure disorder. Casey was sedated and intubated in the ER and transferred to ICU. Once admitted, there was no evidence of tonic-clonic activities. Urgent EEG was not consistent. Neurology was consulted and decision was made to place Casey on Trileptal therapy. He was discharged to home with instructions to follow up with neurology in 2-3 days.

JANSEN, ELLEN PH.D.: 6/7/04
Neuropsychological evaluation at Shands Neurocognitive Clinic at request of Casey's parents. Casey was tested in 1998 and 2001 and was found to have significant cognitive

impairment. He had progressed well with cochlear implant and routinely spoke in sentences that were clearly articulated. He was being considered for bilateral cochlear implant.

Casey had received private speech, physical and occupational therapy, including intensive auditory verbal therapy to maximize the use of his cochlear implant. He received special education services through the school system. For the past year, he was in a specialized hearing impaired classroom for children with cochlear implants. He was to remain in that class for the upcoming year as a kindergartner. He also received some private ST at Shands as well. Mother reported Casey was struggling to learn letter names and letter sounds and seemed to learn best through manipulative activities. He displayed a short attention span but no disruptive behavioral problems.

In the home setting, Casey was generally happy and calm. He tended to comply with requests. He was very friendly with others and tended to be overly friendly not recognizing appropriate social boundaries.

Test administered included:

- Wechsler Intelligence Scale for Children-4th Edition (WISC-IV)
- Expressive Vocabulary Test (EVT)
- Developmental Test of Visual-Motor Integration (VMI-IV)
- Bracken Basic Concept Scale-Revised (BBCS-R)
- Child Behavior Checklist (CBCL)
- Vineland Adaptive Behavior Scales (VABS)

Testing indicated global cognitive functioning within the mildly to moderately mentally handicapped range. Adaptive behavior skills were also within the moderately mentally handicapped range. Casey continued to function at a pre-kindergarten level in his academic readiness skills. He knew most of his colors and some of his shapes but continued to have difficulty with some of them. He also was having difficulty learning letter names and letter sounds. Visual motor integration skills were within the mildly mentally handicapped range, whereas most receptive and expressive language skills fell within the moderately mentally handicapped range. Results of behavior rating scales completed by his mother indicated social immaturity and attentional problems. Teacher rating scales indicated no significant attentional deficits or hyperactivity in the classroom, but slow academic progress was noted.

On the basis of the results, Casey displayed significant cognitive impairment reflective of his impaired neurological status. He was making progress in all developmental spheres

and, in particular, had responded very well to his cochlear implant. He was likely to need ongoing intensive language therapy as well as a highly structured and individualized educational program that incorporated multisensory and manipulative activities to facilitate learning and long-term retention. Re-evaluation in three years recommended to assess progress and make further programming recommendations.

Records Reviewed:

Jansen, Ellen Ph.D.: 6/7/04 (In File)
Tampa Children's Hospital: 2/21/04 - 2/23/04
Tampa Children's Hospital: 5/1/02
Children's Medical Services: 6/29/00 - 3/1/04
Doe, Jane M.Ed., CRC/Vocational Report and Life Care Plan: 7/9/04
Shands Clinic: 3/15/00 - 5/25/04
Ulrich, Jacob M.D.: 4/28/03 - 6/25/04

ADDENDUM: 9/10/04

CORT, BRODY M.D.: 8/3/04
Neurological consultation. Review of systems revealed left cochlear implant. Casey had bilateral deafness. He wore glasses. He had difficulty chewing on the right side. He had problems with epistaxis. He wheezed with weather changes. He had seizures and some staring episodes. Attention span was short and he distracted easily. He was impulsive and frustrated rather readily. He was in special classes. In school, he received PT one hour per week, OT one hour per week and ST three days a week. His right side seemed to be a little smaller than the left. Although he made significant improvement, he was still well behind. He had a major seizure in 2/04. He still had minor seizures once or twice a month where he was unresponsive.

