Waite v. Church of Jesus Christ, Latterday Saints et al
Doc. 28 Att. 1

Exhibit "C"

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WILLIAM A. BURKHART, PH.D., ABPN

NEUROPSYCHOLOGICAL EVALUATION AND CONSULTATION

Name: Thomas Waite
Birthdate: August 16, 1983
Injury Date: August 21, 2003
Referred By: Richard C. Eymann
Record Review: October 15, 2006
Neuropsychological Examination: October 24, 2006
Consultations: October 16 and November 1, 2006
Date of Report: November 15, 2006

Identifying Information and Procedures:

Thomas Waite is a 23-year-old gentleman who sustained a very severe Traumatic Brain Injury on August 21, 2003. He was riding in the back of a pickup truck with a canopy on it, as part of his LDS mission work, when the truck was struck by another vehicle, causing him to be ejected and land on his head with considerable force. The EMTs found him unresponsive at the scene and intubated him. Initial brain CT identified profuse subarachnoid bleeding and occipital skull fracture, along with bifrontal parenchymal bleeding. Repeat brain CT revealed increasing bifrontal contusions, right greater than left with increasing mass effect and edema, requiring ICP monitor placement. It was 4-6 days post-injury before he began responding to simple commands and opening his eyes. He required ventilator support for up to the 8 days post-injury. He remained confused, disoriented and agitated with impulsivity and aggressiveness or poor temper control for roughly 4 weeks post-injury, past when he was transferred from Deaconess Medical Center to Rancho Los Amigos on September 10, 2003. His delirium and agitation required 4-point restraints for up to 1 ½ weeks after his admission to Rancho Los Amigos. When he was discharged on October 2, 2006, he was noted to be still confused about past events and still prone to an easy agitation or losing his temper. Neuropsychological evaluation prior to discharge identified significant residual issues with complex attention, speed of processing, mental organization, and memory retrieval. Subsequent neuropsychological evaluations (in May and December 2004) have identified improvement, but continuing problems with attention, speed of processing, memory, impulse control and judgment.

Per request from Mr. Eymann and with regard to his general questions about MVA-related neuropsychological condition(s) and prognosis, on November 15 the medical file (5 inches of medical records provided through Mr. Eymann's office) was reviewed. Based on impressions and conclusions discussed via phone conference with Mr. Eymann on November 16, interview with Mr. Waite and his mother was scheduled and completed on October 24. Also on that date, a battery of tests was selected and administered, including some updated memory testing, but for the most part expanded and more detailed testing in the areas of executive attention and problem-solving.

DIPLOMATE, AMERICAN BOARD OF PROFESSIONAL NEUROPSYCHOLOGY

neuropsychology, rehabilitation, and general clinical psychology

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The following tests were administered on October 24, 2006:

Behavioral Assessment of Dysexecutive Syndrome (BADS); Zoo Map
Delis-Kaplan Executive Function System (D-K EFS; most subtests)
IVA Continuous Performance Test
Rey Auditory Verbal Learning Test (Rey AVLT)
Rey Complex Figure Test (Rey CFT)
Test of Everyday Attention (TEA; selected subtests)
WAB Neurobehavioral Status Examination

Between November 13 and 15, 2006 available neuropsychological test data from 2004 (from Dr.'s Green and Tindall) were reviewed, in conjunction with the updated and expanded testing done on October 24. In conjunction with report preparation completed on November 15, 2006, initial record review was expanded and all these test data were interpreted in context with that review and the information obtained from interview with Mr. Waite and his mother, also on October 24.

Pertinent Excerpts from Medical Records:

August 21, 2003 - American Medical Response - unconscious secondary to MVA ejection... Was riding in back of pickup with canopy on it... Patient was immediately unconscious with irregular respiration. Laceration to back of his head... unconscious... Patient ejected.

August 21, 2003 - Deaconess Medical Center (Emergency Admission Report) - ... 20 year old male who was riding in the back of a pickup truck when they were struck by another car. He was unrestrained and flew out of the back of the pickup and landed on his head with considerable force. On arrival, EMS found the patient apneic and unresponsive, and they intubated him in the field. En route he began to respond a little bit more, writhing around and making unpurposeful movements and at times possibly reaching for the endotracheal tube. He was given a second dose of succinylcholine in the field for agitation to facilitate transport... While in the emergency room, the patient's laceration on his eyebrow, the laceration on his arm, and the laceration on the back of his scalp were repaired... The CT scans demonstrated a subarachnoid bleed profusely, as well as an occipital fracture that was nondisplaced. In addition, there were small bifrontal parenchymal bleeds. There were no signs of herniation or midline shift. The CT scan of the face is negative for facial fractures, and the CT scan of the neck is also negative for fractures... IMPRESSION: 1. Multi-trauma. 2. Subarachnoid bleed. 3. Occipital fracture. 4. Bifrontal parenchymal bleeds. 5. Facial, scalp and arm lacerations.

August 22, 2003 - Deaconess Medical Center (Operative Report) - ... CT scan initially showed very small subfrontal contusion and ventricles approximately normal for age. The CT scan today shows increasing cerebral contusions bifrontal, right greater than left, with increasing mass effect on ventricle and diminished size of ventricles and cisterns. It is felt that he requires ICP monitor placement for measurement of intracranial pressures...

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September 1, 2003 - Deaconess Medical Center (physiatry consultation report) - ... The ICP monitor was eventually discontinued and he was able to be extubated on August 31, 2003... On August 25, 2003 the patient was first reported to be able to follow commands, but with signs of left hemiparesis which have improved, but persisted... By September 1, he was reported to be alert, although he has still been having fevers in the last couple of days of greater than 101. He has been very confused and agitated and has required restraint to keep his neck brace on and keep IV lines in place... COGNITION: This patient is completely disoriented to place. After giving him orientation information about place twice in a row, he did have immediate recall about one second later. After 15 to 30 seconds, he could recall that he was in a hospital only when given a list of choices. After about two minutes, he could not choose hospital correctly from the list. In other words, he has some immediate recall, but near zero sustained attention and zero short-term memory... IMPRESSION: This is a 20 year old man who has had a very severe brain injury associated with severe brain edema and bilateral frontal cerebral contusions. He is primarily now demonstrating a frontal deficit of agitation, impulsivity, and general bilateral cortical deficits of severe impairment of attention and memory abilities. He also has mild left hemiparesis, but strengths include ability to follow commands well and already having the presence of immediate memory and very good preserved language and speech abilities... I think he will eventually have enough cognitive and mobility skills to be able to live alone, although I suspect that he will have some lifelong residual deficits with higher-level cognitive skills, executive functions (thought organization, judgment, and reasoning), and he may have some long-term deficits with having less than normal sustained attention and short-term memory. I think he will become fully ambulatory and independent with dressing, toileting, and other basic care skills except for initially, needing supervision for safety and attentional reasons.

September 10, 2003 - Northwest MedStar (medical transport from DMC in Spokane to Rancho Los Amigos in Los Angeles) - ... Awake, talkative, impulsive, restless at times. Requiring nearly 1:1 supervision for a tendency to remove devices. Patient currently restrained with bilateral soft wrist restraints...

September 10, 2003 - Schaeffer Ambulance Service - ... Patient sustained injuries to bifrontal lobe and temporal lobe, contusions... Patient has fractures C5 and C6, occipital fracture as well... Patient transferred without incident. Nurse states patient can become agitated...

September 10, 2003 - Rancho Los Amigos National Rehabilitation Center (Admission Report) - ... was riding in the rear compartment of a pickup truck with a canopy on 8/21/03 when the truck was struck by another vehicle. Both the canopy and the patient were ejected from the truck. He was found unconscious with agonal respirations at the scene. On evaluation at the emergency room, imaging studies showed bifrontal and bitemporal lobe contusions and a posterior fossa left-sided epidural hematoma. He required a ventriculostomy line for intracranial pressure monitoring and was placed on mannitol for cerebral edema... He required ventilator support for approximately 8 days and had opened his eyes beginning at approximately 6 days following the injury. He developed an aspiration pneumonia which was treated. He was also noted to have an occipital skull fracture and a grade 2 splenic hematoma... No seizures have been reported. Last Dilantin level was 9.2. He continues with prolonged periods of agitated delirium...

September 10, 2003 - Rancho Los Amigos National Rehabilitation Center (Cognitive/Communication Skills Report, Initial) - Rancho Level of Cognitive Functioning: IV/V... sustains attention to task in non-distracting environment for 3 minutes... Agitated/aggressive...

October 2, 2003 - Rancho Los Amigos National Rehabilitation Center (Discharge Report) - ... He continued to have marked periods of agitation, requiring IP Ativan injections. Because of the large requirement for this Ativan, additional medications were added. He also was requiring 4-point restraints during this time for much of the time... On initial Speech Therapy evaluation, Thomas was noted to be at an agitated state, Rancho level IV/V, with mixture of lethargy and alertness. His comprehension was moderate assist, understanding simple verbal input and inconsistently yes/no simple questions and inconsistently following multiple-step commands. He could read at a word level. Expression was maximal assist... He was in speech therapy throughout his stay and improved significantly by the time of discharge. His discharge evaluation showed supervised level of comprehension, could follow multiple items to commands and comprehend simple conversation. He could read at word, sentence and functional level. The expression was at a supervised level. He could express complex ideas, still had poor to fair naming and word retrieval secondary to complexity. He could express in sentences and some conversation. Writing was present with 100% accuracy at sentence length. Vocal quality was normal. Rancho level VI at time of discharge... Social interaction was supervised. He was described as having made strong gains with no longer any agitation or aggression. He does still have some temper problems, getting upset with certain things... because of these slightly elevated Dilantin level at the time of discharge, Dilantin dosage was decreased from 300 mg q.a.m. and 200 mg q.p.m. to 200 mg BID... FOLLOW-UP CARE: recommend referral through insurance or Kaiser to a neurologist for follow-up...

