In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS
No. 08-0585V
Filed: September 24, 2012
(Not to be Published)

SCOTT B. SMITH and REBA L. SMITH, parents of CODY B. SMITH, a minor	*	
Petitioners,	*	Autism; Statute of Limitations; Untimely Filed
v.	*	
SECRETARY OF HEALTH AND HUMAN SERVICES,	*	
Respondent.	*	

DECISION[1]

On August 18, 2008, Scott B. Smith and Reba L. Smith ("petitioners"), on behalf of their son, Cody B. Smith ("Cody"), filed a claim for compensation pursuant to the National Vaccine Injury Compensation Program ("Vaccine Program" or "the Program").[2]

[1] Because this Decision contains a reasoned explanation for the action in this case, the undersigned intends to post this Decision on the United States Court of Federal Claims' website, in accordance with the E-Government Act of 2002, Pub. L. No. 107-347, § 205, 116 Stat. 2899, 2913 (codified as amended at 44 U.S.C. § 3501 note (2006)). In accordance with Vaccine Rule 18(b), a party has 14 days to identify and move to delete medical or other information, that satisfies the criteria in 42 U.S.C. § 300aa-12(d)(4)(B). Further, consistent with the rule requirement, a motion for redaction must include a proposed redacted decision. If, upon review, the undersigned agrees that the identified material fits within the requirements of that provision, the undersigned will delete such material from public access.

[2] The National Vaccine Injury Compensation Program ("Vaccine Program" or "the Program") is set forth in Part 2 of the National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, 100 Stat. 3755, codified as amended, 42 U.S.C. § 300aa-10 et seq. (2006) ("Vaccine Act" or "the Act"). All citations in this Decision to individual sections of the Vaccine Act are to 42 U.S.C. § 300aa.

Petitioners filed the Short-Form Petition authorized by Autism General Order #1,[3] thereby joining the Omnibus Autism Proceeding ("OAP").[4] Short-Form Autism Petition for Vaccine Compensation at 1.

Petitioners have the burden of demonstrating that their case was properly and timely filed under the Vaccine Act's statute of limitations. § 16(a)(2). Based on the undersigned's analysis of the evidence, petitioners have not met their burden, and thus **this case is dismissed as untimely filed.**

I. Procedural History

No medical records were filed with the Petition. Like most other cases in the OAP, the case remained on hold until discovery in the OAP was concluded, causation

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[3] Autism General Order #1 adopted the Master Autism Petition for Vaccine Compensation for use by petitioners filing claims intended to be part of the Omnibus Autism Proceeding ("OAP"). By electing to file a Short-Form Autism Petition for Vaccine Compensation petitioners alleged that:

> [a]s a direct result of one or more vaccinations covered under the National Vaccine Injury Compensation Program, the vaccinee in question has developed a neurodevelopmental disorder, consisting of an Autism Spectrum Disorder or a similar disorder. This disorder was caused by a measles-mumps-rubella (MMR) vaccination; by the "thimerosal" ingredient in certain Diphtheria-Tetanus-Pertussis (DTP), Diphtheria-Tetanus-acellular Pertussis (DTaP), Hepatitis B, and Hemophilus Influenza Type B(HIB) vaccinations; or by some combination of the two . . . .
>
> The petition is being filed within three years after the first symptom of the disorder, or within three years after the first symptom of a vaccine-caused significant aggravation of the disorder. (If the vaccine-related death is alleged, the petition is being filed within two years after the date of death and no later than 48 months after onset of the injury from which death resulted.)

Autism General Order # 1 filed July 3, 2002, Exhibit A, Master Autism Petition for Vaccine Compensation at 2. Autism General Order #1 is published at 2002 WL 31696785 (Fed. Cl. Spec. Mstr. July 3, 2002). Documents filed into the OAP are maintained by the clerk of this court in the file known as the "Autism Master File." An electronic version of the file is available on the court's website. Accompanying the electronic version of the file is a docket sheet that identifies all of the documents contained in the file. The complete text of most of the documents in the file is electronically accessible, with the exception of those few documents that must be withheld from the court's website due either to copyright considerations or to the privacy protection afforded under § 12(d)(4)(A) of the Act. To access the electronic version of the Autism Master File, visit this court's website at www.uscfc.uscourts.gov. Select the "Vaccine Info" page, then the "Autism Proceeding" page.

