OFFICE OF SPECIAL MASTERS
No. [redacted]
[redacted], 2006
Not to be Published

JANE DOE, parent of JOHN DOE, a minor,	*	
	*	
Petitioner,	*	
	*	
v.	*	Entitlement decision; failure to file supportive medical records and expert medical opinion that vaccine injury lasted more than six months
	*	
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	
	*	
Respondent.	*	

DECISION[1]

Petitioner filed a petition on September 23, 2005 under the National Childhood Vaccine Injury Act, 42 U.S.C. § 300aa-10 et seq., alleging that her son John Doe (hereinafter, "John") suffered a reaction to one or more of his vaccinations, resulting in epilepsy, developmental delay, and autism. Petitioner proceeded throughout the case pro se. Petitioner stated in her e-mail attached to the undersigned's Order of September 20, 2006 that she is withdrawing her suit. The undersigned offered respondent the opportunity to file a Rule 4(c) Report and to offer settlement.

[1] Because this decision contains a reasoned explanation for the special master's action in this case, the special master intends to post this 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 clearly be an unwarranted invasion of privacy. Since petitioner previously requested redaction of the undersigned's Order of September 19, 2006, the undersigned assumes that petitioner similarly wants this decision redacted and the undersigned will redact this decision in its electronic version. The caption will read Jane Doe, parent of John Doe, a minor.

On October 6, 2006, respondent filed a Rule 4(c) Report and Motion to Dismiss. The undersigned grants respondent's motion.

FACTS

John was born on August 2, 2001. Med. recs. at 1.[2] On that date, at Paradise Valley Hospital, he was noted to have failure to progress. Med. recs. at 3.

On April 23, 2002, John saw Dr. Leonard M. Kornreich for cracking in his shoulders and elbow. Dr. Kornreich stated John was normal neurologically and a well child. Med. recs. at 14.

On July 11, 2002, John saw Dr. Kornreich. For a week or so, John had had a rash. He had diarrhea while on regular milk. John was significantly obese and had a viral syndrome (diffuse exanthem on trunk, arms, legs, and buttocks with some papular vesicles). Med. recs. at 18.

On July 31, 2002, John saw Dr. George H. Madany who stated that John's red rash came and went. Med. recs. at 19.

On September 23, 2002, John received his fourth acellular DPT vaccination, his fourth HiB vaccination, his first MMR vaccination, his third hepatitis B vaccination, and varicella vaccine. Med. recs. at 15, 17.

Three days later, on September 26, 2002, John saw Dr. Kornreich, who was under the impression that John's vaccinations (MMR, Varivax, DTaP, and Comvax) occurred four days previously, instead of three days. John had a sore arm, a low-grade temperature, and crankiness starting the previous night (two days post-vaccination). Dr. Kornreich's impression was a viral

[2] Because petitioner did not number the pages of the medical records she filed, the undersigned numbered her own copy. The original court copy will, of course, remain unnumbered. The undersigned encouraged the parties to number their own copies as well.

syndrome and a local reaction probably to the acellular DPT (John's skin had a mild exanthum, macular, of the trunk, both anterior and posterior). Med. recs. at 19.

On October 2, 2002, John was in Children's Hospital and Health Center. Dr. Arit Mbagwu stated that John had a fever starting that night. He had a rash and low-grade fever after vaccination. The rash lasted five days. It started three days after vaccination. He also had a red rash over the vaccine site on his right shoulder. That night, he had fever and non-stop crying. He had a temperature maximum of 103.4 degrees. He had a blister on his upper lip three days previously. On physical examination, John was alert and playful. He had very tiny, mild sparse blanching papules mostly on his trunk. Med. recs. at 27. John's neurologic examination was normal. *Id.* Dr. Mbagwu's impression was fever and rash. Med. recs. at 28.

On March 31, 2003, John was in Children's Hospital with a rash for two days on his legs, arms, and mouth. He was afebrile. He had eczema then. The rash had started on his legs and spread to his face. Med. recs. at 36.