Physical examination revealed atrophy of the RUE and RLE. He had a flexion contracture of the right elbow. He also had a tight right heel cord and wore an AFO. The right foot was smaller than the left and the right leg seemed somewhat shorter than the left.

Neurologically, he was perhaps slightly overactive. He had some difficulties with articulation. He really could understand and follow things quite well with his cochlear implant. He had difficulty writing his name, letters and numbers and controlling the pencil. He was able to count up to about six. He had difficulty with right-left orientation. He had difficulty with his ABC's and with colors. He was able to point to a number of pictures in a coloring book but certainly not at an age appropriate level. He had difficulty with auditory memory, sequencing and

retention. He had difficulties carrying out a series of auditory commands and with visual sequencing tasks as well. Left pupil measured 4 to 5 mm, right was 3 mm. The left pupil reacted sluggishly and there was some hippus. There was slight alternating exotropia. There was a mild right central facial weakness. Auditory responses were appropriate with the cochlear implant. When removed, he was not able to hear a whisper in either ear.

Motorically, he had right hemiparesis. When walking, he had a limp on the right foot. He had difficulty when attempting to toe-walk. He walked on his heels with the right foot. He had difficulty in placing a small object into its appropriate receptacle with the right hand and difficulty also with the left hand and a slight tremor of the left hand.

Cerebellar examination showed considerable tremulousness with finger-to-nose type movements on the right and slight difficulty on the left. Rapid finger movements were decreased on the right. He had difficulty with pronation and supination efforts on the right. He was not able to maintain his balance well with his eyes closed. He had increased rebound of his extended right arm in comparison to the left. Opticokinetic nystagmus responses were also decreased bilaterally.

In summation, the left side of Casey's brain was more affected than the right. He had a right hemiparesis. He had atrophy on the right side. The RLE seemed to be smaller and at some point, x-rays would need to be done to check on any scoliosis and a scanogram done to see if there is a difference in the leg length. He did have a significant cognitive delay with difficulties in auditory and visual memory, sequencing and retention. He did have a seizure disorder. He had a speech articulation problem. He had bilateral deafness, which had improved considerably with his cochlear implant.

Casey needed more PT and OT and continuation of his ST. It was felt he would benefit from aquatic therapy, from horseback therapy and recreational therapy. He needed to stay in a small, structured class with as much individual help as possible. He would always require special education classes and medications would possibly be needed at a later date to improve memory, attention and distractibility. He would need to be followed by an ENT in terms of his cochlear implant. He would need following by a neurosurgeon because of his right ventriculoperitoneal shunt. That shunt would possibly need revision as he got older. He felt a MRI scan would be reasonable to fully delineate the abnormalities and damage to the brain. He should continue his Trileptal. He would need blood work about every six months to include a CBC and differential, SGOT, LDH and a BUN. At some point, a

video EEG telemetry might be needed to see if they could further document the absence type seizures. It was possible that medication would need to be added to the Trileptal to control those types of seizures. He needed to be watched behaviorally and might require medication for attention and distractibility. He felt they would see increasing anger, frustration and depression as Casey got older, which would possibly require counseling and/or psychiatric help. Casey was at increased risk for orthopedic changes as he got older and his life span might be shortened by 10% or so allowing for the orthopedic deformities and his seizures.

It was also felt that Casey would not be gainfully employed in a competitive market, but would need a sheltered workshop or a job coach. He would certainly need modification to his home. He would need modifications in terms of a van to transport him to appointments.

Records Reviewed:

Cort, Brody M.D.: 8/3/04

ADDENDUM: 11/10/04

MARION COUNTY SCHOOL BOARD: 2001 - 2004
Records indicate Casey is a 1st grader at Marion County Elementary School. According to his IEP, he receives OT, PT and Language therapy 1X/week. He receives ST 2X/week. Modifications include monitoring for correct marking of answers, flexible timing including extended time, frequent breaks and taking tests in several brief periods and visual cues for test instruction and on answer forms. He receives Duval audiological examination once yearly. He is afforded a bus aide for transportation.

