OFFICE OF SPECIAL MASTERS

Filed: October 4, 2005

LORI MATULA, as parent and legal representative of her minor son, PAUL MATULA,	*	
Petitioner,	*	
v.	*	No. 02-1743V
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	
Respondent.	*	

Lori Matula, Streamwood, Illinois, pro se.

Melonie J. McCall, United States Department of Justice, Washington, D.C., for Respondent.

DECISION[1]

SWEENEY, Special Master

On November 27, 2002, Lori Matula, as the parent and legal representative of her son Paul Matula ("Paul"), filed a petition for compensation under the National Childhood Vaccine Injury Act ("Vaccine Act"). 42 U.S.C. § 300aa-1 to -34 (1991 & Supp. 2002). The petition alleges that Paul received a measles, mumps, and rubella ("MMR")[2] vaccination on December 6,

[1] The court encourages the parties to review Vaccine Rule 18, which affords each party 14 days to object to disclosure of (1) trade secrets or commercial or financial information that is privileged or confidential or (2) medical information that would constitute "a clearly unwarranted invasion of privacy."

[2] The MMR vaccine is "a combination of live attenuated measles, mumps, and rubella viruses, administered subcutaneously for simultaneous immunization against measles, mumps, and rubella." Dorland's Illustrated Medical Dictionary, 1999 (30th ed. 2003).

1999, and between five and fifteen days later, suffered an encephalopathy[3] or encephalitis.[4] But, despite repeated efforts by the special master to communicate with her, petitioner has failed or refused to make any contact with the court. Because petitioner has declined to communicate with the court, this case cannot move forward, and as a direct consequence, the special master is compelled to dismiss the case for failure to prosecute.

Background

Paul was born on September 18, 1998.[5] Pet. at 1; Pet. Aff. at 1. Prior to the MMR vaccination at issue in this case, Paul was a generally healthy child. See Pet. Ex. 3 at 313-17, 319.

On December 6, 1999, after being declared a healthy child, Paul received MMR, oral polio virus ("OPV"),[6] hepatitis B,[7] and Tetramune[8] vaccinations at the office of Stephen M. Sproul, M.D., in Arlington Heights, Illinois. Pet. at 1; Pet. Aff. at 3; Pet. Ex. 3 at 308.

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[3] Encephalopathy is a term used to describe "any degenerative disease of the brain." Dorland's Illustrated Medical Dictionary, supra note 2, at 610.

[4] Encephalitis is the "inflammation of the brain." Dorland's Illustrated Medical Dictionary, supra note 2, at 608.

[5] All references to the Petition shall be designated herein as "Pet. at __." All references to the pertinent Petitioner's Exhibit shall be designated herein as "Pet. Ex.__ at __." All references to Petitioner's Affidavit, filed June 27, 2003, shall be designated herein as "Pet. Aff. at __."

[6] The OPV vaccine is "a live vaccine containing attenuated poliovirus . . . and used for immunization against poliomyelitis; administered orally." Dorland's Illustrated Medical Dictionary, supra note 2, at 2000.

[7] The hepatitis B vaccine is "a noninfectious viral vaccine derived by recombination from hepatitis B surface antigen and cloned in yeast cells; administered intramuscularly for immunization of children and adolescents and of persons at increased risk for infection." Dorland's Illustrated Medical Dictionary, supra note 2, at 1999.

[8] Tetramune is the brand name for a combination diphtheria, tetanus, and pertussis ("DTP") and haemophilus influenzae type b ("Hib") vaccine. Dorland's Illustrated Medical Dictionary, supra note 2, at 1890. The DTP vaccine is "a combination of diphtheria toxoid, tetanus toxoid, and pertussis vaccine; administered intramuscularly for simultaneous immunization against diphtheria, tetanus, and pertussis." Id. at 1998. The haemophilus influenzae type b vaccine protects against infection by the haemophilis influenzae type b bacterium. Id. at 1999.

According to Ms. Matula, on December 11, 1999, she and two of her children, including Paul, attended a family birthday party. Pet. Aff. at 3. At the party, Ms. Matula and her brother and sister "noticed something different about Paul; he was bucking his head a lot and he stopped making eye contact with me. He was walking in circles." Id. Ms. Matula's brother and sister advised her that Paul was probably going through a stage and that she should wait until after the holidays to take him to see a physician. Id.