On June 16, 2003, John had a chest x-ray because of abnormal breathing. The x-ray, according to Dr. Darryl Evora, was normal. Med. recs. at 33.

On July 17, 2003, at 8:56 p.m., John was in Children's Hospital and Health Center. He had an audio analysis and was diagnosed with global developmental delays, including significant speech and language delays. He had a vocabulary of only a few words, combined with gestures, pointing and grabbing. John's mother's pregnancy was complicated by gestational diabetes and large birth weight. John also had gastroesophageal reflux. His hearing behavior was inconsistent. Med. recs. at 34. He had normal hearing for the better ear. John had no problem localizing at threshold levels in the sound field for all tonal and speech stimuli, suggesting

grossly symmetric hearing between ears. He would not tolerate inserts or head phones. Med. recs. at 35.

On June 21, 2004, John had an EEG which was abnormal. He had multifocal frequently-occurring epileptiform discharges from either his temporal or centrotemporal region during sleep. Dr. William Lewis wrote John had the potential for seizures. Med. recs. at 32.

On January 31, 2005, John saw Dr. M.T. Bailony. He had a fever for three days and vomited the day before. His past history included developmental delay, autism, chromosomal inf (the undersigned does not know what "inf" means), mild distention of his abdomen, and short stature. Dr. Bailony's impression was otitis media (ear infection). Med. recs. at 37.

Statement of the Case

The undersigned held the first telephonic status conference on November 4, 2005, during which the undersigned asked Mrs. Doe if she were going to obtain an attorney. The undersigned explained that the pressures of litigating the case would be easier for her if she retained an attorney, but she had the right to continue pro se. The undersigned asked if there were other medical records which she had not yet filed and she admitted there were, but she did not like the information in them; they made her uncomfortable. She stated that John got better but was still autistic. She thinks he had encephalitis. He developed epilepsy.

The undersigned issued an Order dated November 15, 2005, ordering petitioner to file all medical records and test results which she had not previously filed. Petitioner was to telephone the undersigned's law clerk by December 15, 2005 to inform her if she had retained an attorney and, if so, who that person was.

The undersigned issued another Order, dated December 19, 2005, because petitioner did not telephone the undersigned's law clerk by December 15, 2005 and did not file any more medical records or test results. The undersigned gave petitioner until January 6, 2006 to telephone her law clerk and advise her whether or not she had retained an attorney, and ordered petitioner to file all outstanding medical records and test results.

Petitioner sent a letter dated December 14, 2005, stating she did not know the telephone number of the undersigned's law clerk. She stated that she had not retained an attorney but would be contacting one "since it is obvious my son's case requires attention to liability matters." It would take some time for her to secure her son's medical records. She stated she was forced to travel to specialists around the country to meet her son's medical needs. The undersigned filed this letter by her leave attached to an Order dated January 5, 2006. The undersigned put in the Order the name of Professor Peter Meyers and his telephone number because he has a legal clinic that has represented pro se petitioners before. The undersigned also included the undersigned's clerk's telephone number.

Petitioner sent a letter dated January 6, 2006 to the undersigned which was filed on January 17, 2006. She stated that she was traveling in pursuit of medical treatment for John. She brought with her information that she would forward to the court (but never did). She agreed that seeking legal help was a good idea but thought that the evidence in the record was enough to show that John was in a possibly compromised immune state before his September 23, 2002 vaccinations. She stated John tested positive for HHV-6 (human herpes virus 6), and that John had been improperly vaccinated since he was six months of age. Since her theory was that he had a weak immune system, he should not have received live viral vaccines. She reiterated that

enough evidence existed in the record (there is nothing in the record that John has HHV-6 or a compromised immune system) to provide enough proof in this claim. She stated she had acquired a few more records after the ones she filed (but she still did not file them). She concluded that she would forward to the undersigned the possibility of legal help to ease the burden.

