

UNITED STATES COURT OF FEDERAL CLAIMS

OFFICE OF SPECIAL MASTERS

No. 95-57V

Initially Published on December 18, 2000
Withdrawn and Reissued for Publication on January 3, 2001

DOUG SPENCE and LINDA SPENCE *
as next friends of SARAH KAYE SPENCE, *
a minor, *

Petitioners, *

v. *

SECRETARY OF HEALTH AND *
HUMAN SERVICES, *

Respondent. *

TO BE PUBLISHED

DECISION

MILLMAN, Special Master

Statement of the Case

On April 13, 1998, the undersigned issued an opinion on entitlement in favor of petitioners, Doug and Linda Spence, on behalf of their daughter Sarah Kaye Spence (hereinafter "Sarah"), that DPT significantly aggravated Sarah's pre-existing encephalopathy. Sarah was born with chromosomal

abnormalities and brain anomalies, including heterotopias, and had manifested some degree of developmental delay prior to her vaccination. Within three days of vaccination, Sarah had the onset of uncontrollable seizures, followed by a steady course downward in development and skills, a course worsened by brain resections which her uncontrollable seizure disorder necessitated.

At the time of the hearing on entitlement, December 8, 1997, Drs. Leslie J. Raffel and Peter Kollros testified for respondent, while Dr. Marcel Kinsbourne testified for petitioners.

The hearing on damages took place on February 10 and 11, 2000, with the same experts testifying on the issue of sequelae as had testified concerning entitlement. Respondent did not contest that Sarah's pre-existing condition was significantly aggravated but defended during the damages phase that there were limited sequelae of Sarah's vaccine injury and that her damages were not due to her significant aggravation. Instead, respondent argued that they were due to her chromosomal abnormalities and brain anomalies, including her heterotopias.

Respondent and petitioners spent most of two days of testimony disputing thirty pages of itemized expenses. Respondent insisted that numerous items were not compensable because they were not vaccine-related and refused to give a dollar figure for these items even though, if she lost the defense on sequelae, the undersigned would be awarding damages for these items. As a consequence, for over nine hours spread over two days, the court and counsel went through each and every item because respondent would not present an amount for many of these items.

Respondent, in her posthearing brief at pp. 5-6, states that the burden of apportioning damages is petitioners' and, therefore, since petitioners did not so apportion, they did not satisfy their burden. Respondent stated that the undersigned should award damages that reflect, for instance, the difference in

cost between an institution in which Sarah would have been placed if she had not been vaccinated and the cost of one in which she would have been placed due to the significant aggravation of her condition.

Respondent is in error in ascribing the burden of apportionment to petitioners. That burden belongs to respondent and she did not provide any evidence as to the difference in costs between institutions. It is basic to tort law that once plaintiffs (here, petitioners) are entitled to damages, the burden is on defendant (here, respondent) to apportion damages. Wilkerson v. Secretary, HHS, No. 90-0822V, 1998 WL 106132 (Fed. Cl. Spec. Mstr. Feb. 24, 1998); Costa v. Secretary, HHS, No. 90-1476V, 1992 WL 47334 (Ct. Cl. Spec. Mstr. Feb. 26, 1992), vacated and remanded on other grounds, 26 Cl. Ct. 866 (1992). Here, respondent specifically asserted that a lower cost institution was appropriate for Sarah, but not because of any apportionment. Respondent just preferred that institution (to be discussed below). Similarly, although respondent claimed other items were either not vaccine-related or that Sarah would have had to have had some treatment or therapy anyway, she did not apportion between pre-vaccination and post-vaccination conditions.

The intent of the Vaccine Program cannot be to make recovery of damages harder for petitioners than if they were in normal civil courts by putting the burden of apportionment on petitioners in this Program whereas, in civil courts, the burden is on defendants in tort actions. (The purpose of the Vaccine Act was "to establish a Federal 'no-fault' compensation program," H.R. Rep. No. 908, 99th Cong., 2d Sess. 3 (1986).)

