OFFICE OF SPECIAL MASTERS
No. [redacted]
Originally issued [redacted] 2006

* *
JANE DOE, parent of JOHN DOE, a minor, *
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Petitioner, *
*
v. * Failure to participate in
* filing medical records and
SECRETARY OF THE DEPARTMENT OF * expert medical opinion
HEALTH AND HUMAN SERVICES, *
*
Respondent. *
* *

ORDER[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 S. Doe (hereinafter, "John") suffered a reaction to one or more of his vaccinations, resulting in epilepsy, developmental delay, and autism. Petitioner has rejected the idea of obtaining an attorney to represent her son's interests and has proceeded throughout the case pro se.

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[1] Because this order contains a reasoned explanation for the special master's action in this case, the special master intends to post this order 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. When such a decision or designated substantive order is filed, petitioner has 14 days to identify and move to delete 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 delete such material from public access. On September 20, 2006, petitioner so moved, the undersigned granted her motion, and posts the Order now in redacted form.

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 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.

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[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.

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 result of thte 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 is 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 states that she is traveling in pursuit of medical treatment for John. She brought with her information that she would forward to the court (but never has). She agreed that seeking legal help was a good idea but thinks that the evidence in the record is enough to show that John was in a possible compromised state before his September 23, 2002 vaccinations. She states John tested positive for HHV-6 [human herpes virus 6], and that John was improperly vaccinated since he was six months of age. Since her theory is that he has a weak immune system, he should not have received live viral vaccines. She reiterates that enough evidence exists 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 states she has acquired a few more

records after the ones she filed (but she still has not filed them). She concludes that she will forward to the undersigned the possibility of legal help the 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 had not provided 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 regarded 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 has not filed any additional records since 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.

What petitioner needs to prevail in this case, and what she had needed from the very beginning of this case, is 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. Dr. Kornreich thought his rash was due to 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 states John has an immune deficiency, but does not provide a medical record or an expert opinion to support her claim.

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 (which was identified as viral syndrome and local reaction to DPT) 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 suspect vaccinations. Petitioner is well aware that there are numerous medical visits, hospitalizations, and test results that she has not filed. She claims there are lies in the medical records. This is not helpful to her case.

The undersigned has seen the photographs petitioner has filed of John as a toddler. He is adorable. The undersigned can understand how distressing and tragic it can be to have an ill child whose illness persists. The need to treat John's legal case seriously is one reason for petitioner to retain an attorney, a reason petitioner herself realized months ago but from which she has now turned away. Perhaps petitioner does not comprehend that she is not to pay the attorney any fee, but that the attorney's fees will be paid at the end of the case whether or not she prevails. (The attorney may seek costs from petitioner however, but these will be reimbursed at the end of the case).

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. It is now four months later. She has communicated her frustration but not her participation. She still will not file a complete set of medical records or an expert medical opinion.

There are only two courses left if petitioner fails to file more medical records and an expert opinion supporting her allegations: (1) respondent may consider if a litigative risk settlement would be appropriate in this case, or (2) if respondent does not regard settlement as appropriate, the undersigned will dismiss this case.

Respondent is ORDERED to file a report by October 10, 2006, stating whether respondent is seeking to settle this case. The undersigned is aware that respondent has not yet filed a Rule 4 Report. If respondent prefers to file a Rule 4 Report in conjunction with a response to the undersigned's settlement query, respondent may do so, but the undersigned is not ordering respondent to file this report because of the obviously missing medical records and expert report in this case.

IT IS SO ORDERED.

______________________ ___________________________
DATE Laura D. Millman
Special Master