On March 9, 2006, the undersigned issued an Order stating that the undersigned's law clerk had made repeated attempts to reach petitioner by phone but the number petitioner provided was out of service. The undersigned set a status conference for March 17, 2006 at 3:00 p.m. (EST). Prior to the conference, petitioner was to telephone the undersigned's law clerk with her current telephone number. The undersigned included the law clerk's number (this being the third Order in which that number was included).

On March 20, 2006, the undersigned issued an Order reflecting that petitioner did not contact the court with a new telephone number and the status conference set for March 17, 2006 was not held. In petitioner's January 19, 2006 letter, petitioner stated she was obtaining an e-mail address and would furnish the court with this information. She did not provide this information. The undersigned set a new status conference for May 19, 2006 at 3:00 p.m. (EDT). If petitioner failed to communicate with the undersigned or appear at the May 19, 2006 telephonic status conference, the undersigned would have no option but to dismiss this case. The undersigned again encouraged petitioner to seek legal representation.

On May 19, 2006, the undersigned held a telephonic status conference with the parties. Petitioner stated she was in Texas. John had arthritis in his shoulders and ankles. Petitioner stated she wanted an annuity.

On May 22, 2006, the undersigned issued an Order giving petitioner until June 19, 2006 to e-mail or call the undersigned's law clerk regarding whether or not she had found an attorney to handle her case.

On June 27, 2006, the undersigned issued an Order stating that petitioner did not contact the undersigned's law clerk by June 19, 2006. On June 26, 2006, the undersigned's law clerk telephoned petitioner to discuss whether petitioner had retained counsel, and petitioner informed the law clerk that she had not done so and that she was considering withdrawing her petition, but would not make that decision until she had spoken to an attorney. The undersigned ordered petitioner to contact the undersigned's law clerk by July 14, 2006 regarding whether or not she had retained counsel and, if not, whether she would be withdrawing her petition.

On July 14, 2006, the undersigned's June 27, 2006 Order was returned to the court as undeliverable. On July 20, 2006, the undersigned's law clerk left petitioner a message on her cellular phone, asking that she contact the court. Petitioner did not do so. Petitioner did not file any additional records after January 17, 2006.

On August 1, 2006, the undersigned's law clerk telephoned petitioner again, asking she provide the court with a new mailing address, and sending an e-mail to the parties, describing her attempts to reach petitioner and asking petitioner to contact the court as soon as possible. Petitioner did not contact the court. The undersigned gave petitioner a deadline of September 15, 2006 to contact the undersigned's law clerk or this case would be dismissed.

On September 18, 2006, petitioner e-mailed a lengthy message to the undersigned's law clerk, stating that there was a conspiracy against her, that the undersigned had insisted she retain an attorney or she would not succeed in her case, and that there was sufficient evidence in the

record to rule for petitioner. The undersigned's law clerk e-mailed petitioner to reply that she was not obligated to retain an attorney in order to prevail in this case.

DISCUSSION

To satisfy her burden of proving causation in fact, petitioner must offer "(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. Secretary of HHS, 418 F. 3d 1274, 1278 (Fed. Cir. 2005). In Althen, the Federal Circuit quoted its opinion in Grant v. Secretary 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[.]"

In Capizzano v. Secretary of HHS, 440 F.3d 1317, 1325 (Fed. Cir. 2006), the Federal Circuit said "we conclude that requiring either epidemiologic studies, rechallenge, the presence of pathological markers or genetic disposition, or general acceptance in the scientific or medical communities to establish a logical sequence of cause and effect is contrary to what we said in Althen...."

Close calls are to be resolved in favor of petitioners. Capizzano, supra, at 1327; Althen, supra, at 1280. *See generally*, Knudsen v. Secretary of HHS, 35 F.3d 543, 551 (Fed. Cir. 1994).