In D'Ambra v. United States, 396 F. Supp. 1180 (D.R.I. 1973), aff'd, 518 F.2d 275 (1st Cir. 1975), the mother of a four-year-old boy killed by a postal truck sued the United States for her consequent psychoneurosis. The court reflected that she would not be able to recover for the psychological portion

of the damage, but defendant never presented proof of the portion of her damage that was psychological rather than physical. Therefore, defendant was liable for the entire amount of her damages. In discussing the shifting of the burden of proving apportionment to defendant, the court stated:

[W]here the negligent infliction of injury aggravates a pre-existing condition or disease, and no apportionment is possible, it has been held that the defendant is liable for the entire damage, i.e., Newbury v. Vogel, 151 Colo. 520, 379 P.2d 811 (1963) (pre-existing arthritic condition); Kawamoto v. Yasutake, 49 Haw. 42, 410 P.2d 976 (1966) (possible prior back problems and an arthritic condition); Blaine v. Byers, 429 P.2d 397 (Idaho 1967) (pre-existing arthritic condition); Matsumoto v. Kaku, 484 P.2d 147 (Hawaii 1971) (pre-existing back pain), Wise v. Carter, 119 So.2d 40 (Fla. App. 1960) (prior injury). The justifications for this principle are, however, different from that used in the multi-collision cases. It is sometimes said that a tortfeasor takes his victim as he finds him. See Blaine v. Byers, supra. Another rationale is that when a prior condition does not cause pain or disability, the injury caused by the tortfeasor is the proximate cause of the pain or disability. Comment. Apportionment of Damages, 49 Denver L.J. 115, 116 (1972) and cases cited therein. See also Newbury v. Vogel, supra.

Id. at 1180.

The D'Ambra court continued:

Where an injury which is indivisible is caused by the negligence of the defendant concurring with an innocent cause, as a force of nature, the defendant is held responsible for the entire injury. Haverly v. State Line & S.R. Co., 19 A. 1013 (Pa. 1890) (fire caused by negligence and wind); Jackson v. Wisconsin Tel. Co., 60 N.W. 430 (Wis 1894) (negligently left wire plus lightning); Long v. Crystal Refrigerator Co., 277 N.W. 830 (Neb. 1938) (defective building plus wind), and where an injury is theoretically divisible and one cause is innocent, the circumstance most analogous to the instant case, the aggravation of pre-existing injury cases constitutes authority for holding the tortfeasor totally liable.

Id.

In Duty v. United States Dep't of Interior, 735 F.2d 1012 (6th Cir. 1984), one of the two plaintiffs in a car accident had a pre-existing abnormal curvature of the spine at the tailbone (known as spondylolisthesis). However, she had not experienced pain from this condition prior to the accident. After

the accident, she experienced substantial pain and suffering. The court held that defendant was liable for all damages proximately resulting from his negligence even though plaintiff's injuries may have resulted from the aggravation of a pre-existing physical impairment. Id. at 1014.

TESTIMONY

In her opening statement, respondent's counsel said she accepts the undersigned's finding of significant aggravation. Tr. at 293. The issue as respondent phrased it was how much significant aggravation occurred in light of Sarah's pre-existing problems. Tr. at 294.

Respondent stated that Sarah should receive compensation for only her seizure disorder, not for her mental retardation or developmental delay. Petitioners, on the other hand, stated that Sarah's seizures were extremely damaging and caused a substantial decrease in her functions. Respondent does not accept that Sarah's subsequent seizures were causally related to her on-Table seizures.

Dr. Marcel Kinsbourne testified first for petitioners. The undersigned previously held that Sarah's seizures were presumptively due to her fourth DPT vaccination. Sarah has had generalized or grand mal seizures of varying lengths up to two hours. She becomes cyanotic due to lack of oxygen. Cyanosis can cause brain damage and, in Sarah's case, they did. Dr. Kinsbourne testified that Sarah's seizures are damaging and life-threatening. She has had three operations and two resections of her brain. Dr. Wheless, Sarah's treating pediatric neurologist, stated that Sarah's seizures are life-threatening. Status epilepticus is very serious and children can die during it. Seizure discharges cause metabolic needs, but the energy is decreased.