[4] A detailed discussion of the OAP can be found at *Dwyer v. Secretary of Health & Human Services*, No. 03-1202V, 2010 WL 892250, at *3 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

hearings in the test cases were held, and entitlement decisions were issued in the test cases.[5]

During the period between the test case hearings and the final appellate action on the decisions, petitioners, like others in the OAP, were ordered to file medical records in support of their claim. *See* Order, filed August 21, 2008. Petitioners filed Petitioners' Exhibits ("Pet. Ex.") 1-10 and a Statement Regarding Onset ("Pet. Onset") on October 2, 2008.

After reviewing the medical records contained in petitioners' exhibits, respondent filed a Motion to Dismiss the case ("Res. Mot."), asserting that it was not timely filed. Res. Mot. at 1. Respondent asserts that Cody's first symptom of autism, "language impairment," occurred on August 27, 2003, and claims the petition was filed "nearly two years after the relevant limitations period had expired." Res. Mot. at 3-5.

Petitioners filed a Rebuttal to Respondent's Motion to Dismiss ("Pet. Rebuttal") on December 9, 2008. Petitioners assert that "[a]s late as August 31, 2005, the medical profession was uncertain as to the significance of the prior medical events" and that the "[m]edical events cited by the respondent were unrecognizable as a sign of a vaccine injury by the medical profession at large during the stated period." Pet. Rebuttal at 1. It appears that petitioners are asserting an argument that the Vaccine Act contains an implied discovery rule,[6] an argument which was rejected by the U.S. Court of Appeals for the Federal Circuit in *Cloer v. Secretary of Health & Human Services,* 654 F.3d. 1322 (Fed. Cir. 2011). *See* discussion *infra* Part IV

After the final OAP test case appeal was decided, I ordered petitioners to inform the court whether they intended to proceed with their claim. *See* Order, filed September 27, 2010. Petitioners failed to respond. On December 8, 2010, I issued an Order to Show Cause, stating that failure to respond to the order would result in dismissal of the

[5] The Theory 1 cases are *Cedillo v. Secretary of Health & Human Services*, No. 98-916V, 2009 WL 331968 (Fed. Cl. Spec. Mstr. Feb. 12, 2009), *aff'd*, 89 Fed. Cl. 158 (2009), *aff'd*, 617 F.3d 1328 (Fed. Cir. 2010); *Hazlehurst v. Secretary of Health & Human Services*, No. 03-654V, 2009 WL 332306 (Fed. Cl. Spec. Mstr. Feb. 12, 2009), *aff'd*, 88 Fed. Cl. 473 (2009), *aff'd*, 604 F.3d 1343 (Fed. Cir. 2010); *Snyder v. Secretary of Health & Human Services,* No. 01-162V, 2009 WL 332044 (Fed. Cl. Spec. Mstr. Feb. 12, 2009), *aff'd*, 88 Fed. Cl. 706 (2009). Petitioners in *Snyder* did not appeal the decision of the U.S. Court of Federal Claims. The Theory 2 cases are *Dwyer v. Secretary of Health & Human Services*, No. 03-1202V, 2010 WL 892250 (Fed. Cl. Spec. Mstr. Mar. 12, 2010); *King v. Secretary of Health & Human Services*, No. 03-584V, 2010 WL 892296 (Fed. Cl. Spec. Mstr. Mar. 12, 2010); *Mead v. Secretary of Health & Human Services,* No. 03-215V, 2010 WL 892248 (Fed. Cl. Spec. Mstr. Mar. 12, 2010). The petitioners in each of the three Theory 2 cases chose not to appeal.

[6] Petitioners are arguing that the statue of limitations does not begin to run until Cody's injury was recognized by the medical profession at large as an injury caused by a vaccination.

claim. On January 3, 2011, petitioners submitted a response to the September 27, 2010, and December 8, 2010, orders, informing the court that they wished to pursue Cody's claim for compensation. The undersigned deferred any action on the timeliness of this case pending the Federal Circuit's en banc decision in *Cloer*.

Subsequent to the Federal Circuit's decision in *Cloer,* the undersigned ordered petitioners to show cause why this claim should not be dismissed as untimely filed. Order to Show Cause filed July 20, 2012. Petitioners failed to respond to that Order.

II. Factual History.

Cody was born on December 30, 2000. Pet. Ex. 3 at 1. He was the product of a full-term pregnancy complicated by pre-eclampsia. Pet. Ex. 1 at 4; Pet. Ex. 2 at 12. Cody did suffer a scalp injury due to birth trauma. Pet. Ex. 2 at 13. However, no abnormalities were observed in Cody's initial medical exam. *Id.* at 19. No other birth or prenatal difficulties were reported. Pet. Ex. 4 at 19.