Around Christmas, Ms. Matula took her children to her brother's house. Id. Ms. Matula's sister-in-law told her that she thought that Paul was "considerably different" and suggested that Ms. Matula call a physician. Id. Thus, Ms. Matula called a physician's office on December 27, 1999, and spoke with a nurse. Id. She explained to the nurse that she believed that Paul had a reaction to his MMR vaccination but the nurse discounted the possibility. Id. Ms. Matula believed that the nurse became very defensive when she mentioned the vaccination. Id.

Ms. Matula did not take Paul to see a physician until February 28, 2000, when Dr. Sproul performed Paul's eighteen-month examination.[9] Pet. Ex. 3 at 321. Dr. Sproul noted there were concerns about Paul's speech (he had not spoken any words) and repetitive behaviors. Id. Dr. Sproul referred Paul for an assessment regarding his developmental delay, but otherwise assessed Paul as healthy. Id.

Paul was evaluated at the Maine Township Early Intervention Center on March 20, 2000, and April 3, 2000, because of concerns about possible autism. Pet. Ex. 6 at 393. At these evaluations, Ms. Matula speculated that Paul's symptoms had occurred since his December 6, 1999 vaccinations. Id. The evaluators noted that Paul was developmentally delayed. Id. at 394.

On April 14, 2000, Paul was evaluated by Dana M. Brazdziunas, M.D., at Loyola University Medical Center's Behavioral/Developmental Clinic. Pet. Ex. 5 at 386-90. Ms. Matula reported concerns about Paul having speech delays, walking in circles, hitting himself, banging his head against a wall, and having poor eye contact. Id. Paul also had changed from a child who enjoyed being cuddled to one who did not like being touched. Id. at 386. Ms. Matula reported that the problems began occurring about two weeks after his MMR and OPV vaccinations. Id. No seizures were reported at this evaluation. Id. at 387. Dr. Brazdziunas diagnosed Paul as having infantile autism and recommended "chromosomes, fragile X, DNA,

[9] Ms. Matula explains that a contributing factor to why she did not "seek emergent medical care for Paul when I noticed the symptoms that Paul exhibited after receiving his MMR immunization" was that due to certain unfortunate and ongoing events in her life, she was in "a mental and emotional state involving impaired judgment that adversely affected [her] ability to care well for Paul during the first few years of his life." Pet. Aff. at 1.

liver function testing, a CBC, as well as lead testing."[10] Id. at 389. Dr. Brazdziunas did not recommend an electroencephalogram ("EEG")[11] or magnetic resonance image ("MRI").[12] Id. at 389-90.

On April 28, 2000 Dr. Sproul saw Paul for a probable developmental delay and a questionable episode of seizure. Pet. Ex. 3 at 322. Ms. Matula reported that for the first time, that morning, Paul had a ten-second episode in which he was on his hands and knees and seemed to be shaking all over. Id. Afterwards, Paul was limp and tired and urinated all over. Id. Dr. Sproul referred Paul to see a pediatric neurologist. Id.

Thus, on May 10, 2000, Michele Metrick, M.D., evaluated Paul at the Lutheran General Children's Hospital's Pediatric Neurology Clinic. Pet. Ex. 3 at 323-25. Dr. Metrick noted that Ms. Matula reported a possible seizure and in retrospect, remembered five similar spells at age 15-16 months. Id. at 323. Ms. Matula also reported that Paul had personality changes shortly after the first seizure. Id. Dr. Metrick recommended tests to rule out an inborn error of metabolism, as well as an EEG and MRI of the brain. Id. at 325.

Paul underwent a brain MRI on May 12, 2000. Pet. Ex. 1 at 5-6. The MRI revealed multiple regions of abnormal signal within the gray and white matter, indicating a differential diagnosis of tuberous sclerosis,[13] mucopolysaccharidosis,[14] and lipid storage disease.[15] Id. at 6.