October 2, 2003 - Rancho Los Amigos National Rehabilitation Center (Cognitive/Communication Skills Report, Discharge) - Rancho account level of Cognitive Functioning: VI... sustains attention to task in non-distracting environment for 50 minutes... Selectively attends to task in distracting environment for 15 minutes... Impulsive with verbal-cognitive tasks... Confused with past events.

October 16, 2003 - Rancho Loss Amigos National Rehabilitation Center (Summary of Neuropsychological Evaluation) - date evaluated: 9/30/03. CHIEF COMPLAINTS... Occasionally loses his balance... Double vision when attempting to focus on an object... Experiences an inability to "remember recent stuff", difficulty recalling names of new and old acquaintances, and an inability to recall selective information from his past such as the year of his graduation. He also complained of slowed thinking, decreased ability to sustain attention, and occasional word substitution. Continuing and prolonged agitation and delirium requiring the use of 4-point soft restraints, were noted in his chart for up to 1 1/2 weeks following admission to Rancho Los Amigos. He reportedly pulled off medical equipment and would strike out at others in an effort to get out of bed. The patient was placed on Respirdal and BuSpar to target and control his agitation... ACADEMIC AND WORK HISTORY... His mother reported that he had difficulty in school, particularly elementary and junior high school, because of distractibility. He reportedly had difficulty attending in class and often failed to complete tasks on time. He performed much better when placed in a structured environment. He was home

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schooled half his sophomore year after getting into a fight with a peer who made fun of him, and went through a home study program until his last semester of his senior year. Mother further reported that she took him out of school his sophomore year because the family was concerned about his escalating anger and a negative response she received from both teachers and peers after the fight. He graduated from high school in 2001 with average grades. He reported he did not like school because it "was not interesting". He has always had difficulty with mathematics. He attended one semester of college at Fullerton Community College... The patient reported that following graduation, he worked part-time for his grandparents doing land surveying and computer drafting. He held this job until 12/18/03 when he left for his mission. At the time of the accident, he had been on his mission for two weeks... The patient stated that he has always been "pretty quiet" and "doesn't randomly talk to people". He reported that he tends to be very selective when choosing friends because of his religious and moral beliefs and values... SUMMARY OF ASSESSMENT FINDINGS AND RECOMMENDATIONS... Simple auditory attention appears intact while auditory working memory shows some weakening. Simple and complex visual attention is more effective and falls into the borderline range... Decreased performance appears related to slowed processing speed rather than frank inattention... Relative weaknesses were found in abstract thinking and visual motor spatial analysis and synthesis of abstract designs... impaired paragraph recall even though the information was semantically related... Evidence for the presence of retrieval problems and list learning over trials for semantically unrelated words... Difficulties with memory recall for detailed visual information. Remote memory maybe slightly compromised... DIAGNOSES: Axes I: 294.10 Traumatic Brain Injury with deficits in complex attention, speed of processing, mental organization, and memory retrieval. Axes II: V 71.09 No Diagnosis... RECOMMENDATIONS... Although the patient is eager and motivated to return as soon as possible to his mission independently, evaluation results contradict his desire as his performance suggests that he would have significant difficulty managing his responsibilities...

November 4, 2003 - Kaiser Permanente Medical Center (Susan Skinner, M.D., Neurology) -... Leafing through the Rancho notes, at the time he was discharged he had shown a marked improvement.... Mental status alert and cooperative. There is no clear language deficit and his cognitive function and affect appear normal.... Showing a profound improvement. At the time that Rancho discharged him they recommended speech therapy. We discussed having him see speech therapy or not, but agreed that we would send him for speech therapy for an evaluation with the recognition that there may not be any further need for speech therapy. I have also written a letter to the DMV, indicating that I feel he is safe to drive. He has been tapered off of his Dilantin... He has been tapered off of Respirdal right now and I would anticipate he will ultimately be tapered off of trazodone and BuSpar...

May 20, 2004 - Neuropsychological Evaluation (Duane Green, Ph.D., ABPP) - The neuropsychological results indicate mild generalized and specific neuropsychological dysfunction, as well as sensory motor deficits... Many areas of higher cognitive function are intact, including his abstract reasoning, his logical analysis, his complex psychomotor problem-solving, and his flexibility of thought. He does have some residual difficulties in terms of short-term and delayed verbal memory. His visual memory appears relatively intact. He also evidenced variable attention and concentration performances, sometimes performing adequately and sometimes having difficulty. Thomas also demonstrated relative difficulty in terms of his overall speed of processing

information. This, coupled with his verbal memory problems, could account for his subjective complaints of having difficulty in his missionary work of understanding what people are saying to him. Emotionally, Thomas is depressed and is struggling with feelings of inadequacy and low self-esteem. He tends to cover this up with humor and joking, but underneath is hurting psychologically. Recommendations include the need for psychiatric evaluation and follow-up of his medications for his depression. In addition, Thomas needs ongoing psychotherapy with a doctoral level therapist well versed in treating individuals with the residuals of closed head injuries and brain damage. Thomas also needs to be involved in career planning and vocational services to coordinate his long-term plans with his strengths and relative weaknesses so as to not heighten his struggles with the feelings of inadequacy and poor self-esteem.

December 6, 2004 - Neuropsychological Evaluation (Angelique G. Tindall, Ph.D.) - Testing suggested overall intellectual functioning in the high average range with superior verbal skills and high average visual-spatial skills. Measures of speed of processing, however, were in the average range... Verbal fluency was in the average range and inconsistent with his above average verbal intellectual skills. Confrontation naming was mildly below average and attributed to difficulty with word retrieval. Organization and planning of a complex figure was mildly below average secondary to impulsivity and attention errors... Speed on a pegboard task was mildly below average with the preferred hand and below average with the non-preferred hand. New verbal learning and memory were below average for unstructured material and average for structured material... Psychological measures revealed low self-esteem and diminished self-confidence with some depressive symptomatology. Thomas' performance on neuropsychological testing continues to show problems with diminished verbal memory for unstructured material. In the face of above average verbal skill, he is experiencing an average to low average speed of processing of verbal information and some difficulty with high-level verbal organizational skills. This affects his ability to glean context from conversations in which he has to attend to body language, voice inflection and language to comprehend intent... Treatment for Thomas needs to be focused on psychological counseling to build his self-esteem and self-confidence... He also needs vocational services that will advocate for him as he returns to school and work following his mission. He will need to be in contact with Student Services in a university setting to receive assistance with accommodations for learning new material, having extra time to take tests, and being able to keep up with note taking during lectures. He will also need career counseling. For example, with his math skills background, he will likely struggle with an engineering curriculum... It may be useful to consider antidepressant medication to address Thomas' irritability and depressive symptomatology. This medication may assist in decreasing his frustration...

June 3, 2006 - St. Jude Medical Center (Emergency Department Note) - This patient was treated as a critical care patient... The patient had another seizure, generalized tonic clonic. He was given Ativan to resolve it... The patient's seizure in the emergency department was generalized tonic clonic, sudden in onset and appeared non-focal... ADDENDUM: seen by Dr. Erwin Song for status epilepticus. CT results reviewed by me showed frontal encephalomalacia...

June 13, 2006 - Kaiser Permanente Medical Center (Susan Skinner, M.D., Neurology) - On June 3, 2006, he was noted by his parents to be confused and vomiting at 4 a.m.

When the mother went into the room there was actually a wet spot on the bed. He continued to vomit and actually vomited what looked like blood to her. She sat him down in a chair preparing to take him to the emergency room when he had a witnessed generalized tonic-clonic seizure. He did have tongue biting. He was post-ictal after this. He has no recollection of this... IMPRESSION: new onset generalized tonic-clonic seizure... We have also discussed the fact that a Department of Motor Vehicle card will need to be submitted by me. It is recommended that he not engage in activities that might be harmful to him such a swimming, being in a bathtub, etc.... He will continue Dilantin 300 mg QHS...

June 28, 2006 - Kaiser Permanente Medical Center (Brain CT without Contrast) - FINDINGS: There is evidence of encephalomalacic changes in both frontal lobes from previous infarct or trauma...

<u>Overview of Neurocognitive Testing (2004-2006)</u>:

Per psychometry notes from May 18 and 20, 2004, Mr. Waite approached testing with enthusiasm and appeared to try hard. Symptom validity testing with the Victoria confirmed a valid test effort, as did "forced-choice" testing with the CVLT. Likewise, he scored 100% on forced-choice recognition trials that were part of the Rey AVLT, administered as part of my examination.

