In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS
No. 08-0276V
Filed: January 11, 2013

MICHAEL PONZIO and SAMORNRAT PONZIO, parents of JASON B. PONZIO, a minor,	*	
Petitioners,	*	Autism; Dismissal of Claim as Untimely Filed; Equitable Tolling
v.	*	
SECRETARY OF HEALTH AND HUMAN SERVICES,	*	
Respondent.	*	

DECISION[1]

On April 15, 2008, petitioners, on behalf of their son, Jason B. Ponzio, filed a claim for compensation pursuant to the National Vaccine Injury Compensation Program ("Vaccine Program" or "the Program").[2] 42 U.S.C. §§ 300aa-1 to -34 (2006).

[1] Because this decision contains a reasoned explanation for the action in this case, I intend 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, I agree that the identified material fits within the requirements of that provision, I 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"). Short-Form Autism Petition for Vaccine Compensation at 1.

Petitioners have the burden to demonstrate that their case was properly and timely filed under the Vaccine Act's statute of limitations. § 300aa-16(a)(2). Based on my analysis of the evidence, petitioners have not met their burden, and thus **this case is dismissed as untimely filed.**

I. Procedural History

The petition was filed by petitioners on April 15, 2008. Like most other cases in the OAP,[4] the case remained on hold until discovery in the OAP was concluded,

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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 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 Omnibus Autism Proceeding 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 § 300aa-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.

causation 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 test case decisions, petitioners, like others in the OAP, were ordered to file medical records. Respondent filed some of the required medical records on behalf of petitioners on June 25, 2009. Petitioners filed additional records on September 1, 2009. Respondent filed a Statement on October 15, 2009, indicating that respondent was unable to determine, based on petitioners' filed evidence to date, whether the petition was filed within the Vaccine Act's statute of limitations. Respondent's Statement at 4.[6] Thereafter, petitioners filed additional records on November 2, 2009.

After the final test case appeal was decided, the court ordered petitioners on September 23, 2010, to inform the court if they wished to pursue their claim. Petitioners failed to file a response to the court's September 23, 2010, Order. On December 3, 2010, petitioners were again ordered to inform the court if they wished to proceed with their claim or otherwise show cause why the claim should not be dismissed for failure to prosecute.

On December 21, 2010, petitioners filed a Response to the Order to Show Cause, indicating that they "believed that something in one or more of [their son's vaccinations] caused his autism." Petitioners' Response filed December 21, 2010 at 1. Petitioners' Response was interpreted as evidencing their intent to proceed with their claim. The court deferred any additional action on the timeliness of this case pending the Federal Circuit's en banc decision in *Cloer v. Sec'y of Health & Human Servs.*, 654 F.3d 1322 (Fed. Cir. 2011), addressing the Vaccine Act's statute of limitations.

Subsequent to the Federal Circuit's *en banc* decision in *Cloer*, an Order to Show Cause was filed on August 21, 2012, directing petitioners to show cause why this claim should not be dismissed as untimely filed under the Vaccine Act's statute of limitations.

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[4] A detailed discussion of the OAP can be found at *Dwyer v. Sec'y, HHS*, No. 03-1202V, 2010 WL 892250, at *3 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

[5] The Theory 1 cases are *Cedillo v. Sec'y, HHS*, 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. Sec'y, HHS*, 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. Sec'y, HHS*, 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. Sec'y, HHS*, No. 03-1202V, 2010 WL 892250 (Fed. Cl. Spec. Mstr. Mar. 12, 2010); *King v. Sec'y, HHS*, No. 03-584V, 2010 WL 892296 (Fed. Cl. Spec. Mstr. Mar. 12, 2010); *Mead v. Sec'y, HHS*, 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] Respondent's Statement is mistakenly paginated as 1, 2, 3, 1, 2. The page cited here is the second page 1 in the record but I have listed it as page 4 for clarity.

Petitioners responded to that Order on September 19, 2012 arguing that the claim should not be dismissed as untimely filed. Petitioners' Response filed September 19, 2012 ("Pet'rs' Resp.").