Sarah's Table injury caused her seizures. Sarah had a low threshold for seizures because of her heterotopias. Once the seizures began, they perpetuated others. Sarah would have been mentally

retarded in any event, but mental retardation has a wide range from 20 to 80 IQ. At a level of 80 IQ, one is borderline mentally retarded. We do not know how mentally retarded Sarah would have been without the fourth DPT. Thus, we cannot extrapolate how capable she would have been without the vaccination.

Sarah's condition is unique. There are individuals with cases as mild as Sarah's who have not had seizures. Not everyone who has heterotopias has seizures. Sarah did not have seizures until she was 19 months old. According to Dr. Peter Huttenlocher, seizures are most likely to occur later in life, with the average age being 14 years. Sarah had severe seizures in a developing brain. In petitioners' exhibit 32, Dr. Wheless writes in 1997 that he searched the medical literature for abnormalities of the fifth chromosome and found they are not related to seizures. Moreover, on page 309 of the file, which is the second page of Dr. Greenberg's genetic report, line three shows that Sarah's overall findings are less severe than those reported in the literature. Heterotopias are the way her anomaly impairs brain function, but her chromosomal condition is less severe than others. Dr. Wheless cannot apportion between Sarah's damage from her congenital problems and that from her post-vaccinal seizure disorder.

At Sarah's examination at 10 months, she was doing relatively well. With the exception of her gross motor skills (she had hypotonia), she was not considerably below normal. It would be precarious to project her future if she had not had seizures. Thus, where she would have ended up is not predictable. The undersigned so held in my decision on entitlement (that Sarah's phenotype is unique to her). Dr. Kinsbourne agrees. He also agrees with the undersigned's entitlement opinion when I cited Dr. Overhauser who could not provide a list of expected symptoms in the absence of vaccination.

Sarah had a lower threshold for seizures due to her heterotopias. Dr. Wheless could identify particular heterotopias as the foci of her focal seizures. Finding a focus does not mean it is the only one, however. There are multiple foci. It is more dangerous for Sarah to have status epilepticus because of her lowered seizure threshold. Dr. Kinsbourne could not predict when, if ever, Sarah would have seized if she had not received her fourth DPT. Referring to the undersigned's decision on entitlement and my discussion of the Raymond article, Dr. Kinsbourne testified that the onset of seizures later in life leads to a better outcome.

Sarah has had two brain resections and the implantation of a vagal nerve stimulator. Her second brain resection was performed to treat her seizure disorder. Relying on the affidavit of Sarah's special education teacher, Dr. Kinsbourne stated that before the operation, Sarah could walk freely, sit well, and move sideways. After the operation, she was in a wheelchair in which she had to be strapped, had difficulty feeding herself, lost all speech, and had left hemiparesis.

On cross-examination, Dr. Kinsbourne stated that Sarah would have been mentally retarded absent the fourth DPT, but DPT significantly aggravated her condition including her mental functioning. He cannot project her outcome absent the DPT, but she would have been at the high range of mental retardation, about an 80 IQ, and then she could have taken care of herself and worked, such as waiting on tables or pumping gas. Her condition today is moderately to severely mentally retarded (40 to 80 IQ).

At 19 months, Sarah was able to sit and also to cruise. She did have hypotonia. No one can project an IQ from one or two gross motor skills. IQ consists of cognitive, language, and social skills. Doctors usually value the IQ at a later age, such as three years. Sarah's condition has not changed since Dr. Kinsbourne testified in the case on entitlement.