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[10] The results of the chromosome test were normal on May 16, 2000. Pet. Ex. 3 at 333. Further, on July 5, 2005, the genetics department at Lutheran General Children's Hospital indicated that the blood sample for the fragile X test had to be redrawn because of the insufficiency of the prior sample. Pet. Ex. 4 at 371.

[11] An EEG is "a recording of the potentials on the skull generated by currents emanating spontaneously from nerve cells in the brain. . . . Fluctuations in potential are seen in the form of waves, which correlate well with different neurologic conditions and so are used as diagnostic criteria." Dorland's Illustrated Medical Dictionary, supra note 2, at 596.

[12] An MRI is "a method of visualizing soft tissues of the body by applying an external magnetic field that makes it possible to distinguish between hydrogen atoms in different environments." Dorland's Illustrated Medical Dictionary, supra note 2, at 908.

[13] Tuberous sclerosis is a genetic disease characterized by benign tumor-like nodules in the brain ("tubers"), retina, and organs, along with mental retardation, seizures, and benign epithelial tumors. Dorland's Illustrated Medical Dictionary, supra note 2, at 29, 812, 1669, 2049.

[14] Mucopolysaccharidosis is "[a]ny of a group of . . . diseases resulting from defects in degradation of the glycosaminoglycans . . . , which are then excreted in the urine and accumulate in the tissues, affecting the bony skeleton, joints, liver, spleen, eye, ear, skin, teeth, and the cardiovascular, respiratory, and central nervous systems." Dorland's Illustrated Medical

Paul returned to see Dr. Sproul on June 12, 2000, with a chicken pox-like rash. Pet. Ex. 3 at 327. However, at a follow-up examination on June 27, 2000, Dr. Sproul noted that the rash was not chicken pox, but was instead an atopic dermatitis.[16] Id. at 328.

On July 11, 2000, Paul returned to Dr. Metrick for a follow-up examination of the seizures and autism. Id. at 330. Dr. Metrick noted that Paul had remained seizure-free with the exception of some staring episodes. Id. Dr. Metrick observed that Paul was less verbal and appeared more anxious. Id. Further, Paul was awake and alert but had poor eye contact. Id. Dr. Metrick recommended a CT scan and tests to rule out mucopolysaccharidosis and a lipid storage disease.[17] Id. at 331. Finally, Dr. Metrick noted that Paul had not had the recommended EEG but would have one in the near future. Id.

Paul had the brain CT scan on July 17, 2000. Pet. Ex. 1 at 7. The CT scan showed abnormal regions of low density in the white matter but not the abnormalities seen in the grey matter in the MRI. Id.

In August 2000, Paul had another brain MRI. Pet. Ex. 7 at 408. Then, on September 7, 2000, Dr. Brazdziunas called Ms. Matula and informed her that Paul had multiple lesions in his brain in both the white and gray matter, and that the etiology of the lesions was not clear despite multiple tests. Id. at 405. Dr. Brazdziunas explained that she wanted a second opinion. Id.

The second opinion was sought at the Loyola University Outpatient Center on June 1, 2001. Id. at 406. Paul underwent a brain MRI on June 21, 2001. Id. at 428-29. The MRI revealed type I Chiari's malformation[18] with compression of the lower brain stem. Id. at 412,

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Dictionary, supra note 2, at 1179.

[15] Lipid storage disease, also called lipidosis, is "[a] term for several of the . . . diseases in which there is an abnormal accumulation of lipids in the reticuloendothelial cells." Dorland's Illustrated Medical Dictionary, supra note 2, at 1055.

[16] Atopic dermatitis is a chronic inflammation of the skin that is seen in people with a hereditary disposition for itching. Dorland's Illustrated Medical Dictionary, supra note 2, at 495, 1531.

[17] On July 25, 2000, Dr. Metrick informed Lori that the tests for the lipid storage disease were negative. Pet. Ex. 4 at 363.