Routine childhood immunizations were administered to Cody between his birth and July 9, 2002. *Id.* at 10. The medical records indicate that Cody received his MMR and varicella vaccines on January 23, 2002 (at age 1). *Id.*

For the first 6 months, Cody was a generally healthy child.[7] On June 18, 2001, petitioners brought Cody to his pediatric provider at the Arkansas Pediatrics of Conway ("the clinic") because he had a cough and fever, did not sleep through the night, and cried while grabbing his ears. *Id.* at 14. Throughout 2002, Cody visited either the clinic or the emergency room at St. Vincent's Health System for treatment of ear infections. *E.g.,* Pet. Ex. 4 at 11; Pet. Ex. 7 at 74. The notes from Cody's 2 year old well child visit on December 30, 2002, contained a note "Hearing ?" and an entry indicating that he was not talking as much as when he was 18 months old. Pet. Ex. 4 at 2.

On January 3, 2003, Dr. H. Graves Hearnsberger at the Little Rock Audiology Clinic noted that Cody had experienced "four or five [ear] infections in the last few months" and a "regression of his speech." Pet. Ex. 9 at 1. To address his chronic ear infections, Cody had a ventilation tube placement on January 13, 2003. *Id.* at 2. The records from an appointment on January 24, 2003, indicate that Cody's tympanic membranes (TMS or eardrums) were clear following the surgery, but that his fevers and issues with "speech development" and hearing continued. *Id.* at 3. A sound test was performed which showed a "possibility of a little bit of a hearing loss, but it was difficult to ascertain." *Id.* Cody was told to go to a "speech team down at Children's" or to return in 3 to 6 months to retest his hearing. *Id.*

Cody returned to the Little Rock Audiology Clinic on June 9, 2003, and December 8, 2005, for evaluation by Audiologist Jayme B. Pultro. *Id.* at 4-6. In his

[7] *E.g.,* Pet. Ex. 4 at 14 (well child visit). Cody did have congestion and a cold on April 4, 2001. Pet. Ex. 4 at 16.

notes from the December 8, 2005, visit, Dr. Pultro indicated that Cody's hearing sensitivity was normal and recorded concerns about developmental delay and the "possibility of a central auditory processing problem." *Id.* at 6.

On July 6, 2005, Cody visited the University of Arkansas for Medical Sciences Department of Pediatrics ("UAMS") and was seen by Dr. Jill Fussell for "evaluation of a suspected Persuasive Developmental Disorder ("PDD"). Pet. Ex. 10 at 15. Petitioners informed Dr. Fussell that they were concerned that Cody "has developmental delays" and "doesn't demonstrate normal behavior for a 4 year old." *Id.* They added that Cody's school had "mentioned the possibility of autism." *Id.* They explained that Cody "uses jargon frequently and makes odd sounds or noises repetitively," "frequently reenacts Disney movie scripts verbatim," prefers solitary play, and "demonstrates a lack of show and tell behavior." *Id.* at 16. Dr. Fussell's report from that evaluation also indicates that Cody attends the Faulkner County Day School "where he is enrolled in speech, occupational, and physical therapies" and that "[d]evelopmental testing conducted at the Faulkner County Day School indicates severe delay in fine motor skills, moderate delays in social and self help areas, and severe receptive and expressive language delays." *Id.* Dr. Fussell concluded that "Cody displays symptoms of (PPD)" but deferred diagnosis "until further evaluation is concluded." *Id.* at 17.

On August 31, 2005, Cody returned to the UAMS and was seen again by Dr. Fussell. Dr. Fussell administered the Childhood Autism Rating Scale ("CARS"). *Id.* at 6. A score above 30 is considered significant for a diagnosis of autism, and Cody scored a 25. She concluded that Cody "has some features of PPD" but "did not meet the full criteria for a diagnosis of autism." *Id.* at 12. However, hand-outs on autism and PPD were given to petitioners. *Id.* at 17.

During his next visit to the UAMS on June 20, 2006, Dr. Fussell assessed Cody again and found that he scored a 30.5 on his CARS assessment, a significant score for autism. *Id.* at 3. On that date, Dr. Fussell concluded that Cody meets the "diagnostic criteria for mild/high functioning autism." *Id*

III. Diagnostic Criteria for Autism Spectrum Disorders.

No evidence concerning the diagnostic criteria for autism spectrum disorders was filed by the parties in this case. Accordingly, I have relied upon the information contained in this section which is primarily drawn from OAP test case testimony[8] provided by three pediatric neurologists with considerable experience in diagnosing ASD.