Dr. Kinsbourne disagreed with his earlier testimony in answer to my question that mental retardation and Sarah's therapies are related to the trisomy of her 5P. During the entitlement hearing, he testified that only her seizure disorder was compensable (Tr., p. 105, l. 22, to p. 106, l. 9). Her resections damaged her. Occupational therapy, which addresses fine motor control, is used for her left hemiparesis due to her second resection. Sarah's speech was impaired by her operation and she should have speech therapy. Vocational therapy is inapplicable in this case.

Sarah drools because she has difficulty swallowing. She has had cumulative damage to her brain. Severely retarded people often drool. She is spastic and needs foot splints. She limps. She has weakness due to her left hemiparesis. She is stiff, tense, and weak. She is ten years old and still in diapers due to her severe brain damage. She is helpless and cannot do anything for herself. Her vaccine injury contributed substantially to her current condition because of the nature of her seizure disorder which caused repeated anoxia and required two brain resections.

Respondent's counsel referred to respondent's exhibit U, an article about heterotopias.¹ Eighty-two percent of the 33 patients in the study had recurrent seizures, although most had normal intellectual and motor function. Some presented with mild mental retardation and neurological deficits. Dr. Kinsbourne stated that most had mild seizures which occurred after age three.

Respondent called Dr. Peter R. Kollros, a pediatric neurologist, to testify. He stated that DPT caused Sarah's first seizure. Sarah has severe mental retardation, neurologic impairments, an intractable seizure disorder, a genetic condition associated with mental retardation and developmental delay, bilateral

¹ "Periventricular and subcortical nodular heterotopia. A study of 33 patients," by F. Dubeau, et al., *Brain* 118:1273-87 (1995).

nodular heterotopias, and a neuromigrational defect because of a markedly abnormal anterior temporal lobe (which was excised).

The University of Texas Medical Center did a great deal of epilepsy monitoring on Sarah, which led to her two resections. They put grids on her brain to locate the foci of her seizures which were related to her brain abnormality. Sarah's underlying condition is associated with mental retardation. The reason for the two temporal lobe resections was that the vast majority of Sarah's seizures came from a particular focus. After both surgeries, Sarah's seizure frequency temporarily decreased. However, another seizure focus took over and she resumed seizing.

Sarah has multiple, bilateral heterotopias. The Dubeau article (R. Ex. U) refers to periventricular nodular heterotopias and divides them into two groups: patients 1 through 20 had only nodular heterotopias while patients 21 through 33 had additional subcortical heterotopias. Sarah would have fit into this latter group,² all of whom had seizures and some of whom had seizures very early even at two months of age. Of this sub-group, 100 percent had seizures, although of the entire group of 33 patients, 82 percent had seizures. But the group was normal intellectually and motorically.

² The ages of onset for seizures in patients #21-33 as well as whether they are mentally retarded and, if so, their IQS, is as follows: #21 - age 2, 84 IQ; #22 - age 12, 82 IQ; #23 - age 7; 89 IQ; #24 - age 2; low IQ; #25 - age 12; normal IQ; #26 - 2 months; normal IQ; #27 - age 20; 81 IQ; #28 - age 33; 88 IQ; #29 - age 10; 80 IQ; #30 - age 26; low IQ; #31 - age 5; 89 IQ; #32 - age 21; 64 IQ; and #33 - age 8, 92 IQ. R. Ex. U, pp. 1279-80. The authors state, at p. 1281: "Grey matter heterotopias..., like other neuronal migration disorders, give rise to a broad spectrum of severity, from no clinical symptoms to epilepsy and mild intellectual dysfunction." Only one of the patients had status epilepticus. *Id.* at p. 1283. "The patients had normal or only mildly impaired intellectual development." *Id.* at pp. 1283-84. The average age of onset of epilepsy in the group with subcortical nodular heterotopias (patients #21-33) was 12.2 years. Seven or 53% of this group were developmentally delayed. *Id.* at p. 1284, Table 3. "The mechanisms by which heterotopic grey matter results in seizures are...unclear." *Id.* at p. 1285.