Teachers indicated that Casey was a happy young man. He was always a delight to have in the classroom. He was generally compliant in every activity at school. He worked hard in class and tried to please everyone all the time. He got along with people throughout the school campus. His speech was also very intelligible considering his disabilities.

Based on teacher observations, Casey had many areas that need strengthening. Academics were the main concern. He had trouble retaining information (mostly short-term, but sometimes long-term). Overwhelming repetition was a must for him to retain almost all concepts. Casey was repeating most of his mathematics and was doing fairly well. He was also beginning a new reading program (Edmark) that seemed to connect with his needs.

Due to his disabilities, it is very difficult for him to follow along with classroom discussion. His battle with retention of concepts affected his acquisition of regular

concepts without constant repetition, which is not available in regular education classrooms at the extent he requires. This caused a delay in his meeting the standards.

Casey used a FM system in his classroom. He currently could rote count 1-15 and sometimes further to 20. He could demonstrate ABAB pattern and sometimes ABBA. He was working on ABC. His visual discrimination was remarkable. During activities he tended to get easily distracted by others or by his own wandering mind. This causes him to lose track and not maintain focus. He does have the capability to work independently in a very quiet room with no other students. Focusing is a skill he needs to work on. Casey was able to recognize few letters in the alphabet. He had now moved on to using sight words to increase his reading vocabulary. He could recite the days of the week and recognize them in a closed set. He knows colors and shapes. He was receiving physical education in the specially designed format. The teacher was impressed that Casey was able to do most activities but he possibly needed more time to complete the tasks and less repetition of exercises. He fatigued more rapidly than the other children.

Based on PT observation/assessment and teacher input; Casey demonstrated the ability to access educational environment and participated in education activities without the need for adaptive devices or physical assistance. He further demonstrated adequate abilities that enabled him to participate in regular physical education at this time. Casey's physical functioning as it related to the domain of educationally relevant PT, was such that it was deemed as having only a mild effect on his ability to benefit from his educational curriculum.

Based on evaluation last year and observations in therapy, Casey had improved his speech and language skills. He was using longer sentences and increasing vocabulary. He could answer questions about short stories with cues. He could produce s, sh and I, in structured lessons with cues/focusing his attention. He needed to work on auditory skills for listening and processing the information presented. He took time to process the information and had some difficulty maintaining his focus on task at hand. He also needed to increase intelligibility of conversational speech. Language skills of plurals, past tense, auxiliary verbs, articles and some pronouns were not always present in his speech. These disabilities made progress in the regular classroom slow and difficult. His communication with teachers and peers was not always effective and due to the slow processing, he was possibly missing some of what was being taught.

A Psycho-Education Evaluation was performed in October/November of 2001 by school psychologist, Elizabeth

Snow, Ed.S (Report is dated 11/16/01). At that time, Casey had been placed temporarily in the Hearing Impaired, Language Impaired and Speech Impaired programs and was receiving OT and PT. Casey was diagnosed with profound auditory, speech and spoken language delays secondary to hearing loss. He was pre-kindergarten at the time of the evaluation. He had received a cochlear implant on 9/8/98. There was a previous Psycho-Educational Evaluation performed on 4/21/01 by Rita Yonit, Ph.D. using the Stanford-Binet Intelligence Scale - Fourth Edition. That testing revealed an overall level of functioning within the Mildly Mentally Handicapped range. It was noted that Casey's scores on the SB:IV reflected considerable variability, ranging from Low Average Quantitative Reasoning ability to Mildly Mentally Handicapped Verbal Reasoning ability. His visual-motor integration capabilities fell within the Mildly Mentally Handicapped range of functioning, and his pre-academic skills were described as significantly delayed for age. Assessment of Casey's social/emotional functioning revealed only concerns related to inattentiveness. Parent ratings of his overall adaptive behavior fell within the Mildly Mentally Handicapped range of functioning. A relative strength was identified in the area of social skills, but significant delays were found in the areas of communication, daily living, and motor skills (evaluation not included in records).