[8] All of the evidence filed in the OAP test cases is available to any petitioner in the OAP, as well as to respondent. However, I note that there did not appear to be any material disputes in the OAP test cases about what constituted the early symptoms of autism or other ASD. Because omnibus test case decisions are not binding on the other omnibus participants, the primary advantage to both parties in conducting test case hearings is the creation of a body of evidence that can be considered in other cases. *Snyder*, 2009 WL 332044, at *2-3; *Dwyer*, 2010 WL 892250, at *2.

"The terms 'autism' and 'autism spectrum disorder' have been used to describe a set of developmental disorders characterized by impairments in social interaction, impairments in verbal and non-verbal communication, and stereotypical restricted or repetitive patterns of behavior and interests." *Cedillo,* 2009 WL 331968, at *7 (an OAP Test Case). The specific diagnostic criteria for ASD are found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 4th ed text revision 2000 ("DSM-IV-TR"), the manual used in the United States to diagnose dysfunctions of the brain. *See* testimony of Dr. Eric Fombonne in *Cedillo* ("Fombonne Tr.") at 1278A.[9] The manual identifies the behavioral symptoms recognized by the medical profession at large as symptoms of ASD.[10] The DSM-IV-TR contains specific diagnostic criteria for autistic disorder (often referred to as "autism"[11] or "classic autism"), Asperger's disorder, and pervasive developmental disorder-not otherwise specified (most frequently referred to as ("PDD-NOS")). It is not uncommon for parents and even health care providers to use these terms in non-specific ways, such as referring to a child as having an "autism diagnosis," even though the specific diagnosis is PDD-NOS. Of note, a child's diagnosis within the autism spectrum may change from autistic disorder to PDD-NOS (or vice versa) over time.

A. Diagnosing Autism Spectrum Disorders.

The behavioral differences in autism spectrum disorders encompass not only delays in development, but also qualitative abnormalities in development. Fombonne Tr. at 1264A; testimony of Dr. Max Wiznitzer in *Cedillo* ("Wiznitzer Tr.") at 1589-91. There can be wide variability in children with the same diagnosis. One child might lack any language at all, while another with a large vocabulary might display the inability to engage in a non-scripted conversation. Wiznitzer Tr. at 1602A-1604. However, both would have an impairment in the communication domain.

Testing for the presence of an ASD involves the use of standardized lists of questions about behavior directed to caregivers and parents, as well as observations of behaviors in standardized settings by trained observers. Fombonne Tr. at 1272A-74A.

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[9] Transcripts from the OAP test cases, including *Cedillo*, may be accessed at http://www.uscfc.uscourts.gov/omnibus-autism-proceeding (last checked on June 19, 2012).

[10] Pervasive developmental disorders ("PPD") is the umbrella term used in the DSM-IV-TR at 69. I use the term ASD rather than PDD because of the possible confusion between "PDD" (the umbrella term referring to the general diagnostic category) and "PDD-NOS," which is a specific diagnosis within the general diagnostic category of PDD or ASD. *See Dwyer,* 2010 WL 892250 at *1 n.4 & *29 n.108.

[11] I use the term "autism" to refer solely to the specific diagnosis of "autistic disorder."

One behavioral symptom alone, such as hand-flapping, would not be diagnostic of an ASD, but if present, it would be a symptom that would be part of the diagnostic picture. As Dr. Fombonne explained, in diagnosing an ASD, "we try to observe symptoms, and when we have observed enough symptoms, then we see if the child meets these criteria." Fombonne Tr. at 1278A-79; *see also* testimony of Dr. Michael Rutter in the *King*[12] OAP test case ("Rutter Tr.") at 3253-54 (describing diagnostic instruments and their use in clinical settings).

Typically in children with autism spectrum disorders, the symptoms have been present for weeks or months before parents report them to health care providers. Fombonne Tr. at 1283. The most common age at which parents recognize developmental problems, usually problems in communication or the lack of social reciprocity, is at 18-24 months of age. Rutter Tr. at 3259-60. The development of symptoms of an ASD occurs very gradually, and it is not uncommon for the parents to be unable to date the onset very precisely. Fombonne Tr. at 1285A-1286A.

