In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS

No. 11–580 V
Filed: July 10, 2012
Not for Publication

ROBERT DEVORE and JOEY DEVORE, as parents and natural guardians of LANDEN DEVORE, a minor,	*	
Petitioners,	*	
v.	*	Dismissal; Failure to Prosecute
SECRETARY OF HEALTH AND HUMAN SERVICES,	*	
Respondent.	*	

Robert Devore and Joey Devore, Boynton Beach, FL, for petitioners (pro se).
Lara A. Englund, Washington, DC, for respondent.

MILLMAN, Special Master

DECISION[1]

On September 9, 2011, petitioners filed a petition under the National Childhood Vaccine Injury Act, 42 U.S.C. §§ 300aa-10 to -34 (2006), alleging that their son Landen suffered from a table encephalopathy or encephalitis following his receipt of DTaP, IPV, hepatitis B, Prevnar, HiB, and Rotateq vaccines on September 17, 2008.

Petitioners were initially represented by counsel. On October 26, 2011, the undersigned

[1] Because this unpublished decision contains a reasoned explanation for the special master's action in this case, the special master intends to post this unpublished decision on the United States Court of Federal Claims's website, in accordance with the E-Government Act of 2002, Pub. L. No. 107-347, 116 Stat. 2899, 2913 (Dec. 17, 2002). Vaccine Rule 18(b) states that all decisions of the special masters will be made available to the public unless they contain trade secrets or commercial or financial information that is privileged and confidential, or medical or similar information whose disclosure would constitute a clearly unwarranted invasion of privacy. When such a decision is filed, petitioner has 14 days to identify and move to redact such information prior to the document's disclosure. If the special master, upon review, agrees that the identified material fits within the banned categories listed above, the special master shall redact such material from public access.

held a telephonic status conference in which petitioners' counsel and respondent's counsel participated. The undersigned issued an Order on October 26, 2011, instructing petitioners to request and file medical records relating to Landen's stay at an Arizona hospital in September or October 2008, pregnancy care records, Landen's pediatric records, and updated records after January 2009. Petitioners were to file these medical records by November 28, 2011.

On November 30, 2011, petitioners' counsel filed a Motion for Leave to Withdraw as Counsel of Record. Petitioners' counsel cited petitioners' failure to communicate with him by telephone or letter. For instance, counsel sent a letter to petitioners on October 17, 2011, requesting their assistance in obtaining the updated medical records. Petitioners did not respond to counsel's letter. In his motion, petitioners' counsel requested an Order granting his withdrawal and provided petitioners' respective addresses.

The undersigned granted the Motion to Withdraw in an Order filed on December 1, 2011, directed the clerk of court to remove the case from electronic filing status, and sent a copy of the Order and a copy of the Vaccine Attorney List to petitioners at their respective addresses. The Order instructed petitioners to contact the undersigned's law clerk by January 6, 2012 to schedule a telephonic status conference.

On January 12, 2012, petitioner Robert Devore contacted the undersigned's law clerk and scheduled a status conference for February 2, 2012. At this time, the undersigned did not have a valid phone number for petitioner Joey Devore. The phone number provided by her former counsel did not accept incoming calls. The undersigned issued an Order on January 13, 2012, memorializing the date and time for the status conference and instructing Ms. Devore to provide a new phone number and to call and confirm her availability for the scheduled status conference. Some time before February 2, 2012, Ms. Devore called the undersigned's chambers and provided her correct phone number.

On February 2, 2012, the undersigned held a telephonic status conference in which both petitioners and respondent's counsel participated. The undersigned discussed the need for updated medical records. In addition, petitioners indicated that the Maglio Christopher & Toale law firm was reviewing Landen's medical records and considering whether to represent petitioners. Ms. Devore also provided her current address and updated phone numbers. The undersigned scheduled the next telephonic status conference for Thursday, March 15, 2012, at 11:00 a.m. (EDT). This date and time was chosen with the approval of both petitioners and respondent's counsel and memorialized in an Order filed on February 2, 2012.

