

**IN THE UNITED STATES COURT OF FEDERAL CLAIMS
OFFICE OF SPECIAL MASTERS**

No. 03-2067V

Filed: April 13, 2012

EVELYN BENNETT, parent of Lance
Bennett,

Petitioner,

v.

SECRETARY OF THE DEPARTMENT
OF HEALTH AND HUMAN SERVICES,

Respondent.

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* Autism; Statute of Limitations,
* Speech and Language Delay;
* First Symptom or Manifestation of
* Onset; Equitable Tolling;
* Dismissal
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DECISION DISMISSING PETITION¹

Vowell, Special Master:

On September 8, 2003, Evelyn Bennett [“Ms. Bennett” or “petitioner”] filed a petition for compensation under the National Vaccine Injury Compensation Program, 42 U.S.C. §300aa-10, *et seq.*² [the “Vaccine Act” or “Program”], on behalf of her minor son, Lance Bennett [“Lance”]. Petitioner initially filed the “short form” petition authorized by Autism General Order # 1.³ In essence, by filing a short form petition, petitioner

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 National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, 100 Stat. 3755. Hereinafter, for ease of citation, all “§” references to the Vaccine Act will be to the pertinent subparagraph of 42 U.S.C. § 300aa (2006).

³ The text of Autism General Order #1 can be found at <http://www.uscfc.uscourts.gov/sites/default/files/autism/Autism+General+Order1.pdf> [“Autism Gen. Order #1”], 2002 WL 31696785 (Fed. Cl. Spec. Mstr. July 3, 2002).

asserted that (1) Lance had a disorder on the autism spectrum and (2) that one or more vaccines listed on the Vaccine Injury Table⁴ were causal of Lance's condition.⁵

Respondent moved to dismiss petitioner's case, asserting that the petition was filed outside the Vaccine Act's 36 month statute of limitations because the statute of limitations started running on October 10, 1998, Lance's second birthday, when his speech delay was noted. § 6(a)(2); Respondent's Motion to Dismiss ["Res. Mot."], filed Mar. 16, 2009, at 4. Petitioner, however, argues that the statute of limitations did not start running until January 11, 2001, when Lance was diagnosed with autism, and therefore the petition was timely filed. Petitioner's Response to Motion to Dismiss ["Pet. Res."], filed May 6, 2009, at 6.

Petitioner has the burden to demonstrate that her case was properly and timely filed. Based on my analysis of the evidence, petitioner has not met her burden, and thus **this case is dismissed.**

I. Procedural History.

This petition was filed on September 8, 2003. Like many other cases in the Omnibus Autism Proceeding ["OAP"],⁶ the case remained on hold until discovery in the OAP was concluded, causation hearings in the test cases were held, and entitlement decisions were issued in the test cases.⁷

During the period between the test case hearings and the final appellate action on the decisions, petitioner, like others in the OAP, was ordered to file medical records in support of her claim. Petitioner filed Petitioner's Exhibits ["Pet. Exs."] 1-6 on February

⁴ 42 C.F.R. § 100.3 (2010).

⁵ The two theories of causation specifically addressed in Autism Gen. Order #1 were that the measles, mumps, and rubella ["MMR"] vaccine was causal [the "MMR theory" or "Theory 1"] or that vaccines containing a mercury-based preservative called thimerosal [the "TCV theory" or "Theory 2"] were causal, or that a combination of the MMR vaccine and TCVs were causal.

⁶ 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).

⁷ 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.

11, 2009. After reviewing the medical records contained in petitioner's exhibits, respondent moved to dismiss the case, asserting it was not timely filed. Res. Mot. at 1.

After the final OAP test case appeal was decided, I ordered petitioner to inform the court if she wished to continue to pursue her claim. Order, filed Sept. 15, 2010. Ms. Bennett responded with a letter indicating that she wished to continue with her claim. I then ordered petitioner to file a statement identifying her theory concerning how Lance's vaccines caused his autism spectrum disorder. Order, filed Oct. 18, 2010.

The causation statement, filed January 27, 2011, noted that Lance had received routine childhood vaccines, some of which contained thimerosal. Causation Statement at 1-2. Additionally, the statement noted that high levels of lead were found in Lance's body and that mercury was present in the DTaP (and/or DT/DTaP) vaccines that Lance received on the following dates: December 10, 1996, March 26, 1997, September 22, 1997, February 8, 1999, and August 16, 2002. In addition, the statement alleged that Lance shows evidence of the same, or similar, mitochondrial dysfunction commonly found in children with autism.