Dr. Kollros testified that Sarah's specific genetic deficit has a highly variable IQ. He does not know how much cyanosis she had from her seizures. In her first year, she did not have any cyanosis. The MRI taken after her first seizure did not show evidence of focal infarction. The early MRIs did not mention her heterotopias, which Dr. Kollros admitted was due to the incompetence of the radiologist reading it. Tr. at 389. Dr. Kollros attributes a substantial amount of Sarah's mental retardation to the trisomy of her 5p. That genetic defect should result in an IQ between 20 and 80. Tr. at 392. Dr. Kollros does not remember if Sarah experienced cyanosis in the second year of her seizure disorder. Her brain abnormalities may have caused her mental retardation.

By the time Sarah had her first seizure, she was not walking, had four words, and was severely globally delayed. By April 29, 1991, at the age of ten months, she could not sit which indicated that she was developmentally delayed. At thirteen months, on July 12, 1991, she sat up when put into a sitting position. Children should be able to maintain a sitting position at seven and one-quarter months. Tr. at 395. Dr. Kollros agrees with Dr. Kinsbourne that in a ten-month-old, calculating IQ is meaningless. At 19 months, Sarah had just begun to cruise, which is normally done at nine months. He thinks Sarah could have had an IQ or a developmental quotient of 47 then.

Dr. Kollros testified that Sarah had a very significant setback after her second brain surgery. Some of her developmental delays were her hemiparesis due to complications from that surgery, and the reason for the surgery was the seizure focus due to a heterotopia. Tr. at 398-99.

The undersigned asked Dr. Kollros if his opinion was that every seizure Sarah had, except for the first ones after her DPT, were due to her pre-existing condition. Tr. at 399. Dr. Kollros answered that he did not know. It was difficult to say, but the University of Texas evaluated Sarah and found that she had

focal seizures that were her predominant form of seizure due to specific abnormalities that were congenital. He thinks a substantial majority of Sarah's seizures were due to her brain abnormalities. "It is almost as severe a seizure disorder had she not had the fourth DPT." Id. He thought it impossible to say when she would have seized absent the DPT, but thought there was no relationship between Sarah's initial post-DPT seizures and her seizures months later.

Dr. Kollros testified that it is better never to have seizures. In rats, there is the concept that one seizure kindles another. Whether this applies to humans is controversial. If it does apply, it is unclear which seizure begins the kindling. He thought there was no evidence that the age of onset made any difference in Sarah's condition. She continued to make developmental progress up to her first brain resection. Today, she is still unable to walk, still babbles, has generalized hypotonia, and a developmental quotient of 33. She is at a nine-month level. Sarah's initial and later seizures did not alter her structural abnormalities. There was no evidence of anoxia after her first seizure.

Dr. Kollros stated that it is most likely that Sarah's subsequent seizures in 1992 were unrelated to her first seizure after her fourth DPT vaccination. Her first seizure was generalized and unrelated to foci due to a heterotopia. Sarah has agenesis of the corpus callosum, a marker for problems in brain development. The majority of people with agenesis of the corpus callosum have developmental delay. Epilepsies due to neuronal migration are often intractable. Sarah's subcortical and periventricular heterotopias are neuromigrational abnormalities. She has multi-focal abnormalities. Her developmental delay is within the range of patients with chromosomal abnormalities. In Dr. Kollros' opinion, Sarah's current condition is no different from her pre-DPT condition except for the signs and symptoms of working that condition out.

On cross-examination, Dr. Kollros admitted that Sarah's phenotype is unique to her and that her seizures are very severe. They would be life-threatening if not treated. It is common for anoxia to accompany status epilepticus seizures. Her second brain resection caused substantial damage to Sarah. The presence of heterotopias in Sarah's brain lowered her seizure threshold.

A skill level of seven to nine months in a ten-month-old does not permit the conclusion of developmental delay. Sarah was not delayed in all areas at the age of ten months. Sarah's social skills at 10 months were not developmentally delayed. But at the age of 19 months, she was not walking or speaking, putting her outside the normal range.