[18] Chiari's malformation is "a congenital anomaly in which the cerebellum and medulla oblongata, which is elongated and flattened, protrude into the spinal canal through the foramen magnum; it is classified into three types according to severity . . . ." Dorland's Illustrated Medical Dictionary, supra note 2, at 1090. Type I Chiari's malformation is the slipping "of the

428-29. Thus, on July 31, 2001, at Loyola University Medical Center, surgeon Douglas Anderson, M.D., performed a craniotomy to repair the malformation. Id. at 412-13. Paul was discharged from Loyola University Medical Center on August 6, 2001. Id. at 443.

On February 1, 2002, Dr. Sproul saw Paul for an upper respiratory infection. Pet. Ex. 8 at 458. Dr. Sproul noted that Paul was alert, active, and playful. Id.

On February 27, 2002, Paul underwent another brain MRI to compare it with the one done on June 21, 2001. Pet. Ex. 7 at 402. The MRI revealed that some areas of high intensity remained but that the previously-seen high intensity within the temporal lobe was not present, nor was the cerebellar tonsillar extension. Id. at 403.

Ms. Matula took Paul to see Dr. Sproul on April 9, 2002, because Paul had developed combative behavior and had increasing episodes of staring spells. Pet. Ex. 8 at 459. Dr. Sproul referred Paul to a neurologist. Id.

Paul was seen by neurologist Mohammad Ikramuddin, M.D., on April 23, 2002. Id. at 462. Ms. Matula reported to Dr. Ikramuddin that Paul's behavioral changes began around the time of his 15-month vaccinations. Id. Dr. Ikramuddin further noted that Paul's last seizure was about one year prior. Id. at 463. Dr. Ikramuddin observed Paul to be alert, awake, and cooperative. Id. Dr. Ikramuddin recommended a vareity of tests. Id. at 464.

The Court's Efforts to Communicate with Petitioner Were Fruitless

On January 24, 2005, petitioner's counsel filed a Motion for Leave to Withdraw. In a status report filed at the same time as the motion, counsel explained that he filed the motion because petitioner had not responded to his e-mail, telephone, or written communications. Counsel requested that the court delay deciding the motion for four weeks to allow petitioner time to communicate with counsel. Thus, in an order dated February 7, 2005, the special master indicated that she would grant the unopposed motion, barring a change in position by petitioner's counsel, on March 7, 2005. The special master actually granted petitioner's Motion for Leave to Withdraw on March 9, 2005. Both the clerk's office and petitioner's ex-counsel were directed to serve a copy of the court's March 9, 2005 order on petitioner.

Then, on March 17, 2005, the special master issued an order directing petitioner, or newly-retained counsel, to contact the court to schedule a status conference by April 22, 2005. Petitioner or newly-retained counsel, if one had been retained, did not contact the court. Thus, on May 10, 2005, the court attempted to call petitioner using the cell phone number petitioner's prior counsel provided the court. Upon calling the telephone number, a message came on indicating that the telephone number was no longer a working number. Subsequently, the court used Internet telephone directories and the "People Search" function on Westlaw to search for a

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cerebellar tonsils into the spinal canal without elongation of the brainstem . . . ." Id.

new telephone number for petitioner and discovered a possible new telephone number in Streamwood, Illinois. On May 31, 2005, the court left a voice mail message for petitioner at the Streamwood telephone number, but petitioner did not return the call.

Thus, on June 9, 2005, the special master issued an Order to Show Cause directing petitioner, by July 11, 2005, to show cause why this petition should not be dismissed pursuant to Vaccine Rules 21(b) and 21(c) for failure to prosecute her claim. The special master warned that failure to show cause would result in the dismissal of the case. The special master directed the clerk's office to mail two copies of the Order to Show Cause to petitioner–one via regular first class mail and one via certified mail. Both copies were mailed to the address on file with the court–671 Beau Court, 1st Floor, Des Plaines, Illinois 60016.

On July 13, 2005, the certified letter was returned to the court as undeliverable because petitioner had moved to a new address. Thus, the special master reissued the Order to Show Cause on July 15, 2005, directing the clerk's office to mail two copies of the Order to Show Cause to petitioner to her new address, 105 Edgewood Lane, Streamwood, Illinois 60107-1614–one via regular first class mail and one via certified mail. The reissued Order to Show Cause directed petitioner to contact the court by August 15, 2005. According to the Return Receipt, the certified letter was delivered and signed for on July 22, 2005.