Tests administered included the Leiter International Performance Scale-Revised; The Developmental Test of Visual-Motor Integration, Bracken Basic Concept Scale-Revised; Meadow-Kendall Social Emotional Assessment Inventory for Deaf and Hearing Impaired Students. Casey scored in the borderline range of overall intelligence. Process testing showed that his visual-motor integration capabilities were significantly below age expectancy and were significantly below Casey's current intellectual ability estimate. Assessment using the Bracken-R showed that his pre-academic skills were below age expectancy and significantly below his current ability estimate. Assessment in the area of social/emotional functioning revealed that Casey exhibited an average level of sociable and communicative behaviors, slightly more impulsive, dominating behaviors, was much more developmentally delayed and exhibited more anxious, compulsive behaviors, when compared with the behavior of other hearing impaired boys his age.

Evaluation was performed to assist IEP Placement Committee in making appropriate educational decision and for PT and OT to aid in determining his eligibility for continued services.

Records Reviewed:

Marion County School Board

Individual Education Plan: 2004-2005 (In File)
Psycho-Educational Evaluation: 11/16/01 (In File)

ADDENDUM: 5/24/05

TAMPA CHILDREN'S HOSPITAL: 3/19/02; 2/21/04 - 2/23/04; 7/6/04

Tampa Children's Hospital: 3/19/02
Casey underwent right Achilles and hamstring release. He tolerated the procedure well and was discharged to home. Activity instruction was as tolerated.

Tampa Children's Hospital: 2/21/04 - 2/23/04
History indicates Casey began vomiting around 9-10PM. Mother noted weakness on right side and that he was wobbly when walking. She noticed some twitching of the right corner of the mouth and some right eye deviation when he arrived in the ER.

Upon arrival to the ER, Casey was noted to have ineffective respirations. He was intubated. X-rays in the ER showed clear lung fields, normal heart size, and ventriculoperitoneal shunt in place. Head CT demonstrated ventricles that had actually decreased in size since 1999. Seizure was suspected and Casey was admitted. He was started on Dilantin.

Casey was extubated in the afternoon of the 21st. Neurosurgical consult was obtained on 2/22 and Casey was alert and responsive, though physically he was disoriented, totally unsteady in gait and quite ataxic. Impression was progressive seizure disorder, which decompensated with an acute event and subsequent hypoxemia and he was now recovering. He would need PT, OT and ST and intensive support.

Trileptal was started on 2/23/04. No further seizure activity was noted and Casey was discharged to home.

Tampa Children's Hospital: 7/6/04
Casey underwent CT scan of the temporal bone for possible placement of right cochlear implant. Discharged to home.

Records Reviewed:
Tampa Children's Hospital: 3/19/02; 2/21/04 - 2/23/04; 7/6/04

ADDENDUM: 6/21/05

GI, DERRICK M.D.: 5/4/05
Follow up for complex partial epilepsy. He had not seen Casey since 3/9/04. He had done well in the interim. He did have what appeared to be definite complex partial

seizures in early March of 2004. Examiner was not contacted. They lasted for approximately 2-4 minutes and were characterized by eye deviation to the right, right arm posturing, diminished responsiveness followed by a postictal period of fatigue and vomiting. Furthermore, it took him more than a week before he returned to baseline level of alertness and balance. Other concerns had been of unwitnessed possible seizures in that at times, Casey was enuretic at night; however, that occurred without other evidence of a seizure such as blood on the sheets or significant disruption of the bed linen.

He had on and off days where his level of alertness and balance fluctuated. He had on occasion, what the family called ''absence type'' seizures, where for several seconds he appeared to be unresponsive. Those occurred under a variety of settings, and the history was not strongly suggestive of absence seizure. The events appeared to be either a behavioral phenomenon or a brief partial seizure.