On March 15, 2012, petitioners did not appear for the scheduled status conference. Respondent's counsel informed the undersigned's law clerk that Maglio Christopher & Toale had agreed to represent petitioners. The law clerk called the law firm, which confirmed that the firm reviewed the case and sent petitioners a retainer packet. At that time, petitioners had not returned the packet with their signatures.

The undersigned issued an Order on March 15, 2012. The Order stated that if petitioners retained an attorney from Maglio Christopher & Toale, then the attorney will file a motion to substitute the counsel of record. Alternatively, if petitioners did not retain an attorney, then they

were to call the law clerk by March 30, 2012 to schedule another status conference. Petitioners did not contact chambers or file a motion for substitution of counsel.

On May 25, 2012, the undersigned issued an Order to Show Cause, ordering petitioners to contact her law clerk to schedule another telephonic status conference or advise her that they have retained counsel, or risk dismissal of their case for failure to prosecute.

The law clerk called Maglio Christopher & Toale on May 22, 2012. A paralegal informed the law clerk that petitioners had not yet returned the firm's retainer packet. The paralegal confirmed that the addresses that the court has on record are the same addresses that the firm has in their records. The law clerk contacted Maglio Christopher & Toale again on July 10, 2012. A paralegal stated that the firm sent petitioners a letter on March 27, 2012, informing petitioners that the firm was closing their file.

To date, petitioners have neither contacted chambers to schedule another status conference nor have they filed a motion for substitution of counsel.

FACTS

Landen was born on February 25, 2008. Med. recs. Ex. 1, at 1.

On September 17, 2008, Landen received DTaP, IPV, Hepatitis B, Prevnar, Rotateq, and HiB vaccinations. Med. Recs. Ex. 1, at 1.

On December 9, 2008, Landen was admitted to Miami Children's Hospital. Landen presented with developmental delay and hypotonia. His parents stated that Landen does not make eye contact and does not track. Before six months of age, he was standing with support. After six months of age, Landen went limp when encouraged to stand with support. Med. recs. Ex. 4, at 1.

Dr. Oglesby examined Landen and observed that he had a head lag and was hypotonic. Landen was diagnosed with global developmental delay and marked hypotonia. Med. recs. Ex. 4, at 2.

On December 10, 2008, Landen had a brain MRI performed, which was unremarkable. Med. recs. Ex. 4, at 3.

On December 9, 2008, Landen had a neurology consultation with Dr. Sayed Naqvi. Landen's parents gave a history to Dr. Naqvi and explained that before Landen was six months old, he was able to hold his head up and stand. His mother said that Landen never tracked or followed, and both parents noted that since birth, Landen's eyes rolled up and he had staring spells. The parents stated that these were gradually getting more frequent. The parents also reported that after Landen had his immunizations, he seemed slow and lethargic during the flight to Arizona the next day. It was about this time that the parents noticed Landen's regression. He was no longer active, he stopped standing and putting weight on his legs, and he stopped holding his neck up. In the section for Landen's family history, Dr. Naqvi noted that the mother's great

aunt and the father's aunt were diagnosed with mental retardation. Med. recs. Ex. 4, at 17.

In his assessment, Dr. Naqvi stated that Landen had developmental delay, hypotonia, and paroxysmal eye movement. He ruled out seizures and genetic or metabolic disorder. Med. recs. Ex. 4, at 18.

During a genetic consultation on December 10, 2008, the mother gave a history and reported that at six months of age, Landen tracked, was interested, and stood up. The mother said that when Landen was two to three months old, he was able to roll over. She felt that Landen regressed after the six-month vaccinations. Med. recs. Ex. 4, at 20.

During a consultation with Dr. Roberto Warman, an ophthalmologist, on December 10, 2008, Dr. Warman noted that the chart says there are paroxysmal eye movements but that he did not see them. The mother told Dr. Warman that Landen never developed a good fixation. Landen would not blink to light and would not fix or follow during the examination. Med. recs. Ex. 4, at 21.