To date, petitioner remains either unable or unwilling to prove her case because her only response to the special master has been silence. Indeed, it is readily apparent that the special master's best efforts to locate petitioner were in vain. Petitioner has maintained her silence despite receipt of court orders urging her to contact the court and cautioning her that her petition would be dismissed if she failed to respond. Despite this actual knowledge of the need to move the case forward and the potential for dismissal, petitioner has not contacted the court.

The special master is not obligated to search for a petitioner. To the contrary, it is petitioner's affirmative continuing obligation to keep the court informed concerning her current address and telephone number. See Vaccine Rule 14(b), (d). Vaccine Rule 14(d) provides in part that: "[t]he term 'counsel' or 'attorney' in the Vaccine Rules shall include unrepresented parties." Vaccine Rule 14(b) requires in pertinent part that "[t]he attorney of record shall include on all filings the attorney's name, address, and telephone number. The attorney of record for each party shall promptly file with the clerk a notice of change in address." Thus, both common sense and the Vaccine Rules obligated petitioner to keep the court informed as to her current address and telephone number. Not only has petitioner failed to file a notice of change in address and telephone number, or otherwise advise of court of her new contact information, errors which could have occurred through oversight, but she failed or refused to contact the court despite the actual knowledge that the special master had taken great pains to locate her and move her case forward.

Although cognizant that dismissal of a pro se petition is a harsh result, the special master is left no option. The special master is not imposing a 'one-strike-and-you're-out' rule on this

petitioner. To the contrary, petitioner appears wholly unconcerned that her case will be dismissed for failure to prosecute. Petitioner has disregarded the court's orders and has failed to or refuses to provide up-to-date contact information. The special master construes petitioner's silence as a willful failure or refusal to comply with court orders. Thus, the court is compelled to dismiss the case for failure to prosecute. Dismissal is appropriate here because petitioner's failure to act appears willful, is in violation of court orders, and is repeated despite the clear warnings that such a sanction will be imposed. See Sapharas v. Sec'y of HHS, 35 Fed. Cl. 503 (1996); Tsekouras v. Sec'y of HHS, 26 Cl. Ct. 439 (1992), aff'd per curium, 991 F.2d 810 (Fed. Cir. 1993); see also Claude E. Atkins Enters., Inc. v. United States, 899 F.2d 1180, 1183 (Fed. Cir. 1990) (stating that Rule 41(b) allows the court to dismiss a case on its own motion based upon plaintiff's to prosecute or to comply with court rules or orders).

Even though the special master is dismissing this case for petitioner's failure to prosecute, the special master has reviewed the factual record in this case and finds that petitioner has failed to provide any evidence to prove a prima facie case for entitlement under the Vaccine Act.

Respondent's Rule 4(b) Report

Counsel for respondent filed respondent's Rule 4(b) Report on March 8, 2005, indicating that in the government's view, this case was not appropriate for compensation because petitioner has proved neither a Table injury nor actual causation. Resp't Rep. at 4-8. Specifically, respondent avers that petitioner has not shown Paul to have a Table encephalopathty or Table encephalitis nor has petitioner shown that the MMR vaccination Paul received on December 6, 1999, caused Paul's alleged encephalopathy or encephalitis. Id.

The Vaccine Act

Pursuant to 42 U.S.C. § 300aa-13(a)(1), the court shall award compensation if petitioner[19] proves, by a preponderance of the evidence, all of the elements set forth in § 300aa-11(c)(1)[20] of

[19] Section 11(b)(1) requires that: (1) only the "person who sustained a vaccine-related injury, [or] the legal representative of such person if such person is a minor or is disabled" can bring an action for vaccine injury-related claims (so long as the requirements of subsection (c)(1) are satisfied) and (2) that no previous civil action was filed in the same matter.