The Grooved Pegboard Test administered through Dr. Green in May 2004 confirmed below average left-hand fine motor speed/coordination relative to average ability with the right dominant hand, consistent with Mr. Waite's post-injury history of left hemiparesis. Otherwise, bilaterally diminished grip strength was measured. Sensory-perceptual testing reflected left-sided hearing loss, consistent with Mr. Waite's report of hearing loss with tinnitus in his left ear. He produced 8 errors on the Speech-Sounds Perception Test, per Heaton norms translating into mild impairment and probably at least partly reflecting hearing loss. Reports of diminished smell and taste were noted.

Per the WRAT-3 that was part of Dr. Green's examination, Mr. Waite demonstrated high school to post-high school spelling and word recognition skills, but only fifth grade arithmetic. It was noted that he had pre-injury learning issues with arithmetic, as well as issues with being "easily distracted" and "not applying himself". Fullerton Union High School transcripts were obtained by Dr. Green, which per my review indicate graduation in June 2001 with a GPA of 2.61. He was homeschooled for most of his junior and senior years, producing mostly A's and B's with a few C's. Freshman and sophomore grades include him A's in physical education and Band, B's in art and Spanish, and otherwise C's and D's in English, math, and science. Dr. Green mentioned a pre-injury college GPA of 2.5, per his review of a Fullerton Community College transcript from the spring of 2002.

The WAIS-III was administered by Dr. Green in May 2004 and Dr. Tindall in December 2004. The subtest score profile is essentially the same over the two test administrations, notably with the exception of substantially improved with scores on Similarities and Matrix Reasoning, probably reflecting some practice effect and otherwise on Similarities (increased from the 84th to 99th percentile), I would suspect, psychometry scoring error

(not verifiable at this point, since the raw WAIS-III protocols or answer/scoring sheets are not available to me at this time).

Scoring anomalies on Similarities and Matrix Reasoning repeat testing (May to December 2004) notwithstanding, the impression from the WAIS-III is a premorbid intellectual baseline as high as 84th percentile (1 standard deviation above average). Premorbid issues with arithmetic most likely combined with injury-related complex attention deficits resulted in only a marginally normal (16th percentile) score on Arithmetic. Mr. Waite produced Digit Span "summary" subtest scores at his baseline, but notably per Dr. Green's test protocol the longest string of digits repeated backwards (5) is proportionally lower than expectation, given the longest string of digits repeated forwards (8), most likely reflecting complex attention or working memory deficits. Speed of processing proved slow, inferable from 25th percentile scores on Digit Symbol-Coding (both on Dr. Green's and Dr. Tindell's testing). Slowed visual-spatial speed or reduced visual scanning agility was evident on my examination, per TEA Telephone Search (his score, ranked at the 10th percentile).

Mr. Waite completed Trails B in 45 seconds with Dr. Green and in 52 seconds with Dr. Tindall. The implication is a capacity for complex attention (divided or shifting attention) better than 75 to 90% of his healthy age peers. And with Dr. Green he scored within an average range for his age on the Stroop Color and Word Test, implying a capacity for still normal selective attention. But per the DK EFS Color-Word Interference Test, administered as part of my examination, he scored substantially below baseline (1 SD deviation) when attentional-set shifting was added to the more basic selective attention demands, i.e. with Inhibition/Switching versus Inhibition alone. Similarly, he showed substantial (more than 1 SD deviation) on Verbal Fluency Category Switching versus Category Fluency.

On the PASAT, administered by Dr. Green, Mr. Waite very definitely showed substantially diminished complex attention or working memory skills. While he was able to score within an age and IQ expected range on the first two series, he produced scores 1-2 SD's below age and IQ expectation on the more brain-sensitive third and fourth series (27 and 31 errors, respectively, deviating sharply from the expected mean number of errors: roughly 12 and 18).

On my examination, per the IVA Continuous Performance Test, Mr. Waite proved 2 standard deviations below expectation with regard to selective attention consistency or reliability.

Across all test administrations, weakness in attentional focus or effectiveness with regard to attending to new information is evident. Per the CVLT, administered by Dr. Green, Mr. Waite's immediate recall on the first learning trial is 1-2 standard deviations below expectation, as is his learning progression (Learning Slope). He similarly showed diminished and limited attention for "one trial learning", per a 25th percentile score on WMS-III Logical Memory I (administered by Dr. Tindall).

Not surprisingly with all these tests reflecting or implying attention deficits affecting initial learning, on delayed recall measures he produced a wide range of scores and significant variability or lack of reliability. Per the Rey AVLT, the one my office administered, he

was able to recall 14 words on long-delay, even though he had only recalled 10 words on short-delay. And although he recalled 11/15 words without cues on Dr. Green's CVLT long-delay, he recalled only 7/15 on Dr. Tindall's Rey AVLT long-delay.

Short-term memory in itself, i.e. the ability to retain and recall whatever information was successfully learned in the first place, proved still "normal" (age-appropriate), although possibly below premorbid intellectual baseline, per WMS-III General Memory (at the 58th percentile).

Mr. Waite demonstrated a capacity for still normal executive problem-solving on several tests, "average" for his age and 13 years of education, even though possibly below his baseline. Specifically, he produced only 21 errors on the Halstead Category Test and he completed all 6 Wisconsin Categories with only 8 Perseverative Responses. He produced 50th percentile scores on both DK EFS Sorting and the Tower Test and an age/education-congruent Total Time on Halstead Tactual Performance Test

On the downside, although he was able to produce DK EFS Proverb Test and 20 Questions Abstraction scores approaching his Above Average intellectual baseline, his Total Weighted Achievement score on 20 Questions proved better than only 25% of his healthy age peers. And he scored more than 1 standard deviations below age expectation with his drawing (planning/execution) of the Rey Complex Figure, initially with Dr. Tindall in December 2004 and most recently in my examination. Psychometry observation, per my examination, indicated that he was "fast" with this test, while qualitative features in his drawing make it clear that he was impulsive and careless along the lines that we see typically with executive problem-solving deficits. Quantitatively, he scored only 30/36 points with his drawing, scoring at or below the 1st percentile of normal for his age. Similarly, he demonstrated poor planning/organization and/or deficient sequential processing or problem-solving, per the BADS Zoo Map. He made numerous sequencing errors and one rule error on Version 1, while he took an unnecessary or inappropriately long amount of time in preparing to proceed on Version 2.

<u>Overview of Psychosocial/Emotional Coping Inventories</u>:

The MMPI-2 obtained as part of Dr. Green's examination is valid (indicative of balanced reporting of symptoms), but possibly skewed a bit in the normal direction due to 14 items being omitted.

Per the Minnesota NCS (James Butcher) report, his clinical profile matches individuals who are quite depressed with loss of appetite, low energy, and an inability to sleep and who feel tense and irritable with difficulties concentrating and making decisions and feelings of inadequacy, guilt and pessimism about the future. Also per this report, item content reflects low self-esteem and a sense of inadequacy, along with difficulties in managing routine affairs and problems with concentration, memory, and decision-making. Dr. Butcher's report suggests a diagnosis of either Dysthymic Disorder or Major Affective Disorder, in conjunction with social inhibitions or passive and aloof social interactions.

Per my read of the MMPI-2, Mr. Waite produced a classic Major Depression profile: Scale 2 at T74 in conjunction with scales 7, 8 and 0 elevated above baseline to around T60 and scale 9 relatively low at T45. Content scales reflect a marked problem with low self-esteem (LSE at T75). Subscale analysis indicates that distress over cognitive dysfunction or a sense of mental dullness predominates, while subjectively felt depression and energy depletion are somewhat less of a problem, but still significant issues in association with the cognitive loss.

As part of my examination, Mr. Waite produced a valid MCMI-III, i.e. validity indices pointing toward adequate psychological insight and sufficient self-disclosure, but without any over-stating of psychological ills. Axis II BR score elevations indicate marked social anxiety and low self-esteem, possibly passivity or deficient assertiveness. These issues may be long-standing or acquired, i.e. but undoubtedly related in part to MVA-acquired brain injury and related social dysfunction. Axes I elevations reflect substantial levels of both anxiety and depression.

Relevant History and Observations/Concerns, per Mr. Waite's Mother:

Mr. Waite's mother (Carol) indicated on the positive side that "quite of few things have improved", since initially after the injury in 2003. She viewed her son early on as "basically having to go through the stages of maturity all over again", for example "first being able to remember what day it was" and then "learning how to get dressed" and so on. Currently, she feels that he initiates and follows through on things with relatively little assistance from her or anybody else. He has returned to setting goals for himself and manages to keep himself busy. He makes good use of a daytimer, which he was taught to use for his mission work. Emotionally, whereas "at first he didn't want to get out of bed, now he is better able to deal with things". He has returned to displaying his customary good sense of humor.

When he had his seizures this past June, three years post-injury and when everybody thought he was past the critical time when one would occur, he became more depressed. He was told that he should not drive or even watch TV or play video games and so felt "like his life was taken away". Eventually, his neurologist told him that he could watch TV for up to 10 minutes at a time. And then 2-3 months after the seizures, he was released to drive. So at this point, he seems to be back to the baseline improvement in mood she observed with him before the June seizures occurred.