On February 1, 2011, I issued an order explaining that I would wait for the outcome of two cases then on appeal, *Cloer v. Sec'y, HHS*, 85 Fed. Cl. 141 (2008)⁸ and *Carson v. Sec'y, HHS*, 97 Fed. Cl. 620 (2010), before determining whether the claim was filed on time. Order, filed Feb. 1, 2011. On August 22, 2011, noting that the en banc decision in *Cloer* had issued on August 8, 2011, I gave respondent until September 19, 2011 to supplement her motion to dismiss and indicated that petitioner could have until October 18, 2011 to file an additional response. Order, dated Aug. 22, 2011.

Respondent filed a supplemental response addressing *Cloer* ["Res. Suppl. Resp."] and exhibits A-E on September 19, 2011. Petitioner did not file any additional briefing. The issues are now fully joined and the case is ripe for decision. In this decision, I apply the summary judgment standard contained in Rule 56 of the Rules of the Court of Federal Claims ["RCFC"].⁹

⁸ The U.S. Court of Federal Claims decision was reversed and remanded by a panel of the U.S. Court of Appeals for the Federal Circuit. *Cloer v. Sec'y, HHS*, 603 F.3d 1341 (Fed. Cir. 2010). The panel's decision was vacated and rehearing en banc was ordered. *Cloer v. Sec'y, HHS*, 399 Fed. Appx. 577 (Fed. Cir. 2010). The en banc decision was issued on August 5, 2011. *Cloer v. Sec'y, HHS*, 654 F.3d 1322 (Fed. Cir. 2011) (en banc) (rejecting a discovery rule and holding the statute of limitations runs from the first symptom or manifestation of onset recognized by the medical profession at large).

⁹ According to RCFC 56, "the court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law."

II. Evidence Concerning Vaccinations, Symptoms, and Diagnosis.

Lance was born on October 10, 1996. Pet. Ex. 1, p. 1. He received routine child immunizations from birth until August 16, 2002. Pet. Exs. 4, p. 2; 6, pp. 18-19. At his 12 month check-up, Lance was able to sit alone. He had begun babbling at around 8 months. Pet. Ex. 4, p. 4. On January 19, 1998, at his 15 month well baby check-up, Lance was still “mostly babbling” and was not talking. *Id.*, p. 5. He crawled and climbed on things, but did not walk independently. *Id.*

On June 3, 1998, at 18 months of age Lance was seen for a temperature of 102⁰ Fahrenheit. Pet. Ex. 4, p. 5. His pediatrician, Dr. Earl Rogers, diagnosed him with pharyngitis.¹⁰ *Id.*, p. 6. Doctor Rogers also noted that Lance spoke eight to ten single words, would push and pull toys, and sometimes rode a scooter. *Id.*, p. 5. Two weeks later, on June 17, 1998, Lance was seen again by Dr. Rogers to review his weight and test results. *Id.*, p. 7. Lance’s length was normal, but he was underweight. *Id.* Additionally, his lead levels were increased; the consult note states “check for lead in paint (H. Dept).” *Id.*, pp. 7, 20.

On February 8, 1999, at his two-year well child examination, Lance spoke only three to five single words. Pet. Ex. 4, p. 7. He had a very short attention span. He would stack blocks and handle shapes, but would not pedal his tricycle when around other children. *Id.*, pp. 7-8.

Two months later, on April 21, 1999, Lance was seen by his pediatrician for cold symptoms and a possible low grade fever. Pet. Ex. 4, p. 9. At this appointment, Ms. Bennett was concerned that Lance was still not talking and that his speech was “limited to moans, grunts, and only a very few single words.” *Id.* Lance communicated by motions and gestures, such as bringing an empty sippy cup to someone and moaning when he wanted a refill. *Id.* He would not ask for more milk or juice. *Id.*

On December 29, 2000, when Lance was over three years old, Ms. Bennett completed a history form for Lance before he was seen for the first time by Drs. James and Kathryn Mize. On the form, she indicated that Lance smiled at two months, rolled over front to back at three months, sat at six months, and walked and spoke several words at one year. Pet. Ex. 6, p. 5. She also indicated that Lance did not yet undress himself, nor was he toilet-trained. *Id.* Ms. Bennett responded that he had been seen by a doctor over a prolonged period of time for “not talking.” *Id.* The consult notes from the visit relay that at one and a half years he had three words: “bye-bye,” “mama,” and “Sasha” (his sister’s name). *Id.*, p. 8. Lance required that things be set up in just the right place, or he would get upset. *Id.* It was also reported that he tended to line up his toys in a very specific order, and that he did not like to make eye contact with people. *Id.*

¹⁰ Pharyngitis is inflammation of the pharynx. See DORLAND’S ILLUSTRATED MEDICAL DICTIONARY (32nd ed. 2012) [“DORLAND’S”], p. 1426.