Last two EEG's were done on 2/21/04 and 10/9/03. Both revealed left hemispheric sharp waves. Casey had been on Trileptal since 2/04 when he had a prominent right body focal seizure, which required ICU management, intubation and aggressive anticonvulsant usage.

Casey's school performance fluctuated. He tried very hard, but academically, was just barely succeeding and would have to repeat 1st grade. He was receiving therapies at school once weekly for 30 minutes.

Examination revealed moderate right hemiparesis with increased tone on the right arm and leg, and a circumductive gait when he ran.

Mother was presented with option of increasing Trileptal to 300 b.i.d.; however, she was very reluctant to do so as Casey was excessively sedated with evening dose of that medication. Decision was made to switch to Lamictal. Once that medication was fully advanced, a gradual taper of Trileptal would be initiated. Mother advised that visits should be every 3-6 months dependent on Casey's seizure control and any concerns of side effects.

DEPOSITION OF DERRICK GI, M.D.: 5/18/05
Pediatric neurologist (Pg. 5). Last saw Casey on 5/4/05 (Pg. 72). Within reasonable medical probability, Casey will more likely than not have hemiparesis for the rest of his life. He may have some adaptive skills and may learn to function, but to some degree, he will always have diminished use of the right side. His deafness will also more likely than not persist for the rest of his life (Pg. 79). He will have some degree of disability for the rest of his life,

difficulties in school, with his right side and activities based upon those problems (Pg. 80).

It is very difficult to ascertain if he will have seizures for the rest of his life. The majority of people outgrow their epilepsy and do not need medications. But that is difficult to ascertain. He anticipates Casey will need to be on seizure medication for the next three to five years dependent on how he does. He is having what appears to be complex partial seizures (Pg. 81). He may do EEG's once a year or every other year on Casey, it depends on his course. He defers to the neurosurgeon regarding shunt questions (Pg. 84).

He intends to continue treating Casey. Treatment will consist of visits with himself or office staff twice a year, assuming he does reasonably well, prescribing anti-convulsant medication, occasional blood work or EEG depending upon his progress (Pg. 85).

Casey's chances of outgrowing his epilepsy are 50/50 (Pg. 115). He had conversation with Jane Doe on 6/18/04 regarding Casey's long-term life needs in regard to the seizures (Pg. 116). Casey would not require any additional or specific adult supervision because of his seizures beyond what would be expected for any seven-year old. He would expect him to remain on seizure medication up until the time he may or probably will outgrow his seizures. If seizure free for 2-4 years, he would gradually taper him off the medication to see if they reoccurred (Pg. 117).

He has not told the Jones's that Casey needs to go to some type of inpatient evaluation, hospitalization, or rehabilitation hospital somewhere. He has not told them to buy a wheelchair or any device to help him walk. He has not advised them to get a van with a wheelchair lift. He does not recall being asked those questions by Jane Doe (Pg. 119). He has not advocated any type of schooling in a private school (Pg. 120).

His note from 6/18/04 regarding telephone conversation with Jane Doe indicates they discussed long-term life needs in regards to seizures and chronic anti-epileptic drug use such as Trileptal. The adult dose was 1800 to 2400 milligrams per day. Neurology visits were twice a year. EEG every other year. MRI every four years. Adult supervision with play and activities. Complete blood count, chemistry panel, Chem 12 every year (Pg. 141).

It is his opinion that Casey's seizure condition will probably stay the same or get better and that he will outgrow his seizures and epilepsy as most other patients like him do (Pg. 142). He does not believe he had

recommended to the family that Casey see a psychiatrist (Pg. 143).

DEPOSITION OF RITA YONIT, PH.D.: 5/18/05
Licensed psychologist and director of the neurocognitive assessment program at Shands. Specializes in pediatrics (Pg. 5). Her recommendations for educational programs included ongoing intensive language therapy, a highly structured and individualized education program that incorporated multi-sensory and manipulative activities to facilitate learning and long-term retention (Pg. 59). Casey was not normal from a neuropsychological and cognitive standpoint (Pg. 60). She expects Casey will continue to have significant cognitive impairments in the future, more likely than not for the rest of his life (Pg. 61).