[20] Petitioner, the legal representative of her minor child who was allegedly injured as the result of the administration of a Table vaccine(s), is the appropriate person to maintain this action. In addition, subsection (c)(1) requires, inter alia, that the following elements be satisfied: (1) that the vaccine in question is set forth in the Vaccine Injury Table; (2) that the vaccine was received in the United States or in its trust territories; (3) that the minor child either sustained an injury as a result of the administration of a Table-designated vaccine for a period of more than six months after the administration of the vaccine, suffered illness, disability, injury, or condition from the vaccine which resulted in inpatient hospitalization and surgical intervention, or died

the Vaccine Act and that the illness is not due to factors unrelated to the administration of the vaccine.[21] Section 300aa-11(c)(1)(C) describes the substantive elements petitioner must prove to recover in the Vaccine Program. In this case, petitioner can recover in one of two ways. First, petitioner can recover if she proves a Table injury; in other words, if she shows that Paul received a vaccine listed in the Vaccine Injury Table ("Table"), 42 C.F.R. § 100.3(a), and suffered from an injury associated with that vaccine within the prescribed time period. 42 U.S.C. § 300aa-11(c)(1)(C)(i).

Specifically, in this case, petitioner can recover if she demonstrates that Paul suffered from an encephalopathy within 5-15 days of receiving the MMR vaccination.[22] Unfortunately, petitioner was unable to meet this burden. Although the undisputed facts showed that Paul received the MMR vaccination on December 6, 1999, the special master is unable to find that Paul's subsequent problems meet the statutory definition of encephalopathy.

The Table defines encephalopathy as an acute encephalopathy followed by a chronic encephalopathy persisting for more than six months past the date of vaccination. 42 C.F.R. § 100.3(b)(2). For children under the age of eighteen months who present without a seizure, an acute encephalopathy is indicated by a "significantly decreased level of consciousness" lasting for at least twenty-four hours. Id. § 100.3(b)(2)(i)(A). Further, a "significantly decreased level of consciousness" is defined by the presence of at least one of the following three clinical signs for twenty-four hours or longer: (1) decreased or absent response to the child's environment, (2) decreased or absent eye contact, or (3) inconsistent or absent responses to external stimuli. Id. § 100.3(b)(2)(i)(D). Additionally, "[t]he following clinical features alone, or in combination, do not demonstrate an acute encephalopathy or a significant change in either mental status or level of consciousness . . . : Sleepiness, irritability (fussiness), high-pitched and unusual screaming, persistent inconsolable crying, and bulging fontanelle." Id. § 100.3(b)(2)(i)(E).

Five days after vaccination, petitioner states that she noticed behavioral changes in Paul, which she described as: "bucking his head a lot and he stopped making eye contact with me. He was walking in circles." Pet. Aff. at 3. Petitioner also states that she called a physician's office on December 27, 2005, and reported her belief that Paul had a reaction to his MMR vaccination. Id. However, neither the initial symptoms noticed by petitioner nor the telephone call petitioner made to the physician's office were recorded in the contemporaneous medical records. The Vaccine Act specifically provides that "the special master or court may not make a finding [of

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from the administration of the vaccine; and (4) that the petitioner, as her son's legal representative, has not previously collected an award or settlement of a civil action for damages arising from the alleged vaccine-related injury or death.

[21] Of course, the petition must also be filed within the statutory period. 42 U.S.C. § 300aa-16(a). The petition in this case was timely filed.

[22] Encephalopathy is listed as a Table injury for the MMR vaccine. 42 C.F.R. § 100.3(a).

eligibility and compensation] based on the claims of a petitioner alone, unsubstantiated by medical records or medical opinion." 42 U.S.C. § 300aa-13(a)(1). Accordingly, the special master is unable to find that the symptoms observed by petitioner constitute a Table encephalopathy. Thus, petitioner was required to proceed on an actual causation theory.

Under an actual causation theory or "off-Table" claim, § 300aa-11(c)(1)(C)(ii), petitioner must prove that Paul's alleged encephalopathy or encephalitis was caused in fact by his MMR vaccination. Congress explained what it intended by this causation requirement:

> [T]he petition must affirmatively demonstrate that the injury or aggravation was caused by the vaccine. Simple similarity to conditions or time periods listed in the Table is not sufficient evidence of causation; evidence in the form of scientific studies or expert medical testimony is necessary to demonstrate causation for such a petitioner.