On January 11, 2001, when Lance was four years of age, Dr. Albert L. Sprinkle, at the Valley Psychiatric Associates, P.C., diagnosed him with autism. Pet. Ex. 5, p. 2. Lance was accompanied to the appointment by Ms. Bennett and his maternal grandmother. *Id.*, p. 1. Per their history, Dr. Sprinkle recorded that Lance tended to play with himself, had very limited imitative play, and “more frequently [would] play by lining his toys up in a row or banging them.” *Id.* Additionally, Lance “self stimulate[ed] by flapping his hands or rubbing his arms.” *Id.*, p. 1. Ms. Bennett and his grandmother reported that he had a “very short attention span” and did not stay with any one task very long. *Id.* Lance also could not “tolerate any change” and would become very upset if the furniture was moved or if a different route was taken somewhere. *Id.* According to Dr. Sprinkle’s report, Lance had “some early development delays,” such as not walking until 17 months. *Id.* Although Lance had a few words at age two, he was reported to have no language skills. *Id.*, p. 2. During the evaluation, Lance “constantly ran around the room, jumping off the furniture and getting into everything,” and “used very little non-verbal communication and mostly grunted when he wanted something.” *Id.*

III. Diagnostic Criteria for Autism Spectrum Disorders.

Only respondent filed any evidence¹¹ concerning the diagnostic criteria for autism spectrum disorders [“ASD”]. The information contained in this section is drawn from that evidence. The transcript excerpts contained in Res. Exs. C-E were from OAP test case testimony provided by three pediatric neurologists with considerable experience in diagnosing ASD.

“Autism Spectrum Disorder” or “ASD” is an umbrella term for certain developmental disorders, including autism (also referred to as autistic disorder), pervasive developmental disorder—not otherwise specified [“PDD-NOS”], and Asperger’s Disorder. See R. Luyster, et al., *Language Assessment and Development in Toddlers with Autism Spectrum Disorders*, *J. Autism Dev. Disord.* 38: 1426-38, 1426 (2008) [“Luyster”] filed as Res. Ex. A. Pervasive developmental disorders is the umbrella term used in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 4th ed. text revision 2000) [“DSM-IV-TR”] at 69, rather than ASD. I use the term ASD throughout this opinion 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. I use the term “autism” to refer solely to the specific diagnosis of “autistic disorder.”

¹¹ 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.

The specific diagnostic criteria for ASD are found in the DSM-IV-TR, the manual used in the United States to diagnose dysfunctions of the brain. Res. Ex. C, excerpt of testimony of Dr. Eric Fombonne in the *Cedillo* OAP test case [“Fombonne Tr.”] at 1278A. The manual identifies the behavioral symptoms recognized by the medical profession at large as symptoms of ASD. The DSM-IV-TR contains specific diagnostic criteria for autistic disorder (often referred to as “autism” or “classic autism”), Asperger’s disorder, and pervasive developmental disorder-not otherwise specified (most frequently referred to as “PDD-NOS”).

A. Diagnosing Autism Spectrum Disorders.

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 Res. Ex. E, 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.

B. The Domains of Impairment and Specific Behavioral Symptoms.

A diagnosis of autistic disorder requires a minimum of six findings from a list of impairments divided into three domains of impaired function: (1) communication; (2) social interaction; 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 *Cedillo* OAP test case, Dr. Wiznitzer described the three

¹² *King v. Sec’y, HHS*, No. 03-584, 2010 WL 892296 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

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.

1. 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. “Delays and deficits in language acquisition” are “among the key diagnostic criteria for autism spectrum disorders.” Luyster at 1426.

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. Luyster at 1426; *see also* 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 1602 A - 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.

2. 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. For PDD-NOS, there must be at least one impairment in this domain. Fombonne Tr. at 1275A.

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 he asked the child for his address. *Id.* at 1601.

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. Others include a lack of imitation, lack of interest in other children, and infrequent seeking to share with others. R. Landa, *Diagnosis of autism spectrum disorders in the first 3 years of life*, NATURE CLINICAL PRACTICE NEUROLOGY, 4(3): 138-47 (2008) ["Landa"], filed as Res. Ex. B, at Table 1.