Casey's bilateral profound hearing loss had a significant impact upon his intellectual and cognitive development and functioning. She could not separate that out from the other medical problems that he has (Pg. 71). She feels sure the hearing loss has affected his speech development (Pg. 72). It has affected his academic performance. It is a component of his intellectual development (Pg. 73).

She had a telephone conversation with Jane Doe on 8/4/04 (Pg. 85). She could not say as to whether Casey could remain at public school in Marion County because the older he gets, she does not know what type of support service would be available to him. She did not know if he was a candidate to go to the The School for the Deaf and Blind (Pg. 88). Casey is still young and she feels it is too early to say what level he is going to get to in the future (Pg. 91).

In her judgement within reasonable probability, Casey is suffering from a degree of mental retardation (Pg. 115). He scored in the mildly to moderate mentally handicapped range (Pg. 116). She cannot state what Casey's ultimate prognosis or level of functioning will be in the future with any precision. She is unable to determine if he will live independently (Pg. 117). She did not have any discussions about that with Jane Doe that she recalls. She does not recall reviewing a life care plan that was being prepared by jane Doe (Pg. 118).

Records Reviewed:

Gi, Derrick M.D.: 5/4/05

Depositions Reviewed:

Gi, Derrick M.D.: 5/18/05
Jansen, Ellen Ph.D.: 5/18/05

ADDENDUM: 7/13/05

KALLAN, ANDREW M.D.: 4/14/04
Neurological examination and review of records. Examination occurred on 4/13/04. According to mother, Casey was receiving PT and OT, ST and auditory therapy at school. He attended a hearing impaired Pre-K classroom.

Developmentally, mother stated Casey was functioning at a 3-4 year level. Casey reportedly had trouble with letter and number recognition. He did know a few sight words. While he could count to 10, he did not always do so with object representation. Socially, he was extremely friendly and enjoyed playing with children both his age and younger. He had persistent weakness of his right side, resulting in poor balance. Mother stated Casey used his right side more as an assist.

Casey was taking Trileptal. Medication was started on 2/24/04 after he was hospitalized for right-sided focal seizures. He had no further convulsive seizures, although his mother reported that he continued to have ''blackout spells'' which she described as petit mal seizures. Spells lasted for 30 seconds and occurred anywhere from several times per day to as infrequently as once every week or so.

On examination, Casey's pupils were sluggishly reactive. His tongue was midline, although he did have persistent fasciculations of the right side of his tongue. His speech was somewhat nasal and thus it was at times somewhat difficult to understand his pronunciation of words.

Motorically, he had mildly increased tone in the right arm, both proximally and distally including alternating supination/pronation of the distal arm and wrist. He tended to walk with his right arm postured (bent at elbow with hand open). He had mildly decreased strength in both flexors and extensors of the right arm, as well as with wrist flexors and extensors and grasp. He demonstrated mildly increased tone in his right leg and with a slightly tight heel cord on the right compared to the left side. There were 2-3 beats of ankle clonus noted on right side.

Gait was hemiparetic with obvious circumduction on right side. He was able to catch a basketball, although he did so awkwardly. He caught it primarily using his left arm and hand and used his right open hand as an assist.

Casey was a 7 1/2 year old child who's cognitive, neurological and language deficits were directed related to the bacterial meningitis acquired on 9/23/97. While it was true that Casey had improved greatly since that time, these deficits were permanent in nature and would impact greatly

on his future life care needs. It was clear that had the diagnosis of bacterial meningitis been made earlier on 9/23/97, there would have been an ever increasingly greater chance that he would have been spared the devastating sequelae from that infection, with the possible exception of the sensorineural hearing loss, which is often an early sequelae of pneumococcal meningitis.