1. Autistic Disorder (Autism).

A diagnosis of autistic disorder requires a minimum of six findings from a list of impairments divided into three domains of impaired function: (1) social interaction; (2) communication; and (3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. At least two findings related to social interaction and at least one each in the other two domains are required for diagnosis. To meet the diagnostic criteria for autism, the child must have symptoms consistent with six of the twelve listed types of behavioral impairments. Furthermore, the abnormalities in development must have occurred before the age of three. Fombonne Tr. at 1264A, 1279; Wiznitzer Tr. at 1618; Rutter Tr. at 3250. Although the majority of children with autism have developmental delays, many are of normal intelligence. Fombonne Tr. at 1276; Rutter Tr. at 3256. In testimony in the *Cedillo* OAP test case, Dr. Wiznitzer described the three domains as the "core features" of a diagnosis on the autism spectrum. Wiznitzer Tr. at 1589-92. Children with autism are most symptomatic in the second and third years of life. Wiznitzer Tr. at 1618.

2. Pervasive Developmental Disorder-Not Otherwise Specified.

The DSM-IV-TR defines PDD-NOS as "a severe and pervasive impairment in the development of reciprocal social interaction," coupled with impairment in either communication skills or the presence of stereotyped behaviors or interests. DSM-IV-TR at 84. The diagnosis is made when the criteria for other autism spectrum disorders, or other psychiatric disorders such as schizophrenia, are not met. *Id*. It includes what has been called "atypical autism," which includes conditions that present like autistic disorder, but with onset after age three, or which fail to meet the specific diagnostic

[12] *King,* 2010 WL 892296.

criteria in one or more of the domains of functioning. *Id*. As was noted in the *Dwyer* OAP test case, this is the most prevalent of the disorders on the autism spectrum. *Dwyer,* 2010 WL 892250 at *30.

3. Asperger's Disorder.

Asperger's syndrome is a form of high-functioning autism. It presents with significant abnormalities in social interaction and with restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. *See* DSM-IV-TR at 84.

B. The Domains of Impairment and Specific Behavioral Symptoms.

1. Social Interaction Domain.

This domain encompasses interactions with others. Fombonne Tr. at 1264A. There are four subgroups within this domain. Wiznitzer Tr. at 1594. The subgroups include: (1) a marked impairment in the use of nonverbal behavior, such as gestures, eye contact and body language; (2) the failure to develop appropriate peer relations; (3) marked impairment in empathy; and (4) the lack of social or emotional reciprocity. Wiznitzer Tr. at 1594-96. To be diagnosed with autism (autistic disorder), the patient must have behavioral symptoms from two of the four subgroups. Wiznitzer Tr. at 1594. For an Asperger's diagnosis, there must be two impairments in this domain as well. DSM-IV-TR at 84. Children who do not display "the full set of symptoms" are diagnosed with PDD-NOS. Fombonne Tr. at 1275A. Symptoms used to identify young children with impairments in the social interaction domain include lack of eye contact, deficits in social smiling, lack of response to their name, and the inability to respond to others. Fombonne Tr. at 1269A-70A.

Doctor Wiznitzer described the degrees of impairment in interactions with others as a continuum, with affected children ranging from socially unavailable to socially impaired. A child who is socially unavailable may exhibit such behaviors as failing to seek consolation after injury or purposeless wandering, or may simply appear isolated. Wiznitzer Tr. at 1598. A less impaired child might be socially remote, responding to an adult's efforts at social interaction, but not seeking to continue the contact. This child might roll a ball back and forth with an adult, but will not protest when the adult stops playing. Wiznitzer Tr. at 1599. Given a choice between playing with peers and playing by himself, a child with impairments in social interaction will play by himself. *Id.* Some children with ASD demonstrate socially inappropriate interactions, such as pushing other children in an effort to interact. Wiznitzer Tr. at 1600. A higher functioning child might attempt interaction, but does so as if reading from a script. As an example, Dr. Wiznitzer discussed a patient who, when asked where he lived, could not answer, but responded appropriately when Dr. Wiznitzer asked the child for his address. *Id.* at 1601.

2. Communication Domain.

The communication domain involves both verbal and non verbal communication, such as intonation and body language. Fombonne Tr. at 1263; Wiznitzer Tr. at 1602A. Language abnormalities in ASD encompass not only delays in language acquisition, but the lack of capacity to communicate with others. Fombonne Tr. at 1267A. Impaired communication abilities are one of the "most important and early recognized symptoms" of autism. *Dwyer* OAP test case at *31.