Further on the positive side, it seems that since the injury he decided to take school more seriously. She figures that his problems with distractibility, spelling and arithmetic started in maybe the third grade. He was always physically disinhibited and carefree from that standpoint, even though he may have been socially sensitive or self-conscious. In junior high he learned to play the saxophone and loved to play it, but ended up not continuing in band, because he did not want the pressure. She further noted that he was perfectionistic about his art work. He loved to draw, but she thinks he turned his work in late, because he felt it had to be perfect.

On the downside, even though he has overcome a lot of his earlier post-injury temper problems, he can still "agitate too much" and become frustrated with things. Along this line, he has not returned to the point where he was before the accident. As an example,

during the drive to my office it really bothered him that the street signs were not clear, to the point that he had difficulty letting it go for getting past his frustration. Before the accident, he was more likely to say "whatever" and generally be more easy-going. Now, it seems that everything has to be "in order", if he is to relax. Before the accident, he was physically fearless, for example in scouting activities or when he was little, when he would climb high on top of a roof or something and sit on top of it without worrying about falling. Now he is shaky with regard to his physical capacities.

She is also noticed that he is easily confused or embarrassed in social situations, which ordinarily he would know how to handle on his own and figure out without much thought. Recently, he asked for help in figuring out how to respond to a girl who was him being nice to him, when he has no interest in her. He had limited experience with dating or girlfriends before his injury, but he never became overly concerned about how to deal with girls and would just figure things out for himself.

Now, he generally worries a lot about his social life and worries a lot about his future. He worries about whether he will be able to get a job and keep it. She feels strongly that it is important for him to complete college, regardless of what specifically he may do with the degree. As she understands it, he feels the same way. She realizes that school stresses him a great deal, but feels confident that he is determined to fight through his learning difficulties and be successful with it.

Earlier on after the injury, he seemed to have a sense that he would not live very long. When the seizures occurred this past June, those feelings came up again, which she and other family members experienced as "a real gloom hanging over the house". She tearfully told me that she is aware that her son is stressed and depressed. She is hopeful that he will open himself up to some kind of counseling. He tends to want to tell her and other people that "everything is okay", even though she knows that "things need to be talked out".

Relevant History and Injury Symptoms and Concerns/Goals, per Mr. Waite:

Mr. Waite told me that his spelling has always been "pretty bad", but that he has had some success in memorizing what a word looks like. Arithmetic was always more challenging for him than spelling, reading or writing. He had trouble grasping the math concepts, partly because of the "crappy education system". But, he loved reading and writing stories. His older brother, now age 25, was always a great student and the smart one, such that it was discouraging when he compared himself to him. He does not feel that he was "the dumb one", but it would really "get to him, if people told him he was stupid".

During his freshman year, he got into a fight with another kid on the basketball team, a kid who was "always riding him". He ended up "punching him and didn't know what he was doing". He broke his knuckles, such that he was unable to play basketball. After that he decided that he did not want to do competitive sports and that instead "sports were to have fun".

To be successful with academics, he just knew he had to work hard. And before the injury, he could rely a lot on his memory, which he feels was always better than average.

He was good at memorizing facts for history class. And he could watch a movie and "recite it back almost perfectly scene by scene".

Academics are valued in his family. His father teaches the fourth grade and his sister is a teacher. He is "programmed to get a college degree and told that if he doesn't, he won't make it". He is working hard now on his AA degree and "there is always talk of transferring to a four-year college". He is a bit "on the fence" with regard to whether or not he wants to or will be able to complete his four-year degree. School stresses him much more than before his injury, because now "his ability to intake information and hang on to it and retain it is less and takes longer". Recently, it seems that he is having an even harder time retain the information. He could not say whether or not the Dilantin in the dosages prescribed after his seizures this past June may have something to do with the increased difficulty. In any case, he "wishes that people didn't have to go that route (get a four-year college degree) and wishes that regular working men could still provide for their family".

He tries to take copious notes in class, so that he can understand his homework. If he is unable to get extra help from tutors, he goes to his father for help. This past summer or last semester, he had to drop a couple classes, which ended up requiring more work than he had anticipated and which were interfering with a math class he was also taking at the same time. When trying to explain to me which semesters this occurred and what or when he restarted school after his injury or stopped and started semesters he has completed, he stumbled and became embarrassed, acknowledging that "dates are confusing for him".

Currently, he is taking general courses and he has "no clue" as to what he wants to do for a major or career. His uncle is a civil engineer and he figures that because of his math problems, nobody expects him to take over the business or do what he does. On the other hand, he figures that he will learn a lot about how to run a business in general, if he just pays attention when he is out there working for him. He is learning a lot about work ethics and general business management. He uses the CAD program, which his uncle taught him and a friend to do. He considers it a "nice job" and appreciates that his uncle is flexible and understanding when he has to take time off for a school exam. He frequently feels overwhelmed by the amount of time his classes require.

Earlier on after his injury, his short-term memory was "horrible". About six months after the accident, he was sent back to his mission, where he found he was unable to remember profiles of people he met two days earlier. Fortunately, he was paired off with another missionary and his partner "carried the weight". He also recalls that he was "emotionally immature" and "bent on being the perfect missionary", missing the bigger picture of fulfilling a call. With regard to friends and dating, he still feels like he is catching up. His friends from high school have moved on to other things. And he feels he never really learned to date and that now he is more or less lost in that area. He really does not even know how to "go out there and build friendships", since back in high school he depended on buddies he grew up with and never had to work at finding friends. Even before his injury, he did not particularly like mixing with a lot of people in group situations, yet he effectively managed a lot of close friendships.

He tearfully told me that he "tries to picture the future and knows that he wants to have a family and a house and work and retire", but that all that to him seems "shaky". He worries a lot about his future and "stresses about school". He "gets really down and that sucks". He further stated to me: "Honestly, sometimes given his doctoral beliefs in the church, he can't wait for the afterwards part, because there's so much pressure now". He explained that he did not want to imply that he ever thinks about killing himself, but made it clear that he often feels "life sucks".

He has sporadically seen a psychologist at Kaiser Permanente, typically not more than every six months. He implied that this has not been particularly helpful, because the doctor just "gives him advice about things he has heard before". As he further stated it, he "knows the principles about how he should be coping, but for some reason doesn't utilize them and still feels the anxiety". The psychologist at Kaiser has suggested antidepressants, but Mr. Waite would prefer learning to cope without them. He may be open to medications at some point in the future to help him cope, but he feels that it would be better if he could do without them.

Summary of Findings, Impressions, and Conclusions:

1. On August 21, 2003 Mr. Waite sustained a very severe Traumatic Brain Injury (TBI), incurred when he was ejected from the truck in which he was riding and thrown on to head with considerable force. The MVA on this date resulted in a close head injury with loss of consciousness with extended ventilator support required, occipital skull fracture and profuse subarachnoid bleeding and evolving and expanding bifrontal contusions, right greater than left with mass effect or edema that required ICP monitor placement. Brain injury is appropriately described as "very severe", based on chart evidence that he remained confused or disoriented and agitated for at least four weeks post-injury, for one a half weeks or so after he was transferred from Deaconess Medical Center to Rancho Los Amigos on September 10, 2003.

2. Mr. Waite by all accounts has improved over the past three years since his injury. Given that he sustained a very severe brain injury, his recovery at least on the surface appears good, particularly since about six months post-injury he returned to complete his LDS mission and by the fall of 2004 he returned to his studies at Fullerton Community College. On the downside, he completed his mission by allowing his mission partner to "carry the weight" and he has been completing college credits in a hit and miss fashion, signing up for classes and then having to drop them when the workload becomes overwhelming. With tutor and family support and a lot of extra time and energy on his part and despite his feeling stressed by his no longer having what he experienced pre-injury and as an above average memory and his "now taking longer to take in information and then retaining less of it", he has been accumulating some credits. He has had to remain living with his parents. He has had great difficulty making friends and feels lost with regard to dating. His mother notes that although he has improved to the point of setting goals and initiating and following through on a lot of activities, he remains dependent on her a lot of decision-making, notably with regard to social situations. He has become overly self-conscious and low in self-esteem. More recently, he has not had any serious loss of temper control, but he remains easily frustrated and irritable. During my interview with him, I noted some impulsivity, as well as easy confusion with timeframes for dates and at times strained verbal comprehension and expression. I

observed some tearfulness, when he was discussing what seems to be extreme anxiety and worry about his academic capabilities, his social functioning and his future. He does not have any suicidal impulses or plans or specific thoughts of wanting to harm himself, but he describes "looking forward to the afterlife", making it clear that for him now, "life sucks". Overall, post-injury records and my interview with Mr. Waite and his mother point toward a young man who remains easily confused with regard to time sequences, who continues to struggle with verbal comprehension and expression, who asked to work extremely hard to compensate for persistent post-accident attention, memory and judgment difficulties, and who suffers with diminished social confidence, severe loss of self-esteem and high levels of both social and generalized anxiety, accompanied at times by suicidal-type thinking.