Based upon the neuropsychological evaluation of 4/12/01, demonstrating significant cognitive, language and motor impairments, as well as my own neurological assessment, it is unlikely that Casey will be self-sufficient and self-supporting through independent living as he grows older. Furthermore, given the multiple, permanent, handicapping conditions, it is unlikely that he would be gainfully employable in the future.

Records Reviewed:

Kallan, Andrew M.D.: 4/14/04

Activities Of Daily Living

Sleep Pattern

Arises: 5:30 AM
Retires: 9:00 PM
Average Hours Sleep/24 Hours: 8-1/2 hours.
Sleep Difficulties: Most days will not nap.

Independence In

Dressing: Some but Mom usually has to help. If he is given a shirt inside out, he will put it on that way. He can not tie his shoes or button shirts. He can put on a pullover shirt and he can assist with dressing. Mom may still have to help him wipe but he is otherwise toilet trained. He still wets the bed.
Housework: He helps to put away the silverware. Mom puts the plates on table and he distributes them. Same for forks. He tries to make his bed. He can feed the dogs.
Cooking: N/A.
Laundry: N/A.
Yard Work: N/A.

Social Activities

Hobbies (Present): He has a wide tire tricycle he likes to ride. He is able to do this. The smaller tire tricycles wobble a little and he would fall over. He likes to sit in the yard and throw a ball for his two border collies, (family dogs). He watches SpongeBob and Spider Man. He does remember the characters.

Personal Habits

Smoking: No smokers in the house.

Socioeconomic Status

Number in Residence: Five. Casey, his parents and two siblings, Andrew age 6 and Kristen, age 12 in August. Paternal grandmother lives next door on their property. Temporarily the paternal grandfather is living with them.
Type of Residence: Mobile Home with addition.

Income

S.S.I. : Family was receiving $450 to $500 monthly. This ended in February of 2005.
Wages: Household income is $40,000 from husband's wages. Network Administrator at SI.
Medicaid: Canceled 2/04 - Income exceeded threshold.

Other Agency Involvement

State Vocational Rehabilitation: No.
State Employment Services: No.
Rehabilitation Nurse: No.
Other Agency: Early Intervention Program/The School for the Deaf & Blind.

Education & Training

Highest Grade Completed: Marion County School System. Currently in a Special Education program.
Miscellaneous Education Information: There are five children in his class with a cochlear implant. Mom's goal is to apply for a McKay scholarship to get him into Oasis School in Ocala. This school provides services for children with learning disabilities but not behavioral problems. Rosie says, ''*They have only one student with a cochlear implant. The next alternative is St. Marks's in MO. If*

that is what he needs that is definitely what we would do. If we reach a point where we are not educating him and the school is not educating him, then I think my options would be limiting him to that.''

Observations

Orientation: Alert but not oriented to age appropriate level.
Stream of Thought: Clear and rational but not to age appropriate level.
Approach Toward Evaluation: Initially reticent and fearful but calms down and participates well.
Attitudes/Insight: N/A.
Appearance: Overtly Disabled.

Tests Administered

Tests Administered: As part of this evaluation process, Casey was administered the Slosson Intelligence Test (SIT-R3) and the Slosson Drawing Coordination Test. Beyond this, I relied on all of the prior testing performed on Casey.

On the Slosson Intelligence Test-Revised-3, Casey demonstrated a raw score of 14 with a mean age equivalent of <2.3, a T-score of 13, and a percentile rank of 1%. His total standard score (IQ) is 41, with a confidence interval of 8 (95%). The Slosson looks only at a verbal score based on attained knowledge. New learning is difficult for Casey and requires repetition, visual cueing and hands on demonstration. In school, he requires small classes, one on one attention, freedom from distraction and support from an auditory therapist familiar with the cochlear implant. He will also require therapeutic support from PT, OT and ST during the developmental years to the extent that it is educationally necessary.