Landen had an EEG done on December 9, 2008, which was normal. Med. recs. Ex. 4, at 46.

On December 29, 2008, Landen was admitted again to Miami Children's Hospital. Landen presented with a history of developmental delay, hypotonia, visual impairment, micropenis, and undescended testes and a new onset of paroxysmal motor events. The events were described as jerking of arms and legs and rolling back of eyes lasting about 30 seconds with no postictal state and no loss of continence. Landen had about one to two seizures per day for two to three weeks and recently had an increase of frequency to two to three episodes per day. Med. recs. Ex. 5, at 1.

Landen's EEG, performed on December 29, 2008, was normal. The LVEP showed a conduction defect in the visual pathway bilaterally. Pyruvic acid was slight elevated. Stereotypic events consisted of myoclonic jerks of the trunk and extremities with no clear EEG correlate and were likely non-epileptic in nature. Med. recs. Ex. 5, at 1.

Landen had an ophthalmic consultation on January 26, 2009 with Dr. Hilda Capo. Dr. Capo's impression was that Landen had a cerebral visual impairment or possibly a delayed visual maturation, severe developmental delay with hypotonia, bilateral astigmatism, and intermittent esotropia. Med. recs. Ex. 7, at 1.

Petitioners have not filed medical records more recent than January 2009.

DISCUSSION

To satisfy their burden of proving causation in fact, petitioners must prove by preponderant evidence: "(1) a medical theory causally connecting the vaccination and the injury; (2) a logical sequence of cause and effect showing that the vaccination was the reason for the injury; and (3) a showing of a proximate temporal relationship between vaccination and injury."

Althen v. Sec'y of HHS, 418 F.3d 1274, 1278 (Fed. Cir. 2005). In Althen, the Federal Circuit quoted its opinion in Grant v. Sec'y of HHS, 956 F.2d 1144, 1148 (Fed. Cir. 1992):

> A persuasive medical theory is demonstrated by "proof of a logical sequence of cause and effect showing that the vaccination was the reason for the injury[,]" the logical sequence being supported by "reputable medical or scientific explanation[,]" i.e., "evidence in the form of scientific studies or expert medical testimony[.]"

Without more, "evidence showing an absence of other causes does not meet petitioners' affirmative duty to show actual or legal causation." Grant, 956 F.2d at 1149. Mere temporal association is not sufficient to prove causation in fact. Id. at 1148.

Moreover, a special master may not find that a petitioner is entitled to compensation "based on the claims of a petitioner alone, unsubstantiated by medical records or by medical opinion." 42 U.S.C. § 300aa–13(1).

Petitioners must show not only that but for the vaccines, Landen would not have had developmental delay and hypotonia, but also that the vaccines were a substantial factor in bringing about Landen's injury. See Shyface v. Sec'y of HHS, 165 F.3d 1344, 1352 (Fed. Cir. 1999).

Since the February 2, 2012 status conference over five months ago, petitioners have failed to prosecute their case. Petitioners did not appear for a scheduled court proceeding and did not respond to the undersigned's March 15, 2012 Order or her May 25, 2012 Order to Show Cause. Since the initial filing of the petition, petitioners have not filed updated medical records or the complete medical records from Landen's September or October 2008 visit to Yavapai Regional Medical Center in Prescott, AZ. Finally, the undersigned specifically stated in her May 25, 2012 Order to Show Cause that if petitioners did not contact the law clerk by June 26, 2012, then their case would be dismissed.

CONCLUSION

Petitioners' petition is **DISMISSED** for failure to prosecute and failure to make a prima facie case. In the absence of a motion for review filed pursuant to RCFC Appendix B, the clerk of the court is directed to enter judgment herewith.[2]

IT IS SO ORDERED.

Dated: _____

_____
Laura D. Millman
Special Master

[2] Pursuant to Vaccine Rule 11(a), entry of judgment can be expedited by each party's filing a notice renouncing the right to seek review.