3. In June of this year Mr. Waite had two generalized tonic-chronic seizures and since has been restarted on Dilantin (300-400 mg qhs). Brain CT at that time revealed still visible encephalomalacic changes in both frontal lobes. This makes it clear that he not only sustained a very severe TBI, but that he still has severe brain injury, visible on imaging studies. Neuropsychological testing completed in May and December 2004 and as part of my examination in October this year consistently and convincingly verifies the kinds of brain injury-related deficits that his history of severe bifrontal contusion and persistent bifrontal encephalomalacia would predict: substantial deficits in the areas of executive attention or working memory, processing speed and sequential thinking or executive problem-solving. Detailed commentary on test scores and interpretation can be reviewed above in the section titled, Overview of Neurocognitive Testing. But to summarize here, despite test evidence for encouraging recovery with regard to basic abstract thinking and retention of whatever new information can be sufficiently attended to and store/consolidated in the first place, there is ample test evidence that selective attention skills and attentional flexibility or ability to switch conceptual set remain highly variable and unreliable. Definite problems with impulsivity, planning, and processing speed, sequencing and organization are evident in his test results. Practically, these kinds of impairments on testing mean that everyday memory, decision-making, and social coping will remain problematic and require substantial assistance from others and/or self-structuring strategies and accommodations or compromise.

4. Clinical observation, self-report, family observations, and psychosocial/personality testing suggests that Mr. Waite is suffering from Major Depression and high levels of Generalized Anxiety. My sense in reviewing pre-injury social functioning is that premorbidly he tended to be disinhibited or fearless at the physical level, while being a bit reserved or cautious at the social level. But, he was never seriously depressed or prone to any serious social anxiety, until after his injury. Personality testing now reflects passive-dependent and socially avoidant-type coping, in my opinion maybe to some degree representing premorbid personality inclinations but in larger part representing mood and personality change due to brain injury.

5. Given that Mr. Waite is now three years post-injury, more likely than not, the executive skill deficits and mood/personality problems historically documented since his injury, seen clinically via interview, and validated by neuropsychological testing will be permanent. Given his youth and enthusiasm and also excellent family support, he can hope for improved functioning, if not some additional brain recovery or at least his becoming more adept at compensating and managing his deficits. But, I would caution

him not to count on any further substantial improvement. The greater portion of any future gains, I believe, will depend on his commitment to regular and intensive neuropsychological counseling and psychiatric care. To the degree that he can learn through psychotherapy and/or with psychopharmacological (antidepressant) support how to better control his anxiety, decrease depression and re-establish some measure of self-esteem and a self concept more suitable to his post-brain injury limitations, he will be less stressed and end up with better energy and more mental reserve and in that sense potentially function better cognitively, emotionally, and socially. Secondarily, occasional cognitive remediation therapy with a Speech Language therapist is his best bet for some further gains.

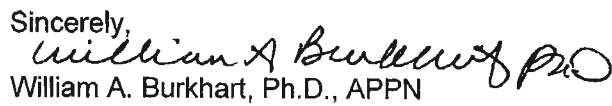
6. Evidence on the record and as reported to me by both Mr. Waite and his mother in October suggests that premorbidly Mr. Waite had relatively mild but discernible issues with distractibility and impulse control, per my opinion possibly something along the ADD/ADHD spectrum. Most likely, he also had a specific arithmetic learning disability. Unfortunately, that history means a more guarded prognosis with regard to his further recovery from or improved management of his frontal lobe brain injury-related executive skill deficits. It should be emphasized that the executive skill difficulties (mood/personality and cognitive/coping difficulties and changes) seen post-injury can be fully accounted for by the well documented severe frontal lobe brain injury sustained in on August 21, 2003. But, any underlying pre-existing congenital frontal lobe-type attention and/or behavioral or learning difficulties undoubtedly were severely aggravated by the 2003 brain injury and those pre-existing issues inevitably mean as well a greater likelihood of permanent severe neuropsychological disability.

7. To reiterate my recommendations for items to be included in Mr. Waite's life care plan, as I detailed them in consultation with OSC Vocational Systems on November 1, 2006, because of the MVA, Mr. Waite will require individual psychotherapy on average twice per week for the next 18 months and then on average once per week for 3-5 years after that, what I would estimate to be overall 6-12 times per year to life expectancy. Once such a psychotherapy relationship is established, I would anticipate that an antidepressant such as Celexa (some kind of SSRI) will be recommended and necessary for his optimal coping and further recovery. That would best be managed by a psychiatrist, initially with monthly visits and then less frequently, as long as a rehabilitation psychologist or neuropsychologist is involved with ongoing psychotherapy and medication monitoring and/or more comprehensive neuropsychological monitoring and re-evaluations. With regard to the neuropsychological evaluations over his lifetime, given his dedication to maximizing his educational and vocational functioning and the likelihood that changing circumstances or unexpected stress loads or social challenges will require relatively frequent change of plans, it would be advisable to fund comprehensive neuropsychological evaluation on average every 3-5 years to life expectancy. Also along these lines, I would like to see him have access to a cognitive remediation therapist (preferably a Speech Language therapist) who understands brain injury-related executive skill deficits and who is geared toward practical or functional compensatory strategies. This kind of therapy should be available over 3-6 sessions, every 3-5 years coinciding with needs to change jobs and/or changing circumstances with regard to relationships or living arrangements.

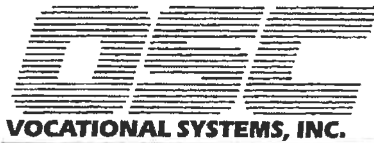
8. Possibly, Mr. Waite will be able to complete some kind of four-year college degree. However, per my estimation, unfortunately he will never be able to compete competitively or continuously in the kinds of jobs typically held for college graduates. He will always need to do relatively structured work with a moderate amount of supervision and will always need to rely on coworkers or supervisors for executive planning, and decision-making, and organization.

I have appreciated the opportunity to evaluate Mr. Waite and offer my opinions and recommendations. I will standby to further assist in this case, should I be asked.

Sincerely,



William A. Burkhart, Ph.D., APPN



VOCATIONAL SYSTEMS, INC.

November 13, 2006

William Burkhart, Ph.D.
10704 Meridian Ave. N., Suite 104
Seattle, WA 98133-9010

Re: Thomas Waite

Dear Dr. Burkhart:

Thank you for speaking with us regarding Thomas Waite's current and future needs. To ensure we have accurately understood your rehabilitation recommendations, please review the enclosed Preliminary Care Plan to ensure it reflects what is necessary and appropriate for treatment of his traumatic brain injury.

Upon your review, please provide your concurrence and/or comment on the format provided below as to whether the Care Plan, on a more probable than not basis, reflects your recommendations for Thomas.

WB The rehabilitation recommendations contained in the Care Plan are necessary and appropriate for Thomas Waite.

Comments: SPEECH THERAPY 36 SESSIONS EVERY 3.5 YEARS (SEE MY REPORT)

[signature] 11-15-06

William Burkhart, Ph.D. Date

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Please return the signature page with your signature via facsimile at 425-486-8701 or in the enclosed self-addressed, stamped envelope. Thank you for your assistance.

Sincerely,

Anthony J. Choppa, M.Ed., CRC, CCM
Rehabilitation Counselor/Case Manager

Enclosures: Preliminary Care Plan
Self-addressed, stamped envelope

cc: Richard Eymann
Thomas Waite c/o Richard Eymann

Curriculum Vitae

WILLIAM A. BURKHART, PH.D., ABPN

DIPLOMATE, AMERICAN BOARD OF PROFESSIONAL NEUROPSYCHOLOGY
neuropsychology, rehabilitation, and general clinical psychology

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Educational History –

Jan 1988 - Nov 1990	post-doctoral supervision in neuropsychology & post-acute head injury rehabilitation Alvin McLean, Jr. Ph.D. / Community Re-entry Services of Washington / Mountlake Terrace, WA.
Mar 1985 - Aug 1985	post-doctoral fellowship in neuropsychology & inpatient head injury / neurological rehabilitation Sureyya S. Dikmen, Ph.D. / University of Washington Inpatient Rehabilitation Unit / Seattle, WA.
Sep 1984 - Feb 1985	post-doctoral fellowship in pain psychology Wilbert E. Fordyce, Ph.D. / University of Washington Pain Clinic & Inpatient Rehabilitation / Seattle, WA.
Sep 1981 - Aug 1982	post-doctoral residency in medical psychology & behavioral medicine / hospital consult-liaison Reed M. Larsen, Ph.D. / Wilford Hall USAF Medical Ctr. Lackland AFB, TX
Sep 1976 - Aug 1981	Ph.D. in Clinical Psychology / Dissertation Title: The IQ Factor in Luria-Nebraska Test Performance H. Newton Malony, Ph.D / Fuller Graduate School of Psychology / Pasadena, CA.
Sep 1980 - Aug 1981	pre-doctoral internship in community mental health & organizational consultation / Linda Friar, Ph.D. Ingleside Mental Health Center / Rosemead, CA.