Respondent's second witness was Dr. Leslie Raffel, a pediatric geneticist. She stated that Sarah would have been significantly mentally retarded due just to the partial trisomy of her 5p. She had clear evidence of global developmental delay before the fourth DPT. She did not have a comprehensive examination after the age of ten months, but she had generalized, persistent developmental delay in all areas at 19 months. All of Sarah's symptoms are consistent with her chromosomal abnormality. Too much has been made about mild phenotypes being associated with a smaller duplication of 5p. There is a fair amount of variability.

With the duplication of 5p, the IQ ranges from 20 to 80. In children with the smallest duplications, when reference is made to a milder phenotype, there is a relative absence of facial dysmorphisms, cardiac abnormalities, and intestinal abnormalities. It is not clear that a mild phenotype is unassociated with mental retardation and seizures. It is difficult to tell what is usual, based on the literature of three or four case reports. There is no direct correlation between the amount of duplication and developmental delay. Every child with the smallest duplication has developmental delay. The absence of mental retardation is due to

the very young age of children reported in the literature. There is a recent article describing two older patients with a small duplication of 5 who have only mental retardation with IQS of 65 and 62. A “phenotype” means a clinical manifestation of a genetic problem. Sarah is unique because she has a smaller duplication than others do.

There was good documentation of significant developmental delay before Sarah received her fourth DPT. Sarah’s duplication involves the p15 band which is closest to the end of the short arm of chromosome 5. Medical science is not yet at the point to link clinical signs to the p15 band. People with duplication of the short arm of chromosome 5 (bands p14 and p15) all have developmental delay, facial abnormalities, and cardiac abnormalities. A partial duplication does not involve the entire short arm of chromosome 5p (bands p11 to p15). In all human chromosomes, there is a short arm and a long arm, and they are not symmetric. We do not know the purpose of chromosome 5p. There are hundreds and thousands of genes on every chromosome.

Sarah has two breaks within her chromosome arm, but there are not supposed to be any breaks. Dr. Raffel has not yet had a patient with exactly the same duplication as Sarah. She has had one or two patients with a duplication of chromosome 5 which involved the entire short arm of chromosome 5 and resulted in severe mental retardation and an unusual facial appearance. It is not unusual, however, to have different results. In Down syndrome, in which there is duplication of chromosome 21, 60 percent of the children have congenital heart defects and 40 percent do not. But the chromosome does not explain why there is this difference. One cannot say that there is a particular chromosomal band that correlates to the worst symptoms. People with duplication of the 5p have hypertelorism, large mandibles, a long narrow head (dolichocephaly), and mental retardation. Comparing Sarah’s first 19 months with her first 28 months,

Dr. Raffel testified that based on the literature and Sarah's degree of developmental delay, Sarah exhibited mental retardation, but the exact degree is difficult to identify. There is a small likelihood that she would have had gainful employment any way. She may have been able to be involved in a sheltered workshop had she not had the fourth vaccination.

On cross-examination, Dr. Raffel admitted that there is no rule that more or less chromosomal involvement equates with a better or worse condition.

DISCUSSION

Understanding what the statutory presumption means is integral to understanding the following discussion. Under the Vaccine Act, an on-Table RSD means that the vaccinee had a seizure within three days of her DPT, followed by two afebrile seizures within a year of vaccination. 42 U.S.C. § 300aa-14(b)(2)(B).³

Sarah's first seizure, on-Table, was on January 25, 1992. Her second seizure was in March. Her third was on April 9, 1992 and was afebrile. Her fourth was on November 22, 1992 and was afebrile. The congressional intent as manifested in the Act is that the vaccinee's seizure disorder is caused by the vaccine. That means that Dr. Kollros' attempt to distinguish Sarah's first seizure, due to fever from the DPT, from her subsequent seizures, months later, flies in the face of the presumption Congress created: that DPT caused in fact Sarah's seizure disorder. The undersigned is not at liberty to ignore a statutory

³ Subsequent to the filing of petitioners' petition, the Department of Health and Human Service promulgated regulations, effective Mar. 10, 1995, removing RSD from the Table. See National Vaccine Injury Compensation Program Revision of the Vaccine Injury Table, 60 Fed. Reg. 26,7689-91 (Feb. 8, 1995), codified at 42 C.F.R. 100.3.

presumption. Thus, the undersigned cannot hold that Sarah had a vaccine-caused seizure but her subsequent seizures that year were a different disorder.