H.R. Rep. No. 99-908, pt. 1, at 15 (1986). The United States Court of Appeals for the Federal Circuit amplified congressional intent:

> To prove causation in fact, petitioners must show a medical theory causally connecting the vaccination and the injury. Causation in fact requires proof of a logical sequence of cause and effect showing that the vaccination was the reason for the injury. A reputable medical or scientific explanation must support this logical sequence of cause and effect.

Grant v. Sec'y of HHS, 956 F.2d 1144, 1148 (Fed. Cir. 1992) (citations omitted). To establish a prima facie case under an actual causation theory, petitioner must demonstrate that the vaccine was not only a "but-for cause of the injury, but also a substantial factor in bringing about the injury." Shyface v. Sec'y of HHS, 163 F.3d 1344, 1352-53 (Fed. Cir. 1999). Thus, both the Vaccine Act and the case law clearly require an expert medical opinion.

Section 300aa-13(b)(1) specifically requires consideration of all relevant medical and scientific evidence presented to the court including:

> (A) any diagnosis, conclusion, medical judgment, . . . regarding the nature, causation, and aggravation of the petitioner's illness, disability, injury, condition, or death, and
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> (B) the results of any diagnostic or evaluative test which are contained in the record and the summaries and conclusions.

A review of the record now under consideration reveals no medical evidence[23] whatsoever to support petitioner's theory that Paul suffered an encephalopathy or encephalitis as a result of the administration of his December 6, 1999 MMR vaccination. Specifically, petitioner has offered no medical expert testimony to support her theory of causation.

As stated above, the Vaccine Act specifically provides that "the special master or court may not make a finding [of eligibility and compensation] based on the claims of a petitioner alone, unsubstantiated by medical records or medical opinion." 42 U.S.C. § 300aa-13(a)(1). Thus, because petitioner is unable to prove by a preponderance of the evidence the matters required in § 300aa-11(c)(1),[24] she cannot carry the "heavy burden" required in off-Table cases to prove that Paul's alleged encephalopathy or encephalitis was more likely that not the result of the vaccination at issue here. There is no doubt that Paul, and by extension, his family, have endured great suffering; nevertheless, the statutory requirements have not been satisfied.

CONCLUSION

Because petitioner has failed to contact the court despite its repeated attempts to contact her, the special master is compelled to dismiss this case for failure to prosecute. Furthermore, the court has reviewed the record in this case and finds that petitioner cannot meet her burden to prove that the December 6, 1999 MMR vaccination caused Paul's alleged encephalopathy or encephalitis.

Given the Vaccine Act's substantive requirements and petitioner's failure not only to meet those requirements and her clear disregard of the court's rules and orders, the special master has no alternative but to dismiss this petition with prejudice pursuant to Vaccine Rule 21(c). However, the special master is mindful that petitioner is proceeding pro se. Due to the extreme nature of the sanction of dismissal, the special master will entertain a motion to grant relief from this dismissal for the limited reasons of mistake, inadvertence, surprise, or excusable neglect. Such motion must be filed within 14 days after the filing of this order. No extensions will be granted. If petitioner desires to proceed with this matter she is strongly encouraged to contact my law clerk, Kristin Baczynski (202-357-6358) in order to provide updated contact information so that a status conference may be scheduled to discuss further proceedings in this case.

Therefore, the special master finds that due to petitioner's failure to prosecute her claim in the above-described manner, her petition should be **DISMISSED** with prejudice pursuant to

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[23] Although the Federal Circuit made clear in Knudsen v. Secretary of HHS, 35 F.3d 543, 548-49 (Fed. Cir. 1994), that when proceeding under an off-Table theory, a petitioner under the Vaccine Act is not required to identify and provide proof of specific biological mechanisms which caused the alleged vaccine injury, a reputable medical explanation of a logical sequence of cause and effect to support petitioner's theory of liability is necessary.

[24] See 42 U.S.C. § 300aa-13(a).

Vaccine Rule 21(c). In the absence of a motion to grant relief from this dismissal or a motion for review filed pursuant to RCFC Appendix B, the Clerk of Court is directed to enter judgment accordingly.

IT IS SO ORDERED.

Margaret M. Sweeney
Special Master