Jul 1979 - Aug 1980	pre-doctoral clerkship in psychological testing & impatient psychiatric services / adolescent clinic Michael P. Maloney, Ph.D. / Los Angeles County - University of Southern California Medical Center Los Angeles, CA
Sep 1972 - Jun 1976	B.A. in philosophical psychology / J. Glen Gray, Ph.D. The Colorado College / Colorado Springs, CO
Sep 1968 - Jun 1976	high school diploma / graduated Lewis-Palmer High School Monument, CO

Professional Work History –

Apr 1998 - present	Staff neuropsychologist and medical psychologist / disability consultant, Swedish Medical Center / Seattle, WA.
Sep 1995 - Apr 2000	Consulting pain psychologist and neuropsychologist Triad Rehabilitation Solutions / Seattle, WA.
Nov 1990 - present	Clinical neuropsychologist, pain psychologist, and rehabilitation consultant
Nov 1988 - present	Staff neuropsychologist and medical psychologist / disability consultant, Northwest Hospital / Seattle, WA. independent practice / Seattle, WA.
Jan 1988 - Nov 1990	Senior neuropsychologist & behavior consultant Community Re-entry Services of Washington / Post-acute outpatient head injury rehabilitation Mountlake Terrace, WA.
Jul 1987 - Nov 1987	Staff Rehabilitation Psychologist Pain Service & Inpatient Rehabilitation Unit Seattle Veteran's Administration Medical Center Seattle, WA.
Sep 1986 - Jul 1987	Neuropsychological consultant / psychologist (CA PE9457) Independent Practice / Napa, CA
Sep 1985 - Jul 1987	Staff Clinical Psychologist & hospital consult-liaison David Grant USAF Medical Ctr. / Travis AFB, CA.
Sep 1982 - Aug 1984	Staff Clinical Psychologist & hospital consult-liaison Ellsworth USAF Regional Hosptial / Ellsworth AFB, SD
Sep 1979 - June 1980	Teaching Assistant / instruction in adult psychotherapy Fuller Graduate School of Psychology / Pasadena, CA

Jul 1978 - Aug 1980 — Adolescent & Family Counselor
HOY Community Mental Health Clinic / Arcadia, CA.

Jan 1977 - Jun 1978 — Counselor & Behavioral Consultant
Sycamores Residential home for Boys / Altadena, CA

Publications and Presentations

Burkhart, W.A. (1997, September) Neuropsychological aspects of parkinson's disease, Presented at Pacific Northwest Neuropsychological Society, monthly meeting

Burkhart, W.A. (1997) Neuropsychological considerations in gamma knife treatment of Parkinson's disease, Northwest Neurosciences Institute Journal, 4(3), 2-3

Young, R.F., Shumway-Cook, A., Vermeulen, S.S., Grimm, P., Blasko, J., Posweitz, A., Burkhart, W.A., Goiney, R. (1998) Gamma knife radiosurgery as a lesioning techinique For movement disorder surgery, Journal of Neurosurgery, 89, 183-193

Professional Associations

American Psychological Association

APA Division 40 / Neuropsychology

APA Division 22 / Rehabilitation Psychology

Brain Injury Association of Washington

International Neuropsychological Society

National Academy of Neuropsychology

Pacific Northwest Neuropsychological Society

Washington State Psychological Association

William A. Burkhart Ph.D.

Deposition / Testimony

2003

1/2003	Testimony	Sally Leighton
1/24/03	Deposition	William Hocking
2/12/03	Deposition	Corrie Yackulic
4/11/03	Deposition	Warren Bobb
8/15/03	Deposition	Timothy Blood
10/2/03	Deposition	Kirsten Skecher
10/21/03	Testimony	Mike Brown
11/2003	Deposition	Janet Rice

2004

2/2004	Deposition	Donald Harrison
2/25/04	Deposition	Joseph Albro
5/2004	Deposition	Robert Unger
7/16/04	Deposition	Linda Gallagher

2005

1/2005	Deposition	George Allen
2/2005	Deposition	Tom Albers
8/2005	Deposition	Ronald Atwood
12/2005	Deposition	Kathy Boyle

2006

2/15/06	Deposition	Corrie Yackulic
4/2006	Testimony	Corrie Yackulic
5/24/06	Testimony	Paul Routt
9/2006	Deposition	Anthony Russo

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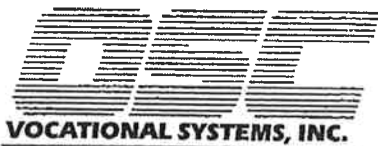
Exhibit "D"



VOCATIONAL SYSTEMS, INC.

November 13, 2006

Richard C. Eymann
Attorney at Law
2208 West Second Avenue
Spokane, WA 99204

Re: Thomas Waite
DOB: 08/16/83
DOI: 08/21/03

Dear Mr. Eymann:

Enclosed is a Preliminary Care Plan coordinated after my clinical assessment of Tom and coordination with Drs. Skinner (treating Neurologist) and Burkhart (Neuropsychologist). Tom has experienced a permanent impairment that will also have an adverse impact on his wage earning capacity. Tom has returned to school at Fullerton College and is receiving accommodations through the Disabled Student Services Office. These currently include additional time for test taking in a private room, peer tutoring in math, as well as assistance from his father on an informal basis with assignments and homework.

As you are aware, Tom was participating in a Mission through his church at the time he experienced a traumatic brain injury. He attempted to return to the Mission without success. Tom states that his plans originally were to finish his Mission and return to school.

Tom has worked for his uncle's engineering firm and described that civil engineering was a vocational goal. The nature and extent of the impairments he experiences will prevent him from successfully competing for and performing as a Civil Engineer. Tom will be capable of working full time, but the position will require more structure and routine as a result of his ongoing cognitive impairment. Thus, it would be more likely that Tom will be employed in a position such as a Computer Drafter or Engineering Technician, as compared to his pre-injury capacity as a Civil Engineer. The average offer for graduates with Civil Engineering degrees at the Bachelor's level in 2005 was $43,679 per year. This is a reasonable benchmark for Tom's pre-injury wage earning capacity. In consideration for the ongoing impairments he experiences as described by Drs. Burkhart and Skinner, Tom with support will complete his education (it will likely take him one to two years longer) and enter the workforce in a job more closely supervised

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that is more routine and repetitive than the skills and abilities required of an Engineer. He could utilize his training and experience to work in the engineering field in a position such as Engineering Technician/Computer Assisted Design and Drafter. The earnings of an entry-level Engineering Technician and Computer Assisted Design and Drafter are approximately $35,360. Tom will experience a permanent reduction in his wage earning capacity based on my understanding that the impairments he experienced, involving the traumatic brain injury are permanent and will pose lifelong challenges to him.

Please accept this as a preliminary report at this time. I have enclosed copies of letters that I have sent back to Drs. Skinner and Burkhart regarding the coordination of Tom's long-term medical and rehabilitation needs, and the prognosis for his condition.

Please contact me should you have any comments or questions concerning this information.

Very truly yours,

Anthony J. Choppa, M.Ed., C.R.C., C.C.M.
Rehabilitation Case Manager

Enclosures: Preliminary Care Plan
Copies of letters to Drs. Skinner and Burkhart

TC/kc

PRELIMINARY

CARE PLAN

FOR

THOMAS WAITE

CURRENT AGE TO LIFE EXPECTANCY

NOVEMBER 2006

Anthony J. Choppa, M.Ed., C.R.C., C.C.M.
OSC Vocational Systems, Inc.
10132 NE 185th St.
Bothell, WA 98011

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PRELIMINARY CARE PLAN
NAME: THOMAS WAITE
DOB: 8/16/83
DOI: 8/21/03

ITEM	PURPOSE	PROVIDER	AGE/INITIATED AGE/SUSPENDED	REPLACEMENT RATE	BASE COST
Neurological Evaluation, Monitoring and Treatment	Monitor neurological sequelae including cognitive deficits and seizure status. Management of pharmacologic intervention.	Susan Skinner, M.D. or local provider	Current Age to Life Expectancy	Office visit in approximately 6 months, then average yearly	$144.00 - $202.00 per visit
Neuropsychological Re-evaluations	Ongoing monitoring of cognitive and emotional status, provide recommendations to address treatment options and/or appropriate accommodations with regard to educational/vocational pursuits and other challenges.	William Burkhart, Ph.D. or local provider	Current Age to Life Expectancy	Average every 3 – 5 years	$1,750.00 per evaluation
PROJECTED EVALUATIONS					

78

PRELIMINARY CARE PLAN
NAME: THOMAS WAITE
DOB: 8/16/83
DOI: 8/21/03

ITEM	PURPOSE	PROVIDER	AGE/INITIATED AGE/SUSPENDED	REPLACEMENT RATE	BASE COST
Psychotherapy (Individual)	Address cognitive behavioral intervention for symptoms of depression and anxiety, and assist with attention, concentration and ability to focus.	Barry Moss, Ph.D., Lauren Schwartz, Ph.D., or local provider	Current Age to Life Expectancy	Average 2 times per week for 18 months - - - - - - - - - - - - - Then 1 time per week for 3 – 5 years - - - - - - - - - - - - - Then 6 – 12 times per year to Life Expectancy	$135.00 - $150.00 per session
Cognitive Remediation Evaluation, Monitoring and Treatment	Periodic consultation with a Speech Language Pathologist to assist Thomas with maintaining and updating his compensatory strategies during major life changes including job and relationship changes. Communication and coordination with Psychotherapist.	Rancho Los Amigos, Newport Language & Speech Center, or local provider	Current Age to Life Expectancy	3 – 6 sessions total	$60.00 - $120.00 per session
PROJECTED THERAPEUTIC MODALITIES					