II. Facts.

Jason was born on August 9, 2002. Petitioners' Medical Records filed June 25, 2009 (Pet'rs' Ex 1) at 14.[7] He received routinely-administered childhood vaccinations between August 10, 2002, and July 31, 2007. *Id.* at 1. Between September 11, 2002, and February 12, 2004, Jason had periodic well-child examinations. *Id.* at 7, 9-13. Jason's 18 month well-child visit record dated February 12, 2004, indicates that Jason had not yet met the milestone of speaking 8-10 words. *Id.* at 7. At this visit, Jason received his Hib, DTaP, and Prevnar vaccinations. *Id.* at 1, 7. Petitioner Michael Ponzio reported in an affidavit dated July 27, 2009, that immediately following his February 12, 2004, vaccinations, Jason suffered a mild seizure, hitting his head "very hard against the floor." Respondent's Exhibit (Resp't's Ex) 1 at 1. Petitioner further reported that this was the first incident of "a pattern of [Jason] hurting his head this way." *Id.* Petitioner indicated that he believed "it was a bad vaccination or vaccinations he received on [February 12, 2004] that caused the whole thing." *Id.*

On May 16, 2005, Jason was diagnosed with autism pursuant to an evaluation from the Walter Reed Army Medical Center, Department of Pediatrics. Pet'rs' Ex. 1 at 5-6; Pet'rs' Medical Records filed November 2, 2009 (Ex 3).[8] A notation under "Developmental History" indicates that Jason exhibited "no true regression, but may have [ ] plateau[ed] at 9-15 months." *Id.* at 5. In an evaluation dated January 26, 2006, it is reported that Jason's mother indicated he had "fairly normal development until age 18 months when he developed poor eye contact, fluctuating mood, decrease in use of speech, more selective in foods eaten, and worsening sleep." Pet'rs' Medical Records filed September 1, 2009 (Ex 2) at 1. An evaluation dated August 20, 2007, from Children's National Medical Center indicates that "Jason present[ed] with a developmental history of regression at 2 years of age. At that time he stopped babbling and stopped feeding himself." Pet'rs' Ex 3 at 1.

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 set forth

[7] Petitioners' medical records filed on June 25, 2009, were submitted to the court by respondent on petitioners' behalf on a compact disc and designated by Notice of Filing as Exhibits 1-13, however the filed records contained on the compact disc were not divided into exhibits, but rather were submitted as one 47 page submission and will be referred to herein as Petitioners' Exhibit One.

[8] It is noted that an additional, more clear, copy of the May 16, 2005, evaluation by the Walter Reed Army Medical Center, Department of Pediatrics, was filed with petitioners' Exhibit 3, which was not paginated.

below at pp 5-10 of this Decision, which is primarily drawn from OAP test case testimony[9] provided by three pediatric neurologists with considerable experience in diagnosing ASD. I further note that the following summary of the information regarding the diagnosis of autism spectrum disorders, set forth at pp 5-10 below, was written and published by my colleague, Special Master Vowell, in *White v. Sec'y of the Dept. of Health & Human Servs.*, 04-337V, 2011 WL 6176064 (Fed. Cl. Spec. Mstr. Nov. 22, 2011).

"The terms 'autism' and 'autism spectrum disorder' ['ASD'] 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 (Fed. Cl. Spec. Mstr. Feb. 12, 2009) (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.[10] The manual identifies the behavioral symptoms recognized by the medical profession at large as symptoms of ASD.[11] The DSM-IV-TR contains specific diagnostic criteria for autistic disorder (often referred to as "autism"[12] 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.

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[9] 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 v. *Sec'y of Health & Human Servs.,* No. 01-162V, 2009 WL 332044, at *2-3 (Fed. Cl. Spec. Mstr. Feb. 12, 2009); Dwyer v. *Sec'y of Health & Human Servs.,* No. 02-1202V, 2010 WL 892250, at *2 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

[10] Transcripts from the OAP test cases, including *Cedillo*, may be accessed at http://www.uscfc.uscourts.gov/omnibus-autism-proceeding (last checked on August 21, 2012).

[11] 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 v Sec'y of Health & Human Servs.,* No. 03–1202V, 2010 WL 892250 (Fed. Cl. Spec. Mstr. Mar. 12, 2010), at *1 FN. 4 & *29 FN. 108.

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

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 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. 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*[13] 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

[13] *King v. Sec'y of Health & Human Servs.,* No. 03-584, 2010 WL 892296 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

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 criteria in one or more of the domains of functioning. *Id*. As was noted in the *Dwyer*[14] OAP test case, this is the most prevalent of the disorders on the autism spectrum. *Dwyer* 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.

[14] *Dwyer v. Sec'y of Health & Human Servs.,* No. 03–1202V, 2010 WL 892250 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

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.