There are four criteria within the communication domain. Wiznitzer Tr. at 1602A. They include: (1) a delay in or lack of development in spoken language, without the use of signs or gestures to compensate; (2) problems in initiating or sustaining conversation; (3) stereotypic or repetitive use of language, including echolalia and repeating the script of a video or radio presentation, such as singing a commercial jingle; and (4) the lack of spontaneous imaginative or make-believe play. Wiznitzer Tr. at 1602A-05.

Language delay, limited babbling, lack of gestures, lack of pointing to communicate things other than basic wants and desires (lack of "protodeclarative" vs. "protoimperative" pointing), are all early symptoms used to diagnose impairments in the communication domain. Fombonne Tr. at 1266A-68A. Doctor Wiznitzer described the failure to share discoveries via language in autistic children as well. Wiznitzer Tr. at 1606A. Children with ASD who have more developed language skills may display difficulties in social communication outside their limited area of interest. *Id*. at 1607.

Within the communication domain, children with ASD have difficulties in joint attention, which Dr. Wiznitzer described as sharing an action or activity with another person or even an animal. They also have problems with what he called metalinguistic skills, referring to the meaning behind the language used, which may be conveyed by tone, body language, humor, or sarcasm. Children with ASD may understand visual humor, illustrated by the cartoon of an anvil falling on the coyote's head, but lack the ability to understand a joke. Wiznitzer Tr. at 1607-09. They focus on the literal, rather than the figurative, meaning of words: telling a child with ASD to "hop to it" may elicit hopping, rather than an increase in speed in completing a task. These children use language primarily for getting their needs met. *Id*. at 1609. A child with ASD might lead a parent to the cookie jar, but would not lead a parent to a caterpillar crawling along the sidewalk.

Children with ASD often have impairments in specific types of play. They may understand cause and effect play, but have difficulties in imitative or representational play. In other words, they can push a button to make a toy figure pop up, but have difficulty with holding a tea party, putting a stuffed animal to bed, or feeding a doll. Wiznitzer Tr. at 1610-11. They also have impairments in symbolic play, in which an object such as a stick represents another object, such as a magic wand or sword. *Id*. at 1612.

Speech and language delays are the symptoms most commonly reported by parents as a concern leading to a diagnosis of ASD. *See* Fombonne Tr. at 1284 (one of first concerns noted by parents is the lack of language development); Rutter Tr. at 3253 (problems in social and communication domains tend to be observed much earlier than stereotyped behaviors).

A deficit in at least one of the subgroups in the communication domain is required for an autism diagnosis. Wiznitzer Tr. at 1602A-1603. An Asperger's diagnosis does not require a communication domain impairment. *See* Fombonne Tr. at 1275A-76. A PDD-NOS diagnosis requires an impairment in either this domain or the patterns of behavior discussed next. *See* Wiznitzer Tr. at 1592.

3. Restricted, Repetitive and Stereotyped Patterns of Behavior Domain.

There are four categories within this domain. They include (1) a preoccupation with an interest that is abnormal in intensity or focus, such as spinning a plate or a wheel or developing an intense fascination with a particular interest, such as dinosaurs, cartoon characters, or numbers; (2) an adherence to nonfunctional routines or rituals, such as eating only from a blue plate, sitting in the same seat, or walking the same route; (3) stereotypic or repetitive motor mannerisms, such as finger flicking, hand regard, hand flapping, or twirling; and (4) a persistent preoccupation with parts of an object, such as focusing on the wheel of a toy car and spinning it, rather than playing with the toy as a car. Wiznitzer Tr. at 1613A-15; Fombonne Tr. at 1271A-72A.

As Dr. Fombonne explained, this domain reflects abnormalities in the way play skills develop, as well as repetitive and rigid behavior. Fombonne Tr. at 1264A. A typical toddler may flick a light switch a few times, but the child with ASD performs the same action to excess. Wiznitzer Tr. at 1616. Doctor Rutter described one child who would not turn right; to make a right turn at a crossroads, he would have to make three left turns. Rutter Tr. at 3252-53.

For a diagnosis of autism, a child must display behaviors in at least one of the categories included in this domain. Wiznitzer Tr. at 1613A. An Asperger's diagnosis also requires at least one behavioral impairment encompassed in this domain. *See* Fombonne Tr. at 1275A-76. A PDD-NOS diagnosis requires either an impairment in this domain or an impairment in the communication domain. *See* Wiznitzer Tr. at 1592.