I believe the IQ score obtained on the Slosson is accurate, in that it reflects the attained knowledge Casey can demonstrate, but it is not an accurate measure of his intellectual function. Based on clinical interview, performance levels in school and other test measures, I do believe Casey falls into a trainable level of mental retardation. It is clear he is well below his age related peers in educational and physical development. In 2003 at age 6, Shands suggested he was functioning developmentally at age 3-4. He has progressed beyond that level at this

time, but the gap between Casey and his age related peers will continue to grow.

I concur with the assessment of others who have indicated he will likely need ongoing intensive language therapy, as well as a highly structured and individualized educational program that incorporates multisensory and manipulative activities to facilitate learning and long-term retention. At the same time, there will come a time that he will benefit from the socialization that comes from having at least a portion of his program mainstreamed.

It is my opinion that he is mildly mentally handicapped and developmentally delayed. This is superimposed on his hearing impairment and cognitive, as well as physical, deficits.

On the Slosson Drawing Coordination test, Casey demonstrated severe deficits in visual motor integration skills. This has been noted in prior testing and is a reflection of a learning disability. He is not processing visual information properly. As a result, he was unable to reproduce simple figures that gradually increased in difficulty. These began with a jagged line, a straight line, a circle, a circle within a circle and a square. He could reproduce the straight line, but none of the other figures were properly reproduced.

Conclusions:

Careful consideration has been given to all of the medical, psychosocial, and rehabilitation/mental health counseling data contained within this file and my report. In addition to the medical, psychosocial and rehabilitation/mental health counseling data, consideration was given to research literature and attention was paid to the practice guidelines for hearing impairment, cochlear implants, developmental delay, cerebral palsy and childhood seizure disorders promulgated by multiple sources and cited in the Life Care Plan. The life care plan was also reviewed by our in-house Physiatrist, Andrea Zotovas, M.D. All of these steps are taken to help in establishing the medical foundation, in addition to the case management and Life Care Planning foundations for the plan.

Based on all the data available for my review and my evaluation of Casey, it is clear that this child is overtly disabled. There is obvious developmental delay, which is evident in his cognitive development, emotional development and motor skills. Additionally, Casey is clearly effected by his total hearing loss, although his functional capacity and communication abilities are improved with the Cochlear implant. He is now able to ambulate with the use of an

ankle foot orthosis, although he displays balance deficits and reportedly falls frequently. He will certainly benefit from proper equipment to enhance his ability to fully participate in his educational program and activities of daily living. Casey will also require continued therapy through his developmental years and ongoing medical management though his life expectancy.

It is not within reasonable rehabilitation probability that Casey will ever live independently. On the other hand, he does not required skilled care and a private hire program will be the most cost effective way of providing home care support. Respite care should be provided to prevent parental burnout, now through age 21. Post-age 21, Option I, will provide a home care attendant. In order to ensure consistency in personnel, I recommend both respite care as a child and home care as an adult be staffed on a private hire basis. Agency personnel may frequently change, leaving Casey to adjust to different caregivers on a regular basis. He requires consistency and structure, which can best be provided by hand-picked and a trained staff of caregivers. A second option for long term care, post-age 21, would be placement in a group home. All of these recommendations, along with additional considerations have been outlined in the life care plan, attached as Appendix A.

A Vocational Worksheet, attached as Appendix B, outlines Casey's capacity to earn pre-injury as compared to his capacity to earn post-injury, along with his loss of earning capacity and related vocational issues. A detailed educational and vocational history was obtained on his family and this information was used to draw conclusions as to his pre-injury educational and vocational history.

After you have had an opportunity to review this narrative report and the attached appendices, please do not hesitate to contact me should you have further questions.

Respectfully Submitted,

Paul M. Deutsch, Ph.D., CRC, CCM, CLCP, FIALCP
Licensed Mental Health Counselor, (FL MH#0000117)
PAUL M. DEUTSCH & ASSOCIATES, P.A.

ATTACHMENTS: Appendix A - Life Care Plan
Appendix B - Vocational Worksheet