Without more, "evidence showing an absence of other causes does not meet petitioners' affirmative duty to show actual or legal causation." Grant, supra, at 1149. Mere temporal

association is not sufficient to prove causation in fact. Hasler v. US, 718 F.2d 202, 205 (6th Cir. 1983), cert. denied, 469 U.S. 817 (1984).

Petitioner must show not only that but for the vaccine, John would not have had autism, epilepsy, developmental delay, and immune deficiency, but also that the vaccine was a substantial factor in bringing about his various illnesses. Shyface v. Secretary of HHS, 165 F.3d 1344, 1352 (Fed. Cir. 1999).

The Federal Circuit stated in Althen, supra, at 1280, that "the purpose of the Vaccine Act's preponderance standard is to allow the finding of causation in a field bereft of complete and direct proof of how vaccines affect the human body."

The Federal Circuit in Capizzano emphasized the opinions of petitioner's four treating doctors in that case. 440 F.3d at 1326.

What petitioner needed to prevail in this case was evidence to support her allegations either from the medical records or from expert medical opinion. The Vaccine Act states, at 42 U.S.C. § 300aa-13(a)(1):

> The special master ... may not make such a finding [in favor of petitioner] based on the claims of petitioner alone, unsubstantiated by medical records or by medical opinion.

The records do support that John had a reaction to his DPT (not his measles) vaccination because Dr. Kornreich thought John's rash was due to a viral syndrome and a local reaction to DPT. But there is nothing in these records to support that any doctor thought that John's epilepsy, autism, developmental delay, or chromosomal inf (whatever that is) were due to his DPT reaction. Of note, John had a persistent rash two months before he received his September 23, 2002 DPT vaccination. Petitioner stated John had an immune deficiency, but did not provide

a medical record or an expert medical opinion to support her claim. He may indeed have had a reaction to his MMR vaccination, but no medical record or expert medical opinion supports that. Petitioner, in addition, has not filed a medical record or expert medical opinion that if John reacted to his MMR vaccination, that reaction caused autism, epilepsy, developmental delay, or immune deficiency. She asserted that his six-month vaccinations caused immune deficiency, but provides no medical record or expert medical opinion to support that allegation.

The Vaccine Act requires that for petitioner to prevail, a vaccine injury must last more than six months. 42 U.S.C. § 300aa-11(c)(1)(D)(i). There is nothing in the medical records petitioner filed that shows that John's vaccine reaction to DPT, which is the only reaction the medical records support and which also identified the cause being due to a viral syndrome, lasted more than six months.

On October 2, 2002, when John was hospitalized, his neurological examination was normal. This does not support petitioner's claim that John had encephalitis, epilepsy, autism, or developmental delay at that time. The undersigned does not know when John developed autism and developmental delay. The undersigned does not know if John ever had encephalitis or epilepsy, although his abnormal EEG June 21, 2004 suggests he had the potential for seizures.

The earliest medical record reflecting John's neurological abnormality is dated July 3, 2003, over nine months after John received the September 2002 vaccinations. Petitioner is well aware that there are numerous medical visits, hospitalizations, and test results that she did not file. She claimed there are lies in the medical records. The absence of medical records is not helpful to her case.

The undersigned can understand how distressing and tragic it can be to have an ill child whose illness persists. The undersigned has continually tried to get petitioner to function in this matter. The undersigned has issued eight Orders attempting to get petitioner to be willing to discuss this case with the court and respondent's counsel. Petitioner has been unwilling to meet telephonically with the court and respondent's counsel since the May 19, 2006 status conference. She communicated her frustration but not her participation. She expressed the desire to withdraw her petition.

Petitioner has not made a prima facie case of causation in fact and her petition must be dismissed.

CONCLUSION

This petition is dismissed with prejudice. In the absence of a motion for review filed pursuant to RCFC Appendix B, the clerk of the court is directed to enter judgment in accordance herewith.[3]

IT IS SO ORDERED.

_____ _____

DATE Laura D. Millman
Special Master

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