D. Summary.

The OAP evidence establishes that a diagnosis of ASD is based on observations of behavioral symptoms. The symptoms are categorized into three domains.

For a definitive diagnosis of autism, the child must display behavioral abnormalities in each of the domains, and must exhibit at least six of the 12 behavioral

criteria in the three domains. There must be at least two behaviors encompassed in the social interaction domain, reflecting the importance of impaired social interaction in diagnosing ASD. The behavioral abnormalities must manifest before the age of three.

Thus, the absence of any specific symptom would not rule out the diagnosis, so long as the requisite numbers of impairments in each domain of functioning are present. Conversely, autism cannot be diagnosed by any single abnormal behavior, but the ultimate diagnosis is based on an accumulation of symptomatic behaviors. The existence of any one behavioral abnormality associated with autism is sufficient to trigger the running of the statute of limitations.

For a diagnosis of Asperger's disorder, the child must display behavioral abnormalities similar to those of children with autistic disorder, but need not have a language abnormality. Fombonne Tr. at 1275A-76; *see also* DSM-IV-TR at 84 (requiring two impairments in social interaction and one in restricted, repetitive, and stereotyped patterns of behavior, interests, and activities for this diagnosis).

For a PDD-NOS diagnosis, the child must display behavioral abnormalities in all three domains. However, this diagnosis is given when the impairments fall short of the criteria required for a diagnosis of autism (autistic disorder). Fombonne Tr. at 1275A.

IV. Arguments and Analysis.

Respondent asserts that this claim was untimely filed. Petitioners have not made any arguments to counter respondent's assertion. Based on the evidence filed thus far, the undersigned concludes that petitioners' claim was untimely filed under the Vaccine Act's statute of limitations.

A. Untimely Filing.

1. The Statutory Requirements.

The Vaccine Act's statute of limitations provides in pertinent part that, in the case of:

> a vaccine set forth in the Vaccine Injury Table which is administered after October 1, 1988, if a vaccine-related injury occurred as a result of the administration of such vaccine, no petition may be filed for compensation under the Program for such injury after the expiration of 36 months after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury…"

§ 16(a)(2) (emphasis added). In *Cloer*, the Federal Circuit affirmed that the statute of limitations begins to run on "the date of occurrence of the first symptom or manifestation of onset of the vaccine-related injury recognized as such by the medical

profession at large." 654 F.3d at 1325. This date is dependent on when the first sign or symptom of injury appears, not when a petitioner discovers a causal relationship between the vaccine and the injury. *Id.* at 1339. When drafting the Vaccine Act, Congress rejected a discovery rule-based statute of limitations in favor of one that does not consider knowledge and runs solely from the date of an event, the first symptom or manifestation of onset. *Id.* at 1338.

In *Markovich*, the court explained the differences between "symptom" and "manifestation of onset," as those words are used in the Vaccine Act. *Markovich v. Secretary of Health & Human Services,* 477 F.3d 1353, 1357 (Fed. Cir. 2007). A symptom may be associated with more than one condition, and it can be difficult for a lay person to connect a symptom with a particular injury. *Id.* Manifestation of onset, on the other hand, is something more clearly associated with an injury. *Id.* Neither requires a doctor making a definitive diagnosis of the injury. *Id.* at 1358 (quoting *Brice v. Secretary of Health & Human Services,* 36 Fed. Cl. 474, 477 (1996)).

2. Applying the Facts to the Law

To determine if this case was timely filed, it must be determined when the first symptom or manifestation of onset of the alleged vaccine injury occurred. Once that date is ascertained, it can be determined if the petition was filed within 36 months of that date.

Because petitioners filed their petition on behalf of Cody on August 18, 2008, the first symptom or manifestation of onset of Cody's autism must have occurred on or after August 18, 2005, in order for the petition to be considered timely. *See Markovich*, 477 F.3d at 1357 (holding that "either a 'symptom' or a 'manifestation of onset' can trigger the running of the statute [of limitations], whichever is first"); *Cloer*, 654 F.3d at 1335 (holding that the "analysis and conclusion in *Markovich* is correct. The statute of limitations in the Vaccine Act begins to run on the date of occurrence of the first symptom or manifestation of onset.").

Although the date of Cody's autism diagnosis, June 20, 2006, occurred after the critical date of August 18, 2005, he exhibited numerous symptoms of autism prior to August 18, 2005.