C. 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. Analysis of the Case

The Vaccine Act provides 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 Court of Appeals for the Federal Circuit affirmed that the "statute of limitations begins to run on a specific statutory date: 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 1340. The date of the occurrence of the first symptom or manifestation of onset "does not depend on when a petitioner knew or reasonably should have known" about the injury. *Id.* at

1339. Nor does it "depend on the knowledge of a petitioner as to the cause of an injury." *Id.* at 1338.

The Federal Circuit also held that equitable tolling of the Vaccine Act's statute of limitations is permitted. *Id.* 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 from bringing 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 filed their vaccine claim on April 15, 2008. Therefore, for the Petition to be timely filed the "first symptom or manifestation of onset or of the significant aggravation" of Jason's injury must have occurred on or after April 15, 2005. §16(a)(2). However, petitioners' medical records and filed statements indicate that Jason exhibited symptoms of his autism-spectrum disorder prior to April 15, 2005 and outside the three year statute of limitations.

As discussed above, a notation on Jason's 18 month well-child visit on February 12, 2004, indicates that he had not yet met the milestone of speaking 8-10 words. Pet'rs' Ex 1 at 7. Jason's May 16, 2005, evaluation from the Walter Reed Army Medical Center, Department of Pediatrics, indicates that Jason exhibited "no true regression, but may have [ ] plateau[ed] at 9-15 months*."* *Id.* at 5; Pet'rs' Ex 3. (Jason was 9-15 months between May 9, 2003, and November 9, 2003). In an evaluation dated January 26, 2006, it is reported that Jason's mother indicated he had "fairly normal development until age 18 months when he developed poor eye contact, fluctuating mood, decrease in use of speech, more selective in foods eaten, and worsening sleep." Pet'rs' Ex 2 at 1. (Jason was 18 months on February 9, 2004). An evaluation dated August 20, 2007, from Children's National Medical Center indicates that "Jason present[ed] with a developmental history of regression at 2 years of age. At that time he stopped babbling and stopped feeding himself." Pet'rs' Ex 3 at 1. (Jason was two years of age on August 9, 2004).

The ASD diagnostic evidence discussed above from the OAP test cases demonstrates that developmental delay, speech delay, and speech regression are recognized by the medical community at large as being symptomatic of autism. The evidence further establishes that a delay in speech is often the first symptom of what is later diagnosed as an ASD. Based on the all of the evidence filed in this case, I find that the first symptom of Jason's autism occurred no later than when Jason was 24 months old, or August 9, 2004, and may have occurred even earlier. Therefore, the petition must have been filed on or before August 9, 2007 to be timely filed. However, the petition was filed on April 15, 2008, more than eight months too late.

In petitioners' response to the court's August 21, 2012 Order to Show Cause, petitioners do not contest that the first symptom or manifestation of onset of Jason's

autism occurred prior to April 15, 2005. Instead, petitioners seek to explain why they were unable to comply with the Act's statute of limitations. Pet'rs' Resp. at 1-2. Petitioners indicate that "[a]fter Jason received the vaccinations on February 12, 2004, he began losing skills that he had already mastered and his generalized temperament changed. . . . He not only stopped learning new skills, he lost previously mastered skills." *Id.* at 1. Petitioners aver that in the 36 months following Jason's February 12, 2004, vaccinations, Jason required a high level of attention and care from petitioners. The time constraints placed on petitioners were further heightened by the obligation to care for another child, as well as by Mr. Ponzio being an active duty serviceperson with the Army. *Id.* at 2. For these reasons petitioners explain that they were unable to "research what options were legally available to us on behalf of our son" and thus could not comply with the Act's statute of limitations. *Id.* Petitioners urge the court not to dismiss their claim as untimely filed and allow them to proceed with their claim. *Id.*

I recognize the severe disability Jason possesses, and I am sympathetic to the constraints placed on petitioners. However, unfortunately for petitioners, the fact that petitioners did not have the time in their busy lives to explore their legal options on behalf of Jason within the Act's statute of limitations period is not a legally sufficient justification to toll the statute of limitations. *See Cloer*, 654 F.3d at 1344-45. Citing to *Pace v. DiGuglielmo*, 544 U.S. 408, 418 (2005), the Circuit 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. While I sympathize with the hardships petitioners confront, I find that petitioners have not evidenced the type of extraordinary circumstances that would legally merit the equitable tolling of the Vaccine Act's statute of limitations in this case.

V. Conclusion.

I have great sympathy for the petitioners' situation. However, under the applicable law, petitioners have the burden to show timely filing. Petitioners have failed to do so. There is preponderant evidence that this case was not 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. § 16(a)(2). Petitioners have neither demonstrated that their claim was timely filed nor have petitioners demonstrated any extraordinary circumstances warranting equitable tolling.

For the reasons set forth above, **this claim is dismissed as untimely filed. The clerk is directed to enter judgment accordingly.** [15]

[15] This document constitutes my 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 right petitioners 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).

IT IS SO ORDERED.

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George L. Hastings
Special Master