Moreover, based on the uncertain testimony of Dr. Kollros (he was not sure whether Sarah's non-DPT-related seizures began in 1992 or 1993) and the more credible testimony of Dr. Kinsbourne (Sarah's seizures were damaging, part of status epilepticus, and related to each other), the undersigned holds that her seizures are all part of one seizure disorder caused by DPT. Petitioners have prevailed on the issue of whether Sarah's seizure disorder, including all of her seizures, stems from her initial seizure post-DPT. But this case does not rest solely on a finding of on-Table RSD. The undersigned has also held that Sarah had on-Table significant aggravation. Sarah's congenital abnormalities made her more susceptible to developing a seizure disorder once DPT triggered the first seizure through a fever. Congress understood that children with pre-existing conditions can become much worse due to vaccine injuries and thus included the category "significant aggravation" among the injuries covered under the Vaccine Act. 42 U.S.C. § 300aa-33(4).

Respondent defends by saying that the seizures are irrelevant to Sarah's mental retardation and developmental delay because her congenital condition (trisomy of 5p and numerous heterotopias) caused them. But respondent's own expert pediatric neurologist, Dr. Kollros, testified that Sarah's resections, done in order to control her intractable seizures, devastated her condition. It is not credible for respondent to say that Sarah's congenital condition is the cause of her mental retardation and developmental delay when Dr. Kollros testified that her resections resulted in her being in a nine-month-old condition, unable to walk, feed herself, or speak, all of which skills she could perform before her resections. This drastic reversal is substantiated in the medical records as well as in the report of Sarah's special education teacher.

Dr. Kinsbourne referred to this in his testimony. Sarah has become a prisoner of her seizure disorder and its consequences.

No one tried to apportion damages between her mental retardation and developmental delay before and after the fourth vaccination. Dr. Kinsbourne did note, however, that although she was delayed prior to the fourth vaccination, Sarah was not terribly delayed and her chromosomal condition was not as serious as her current condition would indicate. She might have maintained a borderline IQ without the effects of the vaccination. Now, she is still in diapers at the age of ten, and helpless. Dr. Kinsbourne testified that, although Sarah might have eventually seized, it is not clear when. If she had seized later in life, her condition would have been better.

The statutory presumption of causation satisfies petitioners' burden that the vaccine caused Sarah to seize. The court holds that Sarah's subsequent seizures are part of her DPT-seizure disorder. Her devastating condition is due to attempts to control her seizure disorder. What remains at issue are Sarah's damages. Respondent does not contest the prior holding of significant aggravation, but refuses to pay for the significantly aggravated condition. (The damages decision of the undersigned is in a separate, unpublished opinion, filed December 21, 2000.)

The undersigned holds that Sarah is entitled to 100 percent of her damages because: (1) she has an on-Table significant aggravation; (2) her on-Table RSD led to her brain resections; (3) her brain resections caused devastating mental retardation and developmental delay, far worse than her condition prior to her fourth DPT vaccination; and (4) once petitioners proved Sarah's damages, respondent did not apportion the damages between her pre- and post-vaccinal conditions.