79

PRELIMINARY CARE PLAN
NAME: THOMAS WAITE
DOB: 8/16/83
DOI: 8/21/03

ITEM	PURPOSE	PROVIDER	AGE/INITIATED AGE/SUSPENDED	REPLACEMENT RATE	BASE COST
Dilantin Level	Monitor therapeutic medication levels and health status.	Lakeview Medical Offices, Anaheim, CA, or local provider	Current Age to Life Expectancy	In approximately 6 months, then average 1 time per year	$121.00 each
Complete Blood Count (CBC)	Monitor for general health status.	Lakeview Medical Offices, Anaheim, CA, or local provider	Current Age to Life Expectancy	In approximately 6 months, then average 1 time per year	$71.00 each
Alanine Aminotransferase (ALT)	Monitor liver function.	Lakeview Medical Offices, Anaheim, CA, or local provider	Current Age to Life Expectancy	In approximately 6 months, then average 1 time per year	$49.00 each
Aspartate Aminotransferase (AST)	Monitor liver function.	Lakeview Medical Offices, Anaheim, CA, or local provider	Current Age to Life Expectancy	In approximately 6 months, then average 1 time per year	$47.00 each
Venipuncture	Blood draw	Lakeview Medical Offices, Anaheim, CA, or local provider	Current Age to Life Expectancy	In approximately 6 months, then average 1 time per year	$15.00 each
DIAGNOSTICS					

80

PRELIMINARY CARE PLAN
NAME: THOMAS WAITE
DOB: 8/16/83
DOI: 8/21/03

ITEM	PURPOSE	PROVIDER	AGE/INITIATED AGE/SUSPENDED	REPLACEMENT RATE	BASE COST
Dilantin* (400 mg) night	Manage and reduce risk of seizures.	Walgreens or local pharmacy	Current Age to Life Expectancy	Monthly	$48.00
Celexa	Manage depression.	Walgreens or local pharmacy	Current Age to Life Expectancy	Monthly	Pending
MEDICATIONS[1]					

[1] Reflects current use. Physician may choose to alter or change medication over time. Dr. Burkhart recommends antidepressant medication such as Celexa be included.

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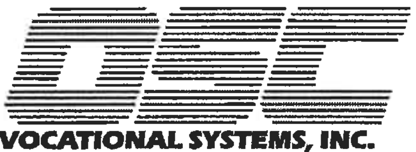

PRELIMINARY CARE PLAN
NAME: THOMAS WAITE
DOB: 8/16/83
DOI: 8/21/03

ITEM	PURPOSE	PROVIDER	AGE/INITIATED AGE/SUSPENDED	REPLACEMENT RATE	BASE COST
Case Management	Coordinate medical and rehabilitation providers, identify appropriate providers, and access resources to assure cost effectiveness, quality of services and crisis intervention.	Local Certified Rehabilitation Counselor or Certified Case Manager	Current Age to Life Expectancy	Average 1 time per month (2 – 3 hours) for the first year upon completion of school - - - - - - - - - - - - - - Then 1 time per quarter (2 – 3 hours) for life	$115.00 - $165.00 per hour
HOME CARE/RESIDENTIAL CARE					

* Services currently being provided by mother.

PRELIMINARY CARE PLAN
NAME: THOMAS WAITE
DOB: 8/16/83
DOI: 8/21/03

ITEM	PURPOSE	PROVIDER	AGE/INITIATED AGE/SUSPENDED	REPLACEMENT RATE	BASE COST
Tutoring	Specific one-on-one assistance with study skills due to continued memory and organizational impairment.	Fullerton College or local provider	Current Age for 2 – 3 years	Weekly (1 – 2 hours) (Professional intervention above and beyond peer tutoring)	$60.00 per hour
Functional Vocational Assessment/Counseling	Provide informational input for curriculum planning and transition from school to post schoolwork. Provide and determine vocational skills, information regarding interests, time management, self-regulation on the job, and appropriate behavior.	Local Certified Rehabilitation Counselor	Current Age to Life Expectancy	Minimum 1 – 2 times (15 – 20 hours each)	$130.00 - $165.00 per hour

EDUCATIONAL/VOCATIONAL NEEDS

8-2

November 13, 2006

William Burkhart, Ph.D.
10704 Meridian Ave. N., Suite 104
Seattle, WA 98133-9010

Re: Thomas Waite

Dear Dr. Burkhart:

Thank you for speaking with us regarding Thomas Waite's current and future needs. To ensure we have accurately understood your rehabilitation recommendations, please review the enclosed Preliminary Care Plan to ensure it reflects what is necessary and appropriate for treatment of his traumatic brain injury.

Upon your review, please provide your concurrence and/or comment on the format provided below as to whether the Care Plan, on a more probable than not basis, reflects your recommendations for Thomas.

_____ The rehabilitation recommendations contained in the Care Plan are necessary and appropriate for Thomas Waite.

Comments:____

____

____

William Burkhart, Ph.D. Date

√ Main Office (Bothell) • 10132 N.E. 185th
Bothell, WA 98011 • (425) 486-4040
Fax: (425) 486-8701

☐ Mt. Vernon Office • 1419 E. College Way
Mt. Vernon, WA 98273 • (360) 424-6239
Fax: (360) 428-4161

☐ Olympia Office • 2101 4th Ave Suite 101
Olympia, WA 98506 • (360) 352-5078
Fax: (360) 352-5417

☐ Edmonds Office • 7500 212th St. S.W., Suite 110
Edmonds, WA 98026 • (425) 672-9600
Fax: (425) 776-5375

☐ Burien Office • 601 SW 152nd St
Burien, WA 98166• (206) 243-1300
Fax: (206) 243-0366

☐ Kingston Office • 26121 Calvary Lane Suite 250
Kingston, WA 98346 • (360) 297-0531
Fax: (360) 297-0532

☐ Moses Lake Office • 406 W. Broadway, Suite G
Moses Lake, WA 98837 • (509) 766-0379
Fax: (509) 765-1392

☐ Bellingham Office • 114 W. Magnolia St., Suite303
Bellingham, WA 98225 • (360) 734-9163
Fax: (360) 738-9524

☐ Tacoma Office • 917 Pacific Ave #308
Tacoma, WA 98402 • (253) 779-5485
Fax: (253) 779-5486

☐ Spokane Office • 1814 N. Normandie
Spokane, WA 99205 • (509) 325-7766
Fax: (509) 325-7666

Please return the signature page with your signature via facsimile at 425-486-8701 or in the enclosed self-addressed, stamped envelope. Thank you for your assistance.

Sincerely,

Anthony J. Choppa, M.Ed., CRC, CCM
Rehabilitation Counselor/Case Manager

Enclosures: Preliminary Care Plan
Self-addressed, stamped envelope

cc: Richard Eymann
Thomas Waite c/o Richard Eymann

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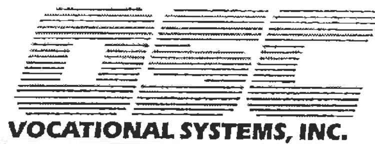

VOCATIONAL SYSTEMS, INC.

November 13, 2006

Susan Skinner, M.D.
411 N. Lakeview Ave.
Anaheim, CA 92807

Re: Thomas Waite
DOB: 08/16/83
DOI: 08/21/03

Dear Dr. Skinner:

Thank you for speaking with us regarding Thomas Waite's current and future needs. To ensure we have accurately understood your medical and rehabilitation recommendations, please review the enclosed Preliminary Care Plan to ensure it reflects what is necessary and appropriate for treatment of his traumatic brain injury.

Upon your review, please provide your concurrence and/or comment on the format provided below as to whether the Care Plan, on a more probable than not basis, reflects your recommendations for Thomas.

_____ The medical and rehabilitation recommendations contained in the Care Plan are necessary and appropriate for Thomas Waite.

Comments:____

____

____
Susan Skinner, M.D. Date

√ **Main Office (Bothell) • 10132 N.E. 185th**
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Please return the signature page with your signature via facsimile at 425-486-8701 or in the enclosed self-addressed, stamped envelope. Thank you for your assistance.

Sincerely,

Anthony J. Choppa, M.Ed., CRC, CCM
Rehabilitation Counselor/Case Manager

Enclosures: Preliminary Care Plan
Self-addressed envelope

cc: Richard Eymann
Thomas Waite c/o Richard Eymann

Anthony J. Choppa, M.Ed., CRC, CDMS, CCM

OSC Vocational Systems, Inc.
10132 NE 185th Street
Bothell, WA 98011
(425) 486-4040 (425) 486-8701 fax
tony@osc-voc.com

Tony obtained his Master's degree in Rehabilitation Counseling from Kent State University in 1979 and his Bachelor's degree from Mount Union College in Alliance, Ohio, in 1976.

He is the Founder and Manager of OSC Vocational Systems, Inc. OSC has multiple offices in Washington State employing over 60 people involved in direct vocational rehabilitation, case management, and care planning services. Tony is a practicing vocational counselor and case manager working on complex injury cases in a variety of settings, including state and federal courts.