To be diagnosed with autism, a child must display abnormal development in three different domains: (1) language and communication; (2) social interaction; and (3) repetitive patterns of play, behavior, or interests. *Snyder,* 2009 WL 332044 at *36.

With regard to the first domain, language and communication, several references to speech delay are found in the records. On January 3, 2003, Dr. Hearnsberger noted that Cody had speech regression. Pet. Ex. 9 at 1. On July 6, 2005, Dr. Fussell recorded that Cody uses jargon frequently and "makes odd sounds or noises repetitively." Pet. Ex. 10 at 16.

Behaviors associated with the second domain, social interaction, include poor eye contact, lack of initiating social interaction with adults and other children, and being oblivious to their surroundings. *Snyder*, 2009 WL 332044 at *37. The records indicate that Cody had such behaviors prior to August 18, 2005. For example, in the medical records from July 6, 2005, Dr. Fussell notes that Cody prefers solitary activity and "demonstrates a lack of show and tell behavior." Pet. Ex. 10 at 16.

The third domain, repetitive patterns of play, behavior, or interests, includes a preoccupation with narrow, restricted subjects, such as watching fan blades turn. *Snyder*, 2009 WL 332044 at *38. Other behaviors linked to the domain are an adherence to specific daily routines, repetitive motor mannerism, such as hand flapping, and focusing on components of an object rather than the object as a whole. *Id.* Cody demonstrated traits connected with this domain prior to August 18, 2005. According to medical records from Cody's July 6, 2005 visit with Dr. Fussell, he "frequently reenacts Disney scripts verbatim." Pet. Ex. 10 at 16.

Although Dr. Fussell did not diagnose Cody with autism until June 20, 2006, she clearly indicated that he displayed symptoms of autism on July 6, 2005. *Id.* at 17. In addition, petitioners took Cody to see Dr. Fussell because they were concerned about developmental delays and the fact that he "doesn't demonstrate normal behavior for a 4 year old." *Id.* at 15. They told Dr. Fussell that the "[s]chool mentioned the possibility of autism." *Id.*

The statute of limitations considers both the first symptoms and the manifestation of onset. Since Cody experienced symptomatic behaviors associated with autism prior to August 18, 2005, petitioners' petition was untimely filed and must be dismissed unless the doctrine of equitable tolling applies.

B. Equitable Tolling.

The doctrine of equitable tolling is a legal principle that acts to overcome a statute of limitations problem in certain situations. If a case is untimely filed and the doctrine of equitable tolling applies, then the case will be permitted to continue.

In *Cloer*, the Federal Circuit held that equitable tolling of the Vaccine Act's statute of limitations is permitted. 654 F.3d at 1340. However, citing to *Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 96 (1990), the Circuit noted that equitable tolling is to be used "sparingly," and not applied simply because the application of the statute of limitations would otherwise deprive a petitioner the opportunity to bring a claim. *See Cloer*, 654 F.3d at 1344-45. Citing to *Pace v. DiGuglielmo*, 544 U.S. 408, 418 (2005), the Circuit also noted that equitable tolling should be applied only in "extraordinary circumstance[s]," such as when petitioner timely filed a procedurally defective pleading, or was the victim of fraud, or duress, *Cloer*, 654 F.3d at 1344-45; *see also Irwin*, 498 U.S. at 96.

Petitioners have not presented any arguments that would support the application of equitable tolling to this claim, and my examination of the record does not disclose any basis for applying equitable tolling to this case.

V. Conclusion.

Petitioners have the burden to show timely filing. Petitioners here have failed to establish that this case was filed within "36 months after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury" as required by the Vaccine Act, or that equitable tolling is merited here. §16(a)(2).

For the reasons set forth above, **this case is dismissed as untimely filed. The clerk is directed to enter judgment accordingly.**[13]

IT IS SO ORDERED.

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Gary J. Golkiewicz
Special Master

[13] This document constitutes the undersigned's final "Decision" in this case, pursuant to § 12(d)(3)(A). If petitioners wish to have this case reviewed by a Judge of the United States Court of Federal Claims, a motion for review of this decision must be filed within 30 days. After 30 days the Clerk of this Court shall enter judgment in accord with this decision. If petitioners wish to preserve whatever rights they may **have to file a civil suit (that is a law suit in another court) petitioners must file an "election to reject judgment** in this case and file a civil action" within 90 days of the filing of the judgment. § 21(a).