At the damages portion of the hearing, respondent contested 104 items (consisting of 216 subparts) of compensation. After the hearing, respondent decreased the items in dispute to 65, practically one-third. (She agreed to five other items consisting of 17 subparts, which increased to 22 undisputed items after the hearing.) Apparently, before the hearing, respondent would not work with petitioners on these items. Hence, the educational process of going through a hearing markedly reduced her contentions about items to be compensated. This educational process could have taken place before the hearing if counsel had been willing to work together. It is a waste of everyone's time and money for respondent to avoid the basic job of determining the appropriate cost of requested items. Regardless of respondent's position on sequelae, she should have computed damages in the alternative in case she did not prevail on the issue of sequelae.

One example of this waste of time was respondent's challenge of petitioners' request for wipes. Respondent estimated that Mrs. Spence needs only five wipes a day for Sarah. Mrs. Spence testified that she uses ten wipes a day for Sarah. The undersigned believes that Mrs. Spence is totally credible and, being the daily caregiver for Sarah, knows how many wipes she needs each day. Petitioners stated that the wipes cost \$3.90 for a 46-count box, for an annual total of \$292.00, in Houston, Texas, where they live. Respondent's life care planner contacted CVS pharmacy, which is not in Texas, and came up with a cost of \$4.99 for an 80-count box, for an annual total of \$219.00. The court discussed the issue of whether Mrs. Spence was entitled to an extra \$73.00 per year, or approximately \$6.00 a month, for the cost of wipes based on the highly improbable supposition that Mrs. Spence would do her shopping thousands of miles away from her home. The undersigned has the definite impression that respondent and/or her life care planner Ms. Moss did not make a serious attempt to determine appropriate costs.

The same wasteful exercise concerned Mrs. Spence's request for diapers. Respondent agreed on the cost per diaper, but not on the frequency of diaper replacement. Respondent later conceded the frequency of diaper changes, but not until after the nine-hour hearing. Respondent's life care planner based her figure on the frequency of diaper replacement based on what a normal child would wear. Tr. at 639, ll. 3-4. However, Sarah is not a normal child and uses more diapers. Respondent insisted on paying just for four diapers per day; Mrs. Spence said she needs six. Respondent's life care planner, Ms. Moss, then said, "I can't discount anything that she [Mrs. Spence] is saying because she is with Sarah on a daily basis." Tr. at 642, ll. 16-17. Ms. Moss explained that she looked at bills and counted the diapers arriving at the house, but Mrs. Spence explained that she had an excess of diapers due to the manufacturer's mistaken delivery of too many of them, which explained why she was not ordering the number she needed (because she had a ready supply). If Ms. Moss had just spoken to Mrs. Spence about the discrepancy between what petitioners requested and what the bills seemed to suggest, we could have proceeded without having this item in controversy. The failure to communicate was also obvious in both parties' life care planners' citing a difference of three dollars (\$9.99 versus \$6.49) for maybe 100 pair, or 50 pair, or 25 pair of latex gloves (the planners were not sure). And this was after the life care planners called the same store. This type of inefficiency is inexcusable.

Counsel are officers of the court and are obliged to come to a hearing with the ability to clarify and narrow the issues for the court to decide. That counsel obviously have great antipathy for each other is no justification for failing to function responsibly. Petty bickering over hundreds of items does not serve the purpose of the Vaccine Act "to establish a Federal 'no-fault' compensation program under which awards

can be made to vaccine-injured persons quickly, easily, and with certainty and generosity.” H. Rep. Rep. 99-908, Pt. 1, 99th Cong. 2d Sess. (Sept. 26, 1986), at 3.

The undersigned alerts counsel in this case and future cases that failure to create adequate life care plans is not acceptable. The undersigned has not published counsels’ names in this case. If behavior similar to that demonstrated in this case recurs, the omission of names will not happen in the future.

The undersigned must commend Mrs. Spence for sitting patiently through interminable wrangling over an extraordinary number of items, and responding honestly and with dignity to the many questions sent her way every time respondent doubted an item’s frequency and/or cost.

CONCLUSION

Petitioners are awarded the damages in a separate opinion on that topic.

IT IS SO ORDERED.

DATED: _____

Laura D. Millman
Special Master