Publications

Field, T., Choppa, A. & Shafer, K. (1984). **Labor Market Access (Rev.)**. Athens, GA: Elliott & Fitzpatrick, Inc.

Choppa, A., et al, (1985). **Washington Workers' Compensation Law.** Eau Claire, WI: Professional Education Systems, Inc.

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Choppa, A., et al, (1989). **Workers' Compensation in Washington - Vocational Rehabilitation Rules.** Eau Claire, WI: National Business Institute, Inc.

Choppa, A. Rappleyea S., (1989). **Transitional Planning.** Learning Disabilities Association of America, 24(6); and State News Focus of the Washington State Head Injury Foundation, 5(6).

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Choppa, A., Cutler, F. & Siefker, J., et al, (1992). **Vocational Evaluation in Private Sector Rehabilitation.** Stout, WI: University of Wisconsin - Stout.

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Choppa, A., et al, (1996). **Vocational Rehabilitation Counselors as Case Managers.** The Case Manager, 7(5).

Choppa, A., et al, (1997). **A Study Guide for the Certified Case Manager Exam.** Athens, GA: Elliott & Fitzpatrick, Inc.

Choppa, A., et al, (1998). **CDMS Study Guide for the Certified Disability Management Specialist Exam.** Athens, GA: Elliott & Fitzpatrick, Inc.

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Field, T., Choppa, A., Dillman, E., Garner, D., Grimes, J., Jayne, K., Kelsay, E., Kilcher, D.G., Kilcher, J. & Taylor, D. (2000). **A Resource for the Rehabilitation Consultant on the Daubert and Kumho Rulings.** Athens, GA: Elliott & Fitzpatrick, Inc.

Choppa, A., et al, (2001). **Comprehensive Study Guide for the exams of Case Manager Certification (C.C.M.), Certification of Disability Management Specialist (C.D.M.S.), Certified Life Care Planner (C.L.C.P.);** Kelsay, M., Kilcher, J., Taylor, D.; Editors, Athens, GA: Elliott & Fitzpatrick, Inc.

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Choppa, A., et al (2003). **Book Review,** The Transitional Classification of Jobs, *Journal of* Life *Care Planning*, Vol. 2, No. 4, 215-218. Athens, GA: Elliott & Fitzpatrick, Inc.

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Choppa, A., Field, T., (2005), **Admissible Testimony: A Content Analysis of Selected Cases Involving Vocational Experts With a Revised Clinical Model for Developing Opinion**, Athens, GA: Elliott & Fitzpatrick, Inc.

Farnsworth, K., Field, T., et al, (2005), **The Quick Desk Reference for Forensic Rehabilitation Consultants**, Athens, GA: Elliott & Fitzpatrick, Inc.

Professional Associations

- National Rehabilitation Association
- International Association of Rehabilitation Professionals
- Case Management Society of America
- National Association of Service Providers in Private Rehabilitation
- International Academy of Life Care Planners

Case Caption/Parties	Location of Case/Court	Deposition or Trial	Referring Attorney
Angelo Reed v. City of Spokane	Spokane County, WA	Deposition	Keith Kessler
Sean Larson v. Berschauer Phillips Construction Co.	Yakima County, WA	Deposition	Terry Abeyta
Kelleher v. Ellensburg School District No. 401, et. al.	King County, WA	Deposition	Terry Abeyta
James and Cindy Brinkman v. Jason Murback, et. al.	King County, WA	Deposition	Jeffrey B. Tuttle
Cheryl Baxter, et. al. v. Tammy Dzidek, et. al.	Benton County, WA	Trial	Marshall Wolfram
Bernard Baxley, et. al. v. Empire Health Services	Spokane County, WA	Deposition	Richard Eyman
David and Cindy Meisner v. The State of Washington and Max J. Kuney Co.	King County, WA	Deposition and Trial	Gail M. Lundgren
Chong Suk & Lloyd Bartel v. Burlington Northern Railroad	US District Court Western District of Washington	Trial	Paul Strittmatter
Brandon Martini	Thurston County, WA	Deposition and Trial	Brad Moore
Matt Balls	Spokane County, WA	Deposition and Trial	D. Duce
Lyle Akehurst	Spokane County, WA	Deposition	Fred Bremseth
Cordero Nieto	Snohomish County, WA	Deposition	Gus Cifelli
Phillip Corral	Skagit County, WA	Deposition	J. Rogers
Seth Becker	Federal Court Lafayette, LA	Trial	James Parker
Terry Leeper	Spokane County, WA	Trial	Janet Rice
Richard Gay	Snohomish County, WA	Trial	Joe Genster
Abel Gurrero	King County, WA	Deposition	Jon Peterson
Shannon Conradi	King County, WA	Deposition	Keith Kessler
Cindy Setern	Pierce County, WA	Deposition	Keith Kessler
Confidential v. Helicopter Co.	US District Court Western District of Washington	Deposition	Keith Kessler
Kim Kincaid	Anchorage, AK	Deposition	Kirsten Tinglum
Ed Shipuleski	King County, WA	Deposition	Lem Howell
Kris Whittamore	King County, WA	Trial	Mary Fleck

Case Caption/Parties	Location of Case/Court	Deposition or Trial	Referring Attorney
Brian Holt	Skagit County, WA	Deposition	Matt Menger
M. Huss	Anchorage, AK	Deposition	Matt Peterson
Kayne Sileray	Pierce County, WA	Deposition	Paul Whelan
Emma Ferguson	King County, WA	Deposition	Ralph Brindley
Vicki Collins	Spokane County, WA	Deposition	R. Fancher
Heather Giles	Spokane County, WA	Trial	Richard Eyman
Kurt Swedelius	King Salmon, AK	Deposition	Richard McKinney
Jill Wilmont		Trial	Ronald Perey
Cynthia Bamby	King County, WA	Deposition	T. Coulsen
Damani Walker	King County, WA	Deposition	Tony Shapiro
David Bertholf	Pierce County, WA	Deposition	Vernon Harkins
Ricky Barber		Deposition	Han Hess
Donald Nelli		Deposition	Gail Lundgren
Jason Kono		Deposition	Dan Hannula
Austin Howell		Deposition	Mary Fleck
Javier Gonzales		Deposition	Keith Kessler
Darla Hanten		Deposition	Tom Graham
Charles Bargas		Deposition	Gail Lundgren
Casey Madison		Deposition	Dan Hannula
Vili Fualaau	King County, WA	Deposition and Trial	Cyrus Vance, Jr.
Cheryl Baxter		Deposition	Daniel Hess
Kyle Pruitt		Deposition	Dean Britt
Gene Ping		Deposition	Workman
Nathan Tracy	Spokane County, WA	Deposition	Richard Eymann
Ralph Mennie		Deposition	Jim Rogers
Bernard Baxley	Spokane County. WA	Deposition	Richard Eymann

Case Caption/Parties	Location of Case/Court	Deposition or Trial	Referring Attorney
WesleySteedley		Deposition	Craig Beetham
Jeff Kuntz	Idaho	Deposition and Trial	Paul Luvera
Jesse Magana		Depositon and Trial	Paul Whelan
Lori Bundrick	King County, WA	Deposition and Trial	Mel Crawford
Robert Lay		Deposition	Greg Arpin
Debra Hollis		Deposition	Timothy Lynch
Ronald Langston		Deposition	Gregg Tinker
Julia Simon	Pierce County, WA	Deposition	Paul Luvera
Kirk Marvin		Deposition	Paul Whelan
Scott Geffre	Spokane, WA	Deposition	Paul Luvera
Velma Thompson	King County, WA	Deposition	Brad Moore
William Taylor	Walla Walla County, WA	Deposition	Brian Putra
Brian Judge	Spokane, County, WA	Deposition	Mel Crawford
Thomas Higgins	Spokane County, WA	Deposition and Trial	Nick Scarpelli
Ethan Kennedy	Coeur d'Alene ID	Deposition and Trial	John Allison
Judith Wambach v. Cohen, MD	Anchorage, AK	Deposition	Matt Peterson
Jan Mortlock	Spokane, WA	Deposition	Richard Eymann
David Causey	Anchorage, AK	Deposition	Tim Lynch
John Sutlick	Walla Walla, WA	Deposition and Trial	Dan Huntington
Art Steele	Spokane County, WA	Deposition	Tim Fennessey
Kenneth Taug	Anchorage, AK	Deposition and Trial	Scott Leuning
Kasaundra Corcoran	King County, WA	Deposition	Joel Cunningham
Emlie Clark	King County, WA	Arbitration	Jackie Walsh

Case Caption/Parties	Location of Case/Court	Deposition or Trial	Referring Attorney
Hanford Litigation	Spokane, WA	Deposition	Richard Eymann
Christopher Ratigan	Seattle, WA	Deposition	Paul Whelan
Jerri Lucier	Fairbanks, AK	Trial	Michael Jungreis
Taryn Andrews	Barrow, AK	Trial	M. Engstrom
Mandelin/Carmichael	Seattle, WA	Deposition	James Rogers
Lee Griesbach	Seattle, WA	Deposition	James Rogers
William Bloodworth	Anchorage, AK	Trial	Anna Webb
John Rorvick	Seattle, WA	Deposition	Joel Cunningham
Gus Gioia	Seattle, WA	Deposition	Tom Harris