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 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. Of significance, 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.

III. Arguments and Analysis.

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. . . .

§ 300aa-16(a)(2).

2. Interpreting the Statute of Limitations.

The date of occurrence “is a statutory date that does not depend on when a petitioner knew or reasonably should have known anything adverse about her condition.” *Cloer v. Sec’y, HHS*, 654 F.3d 1322, 1339 (Fed. Cir. 2011) (en banc). Additionally, the date “does not depend on the knowledge of a petitioner as to the cause of an injury.” *Id.* at 1338. 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.*

In *Markovich*, the court explained the differences between “symptom” and “manifestation of onset,” as those words are used in the Vaccine Act. *Markovich v. Sec’y, HHS*, 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. Sec’y, HHS*, 36 Fed. Cl. 474, 477 (1996)).

3. Applying the Facts to the Law.

To determine if this case was timely filed, I must determine when the first symptom or manifestation of onset of the alleged vaccine injury occurred. Once that date is ascertained, I then compare it to the filing date of Lance's petition to determine if the petition was filed within the Vaccine Act's 36 month statute of limitations.

Because petitioner filed her petition on behalf of Lance on September 8, 2003, the first symptom or manifestation of onset of Lance's autism must have occurred on or after September 8, 2000, 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 Lance's autism diagnosis (January 11, 2001) occurred after the critical date of September 8, 2000, he exhibited numerous symptoms associated with autism prior to September 8, 2000. To be diagnosed with autism, a child must display abnormal development in three different domains: (1) communication; (2) social interaction; and (3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. *Snyder*, 2009 WL 332044 at *36.

With regard to the first domain, communication, several references to speech delay are found in the records. On February 8, 1999, when he was two years old, Lance had a very short attention span and a limited vocabulary of only three to five words. Pet Ex. 4, p. 7. On April 21, 1999, Lance was seen by his pediatrician because Ms. Bennett was concerned that Lance was still not talking and that his speech was limited to moans, grunts, and only a few single words. *Id.*, p. 9. In an evaluation on January 1, 2001, Ms. Bennett indicated that although Lance developed a few words at age two, he then quit talking. Pet. Ex. 5, p. 1. At age four, Dr. Sprinkle's notes indicate that Lance no longer used any language. *Id.*

In her response, petitioner argued that the date of diagnosis (January 11, 2001) was the earliest date by when "Lance's condition was first recognized by the medical profession at large to be related to autism." Pet. Res. at 6. While it is true that no health care provider pointed to Lance's speech delay and stated that it constituted the first symptom of his autism, the statute of limitations begins to run from the "occurrence of an event recognizable as a sign of vaccine injury by the medical profession at large, not the diagnosis that actually confirms such as injury in a specific case." *Goetz v. Sec'y, HHS*, 45 Fed. Cl. 430, 342 (1999), *aff'd*, 4 Fed. Appx. 827 (Fed. Cir. 2001). The OAP transcript excerpts and the medical literature submitted by respondent establish that the speech and language delays exhibited by Lance, as noted in his medical records and histories, are recognized by the medical community at large as symptomatic of ASD, including autism.

Additionally, Lance's diagnosis itself confirms that Dr. Sprinkle believed that at least some autistic behaviors occurred prior to Lance's third birthday. By definition, for a diagnosis of autistic disorder (autism), the abnormalities in behavior must have occurred prior to three years of age. If they occurred before Lance turned three on October 10, 1999, the claim was untimely filed.

The statute of limitations considers both the first symptoms and the manifestation of onset. The DSM-IV-TR requires at least one impairment in communication for a diagnosis of autism. Furthermore, the evidence establishes that a delay in speech is often the first symptom of what is later diagnosed as an ASD. Since Lance experienced symptomatic behaviors associated with autism prior to September 8, 2000, his 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 acknowledged that equitable tolling applies in Vaccine Act cases, but under very limited circumstances, such as when a petitioner was the victim of fraud or duress, or when a procedurally deficient pleading was timely filed. *Cloer*, 654 F.3d at 1344-45. It squarely rejected the applicability of equitable tolling "due to unawareness of a causal link between an injury and administration of a vaccine." *Id.* at 1345.

Petitioner has 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.

IV. Conclusion.

Petitioner has the burden to show timely filing. She has 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. § 300aa-16(a)(2).

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

IT IS SO ORDERED.

Denise K. Vowell
Special Master