

# In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS

No. 08-0880V

Filed: November 5, 2012

Reissued: December 3, 2012

(Not to be Published)

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KENNETH J. ASHMAN and  
LAURA ASHMAN, parents of  
S.A., a minor,

Petitioners,

v.

SECRETARY OF HEALTH AND  
HUMAN SERVICES,

Respondent.

Autism; Statute of Limitations;  
Untimely Filed; Equitable Tolling

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## DECISION<sup>1</sup>

On December 10, 2008, Kenneth J. Ashman and Laura Ashman [“petitioners”] filed a Short-Form “Petition for Vaccine Compensation”<sup>2</sup> pursuant to the National

<sup>1</sup> This Decision was originally filed on November 5, 2012. On November 20, 2012, petitioners requested redactions. Thereafter, I granted in part and denied in part petitioners’ request. Order, filed Dec. 3, 2012; see also, *Langland v. Sec’y, HHS*, No. 07-36V, 2011 WL 802695, at \*6 (Fed. Cl. Spec. Mstr. Feb. 3, 2011) (describing a special master’s discretion to order redaction as “limited”); *Castagna v. Sec’y, HHS*, No. 99-411V, 2011 WL 4348135, at \*14 (Fed. Cl. Spec. Mstr. Aug. 25, 2011) (“A general preference for privacy is not a sufficient basis for redaction.”). In this reissued version, the minor child’s name is redacted to initials and this footnote is changed to reflect the redaction. The remainder of the Decision is unchanged.

<sup>2</sup> By electing to file a Short-Form Autism Petition for Vaccine Compensation, petitioners allege 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.

Vaccine Injury Compensation Program ["Vaccine Program"]<sup>3</sup> on behalf of their son, S.A. By filing a short-form petition, petitioners opted into the Omnibus Autism Proceeding ["OAP"].<sup>4</sup>

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 my analysis of the evidence, petitioners have not met their burden, and thus **this case is dismissed as untimely filed.**

### I. Procedural History.

With their petition, petitioners filed a Motion for Leave to File Short-Form Autism Petition for Vaccine Compensation, *Nunc Pro Tunc* ["*Nunc Pro Tunc* Motion"],<sup>5</sup> alleging that counsel attempted to file their petition on November 14, 2007, and that the copy of the petition which was mailed to respondent was received on November 20, 2007. *Nunc Pro Tunc* Motion at 1, Exhibits A-B. This motion was denied on January 27, 2009.<sup>6</sup> Petitioners filed a motion for reconsideration of this denial on February 17, 2009. Petitioners' motion was denied on March 10, 2009.

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<sup>3</sup> The National Vaccine Injury Compensation Program ["Vaccine 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). All citations in this decision to individual sections of the Vaccine Act are to 42 U.S.C. § 300aa.

<sup>4</sup> A detailed explanation of the creation of the OAP and the effects of opting into it can be found in *Dwyer v. Sec'y, HHS*, No. 03-1202V, 2010 WL 892250, at \*3 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

<sup>5</sup> Petitioners also filed a Motion to Appear *Pro Hac Vice*, requesting that Neal Kitterlin, an associate at Mr. Ashman's law firm ["Ashman Law Offices, LLC"] who was not admitted to practice before the Court of Federal Claims, be allowed to appear and participate as counsel, *pro hac vice*, in accordance with Rule 83.1(a)(2) of the Rules of the United States Court of Federal Claims ["RCFC"]. Motion to Appear *Pro Hac Vice*, filed Dec. 10, 2008, at 1. However, the motion was filed by Mr. Kitterlin and indicated that he was "attorney of record to Petitioners." *Id.* at 1-2. Rule 83.1(a)(2) indicates that "[a]n attorney may participate *pro hac vice* in any proceeding before this court if: . . . (B) the attorney of record for any party has requested and is present for such participation and has received the court's approval." RCFC 83.1(a)(2). In this case, the attorney of record, Mr. Kitterlin, was seeking permission to participate *pro hac vice*. Petitioners' motion was denied on January 21, 2009, and petitioners were ordered to file a Status Report by February 4, 2009, informing the undersigned whether Mr. Kitterlin intended to seek admission to the bar of the United States Court of Federal Claims or if they intended to seek new counsel. Petitioners filed a Status Report indicating they would proceed as *pro se* petitioners on February 4, 2009.

<sup>6</sup> Until September 27, 2012, this case was assigned to Special Master Golkiewicz. He acknowledged that "petitioners' allegation was supported by a copy of a Short-Form Autism Petition for Vaccine Compensation date stamped 'Received' by respondent at the Department of Health and Human Services, as well as affidavits from counsel and counsel's former law clerk in support of their claim" but concluded that he "must deny petitioners' Motion." Order, filed Jan. 27, 2009 (citing *Mojica v. Sec'y, HHS*, 287 Fed. Appx. 103 (Fed. Cir. 2008)).

Thereafter, petitioners, like others in the OAP, were ordered to file all required medical records and to establish that their petition was timely filed under the Vaccine Act's statute of limitations. Order, filed May 29, 2009; see also § 11(c)(2); § 16(a)(2). Petitioners filed the required records on October 30, 2009. Petitioners also filed a Statement Regarding Onset ["Onset Statement"] claiming that the petition was timely filed.

On December 14, 2009, respondent filed a Motion to Dismiss, arguing that the petition was filed after the Vaccine Act's statute of limitations had expired. Petitioners filed a Response to the Motion to Dismiss ["Pet. Response"] on January 25, 2010. No further action was taken on the motion at that time because a decision in a case then pending before the Federal Circuit was expected to clarify how to apply the Vaccine Act's statute of limitations.<sup>7</sup>

After the resolution of the OAP test cases,<sup>8</sup> petitioners were required to inform the Court whether they wished to proceed with their claim. Order, filed Sept. 13, 2010. On February 2, 2011, petitioners filed their Notice of Intent to Proceed. Petitioners later indicated that they were adopting "the causation theories previously advanced in the Omnibus Autism Proceeding." Petitioners' Statement of Theory of Causation, filed Mar. 31, 2011, at 1.

Subsequent to the Federal Circuit's en banc decision in *Cloer*, petitioners were ordered to show cause why this claim should not be dismissed as untimely filed. Order to Show Cause, filed Aug. 21, 2012. On September 20, 2012, petitioners filed their response ["Pet. Resp. to SC Order"]. In addition to arguing that their petition was timely filed, petitioners argued that the statute of limitations should be equitably tolled.

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<sup>7</sup> See *Cloer v. Sec'y, HHS*, 85 Fed. Cl. 141 (2008) (affirming *Cloer v. Sec'y, HHS*, No. 05-1002V, 2008 WL 2275574 (Fed. Cl. Spec. Mstr. May 15, 2008)). 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).

<sup>8</sup> The Petitioners' Steering Committee ["PSC"], an organization formed by attorneys representing petitioners in the OAP, litigated six test cases presenting two different theories on the causation of ASDs. Decisions in each of the three test cases pertaining to the PSC's first theory rejected the petitioners' causation theories. *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).<sup>8</sup> Decisions in each of the three "test cases" pertaining to the PSC's second theory also rejected the petitioners' causation theories, and petitioners in each of the three cases chose not to appeal. *Dwyer*, No. 03-1202V, 2010 WL 892250; *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).

## II. Medical History.

S.A. was born on September 25, 2001, and received the usual childhood vaccinations between October 25, 2001 and May 12, 2003. Petitioners' Exhibit ["Pet. Ex."] 6, pp. 51-52. His medical records show normal physical growth. *Id.*, pp. 48-49. He experienced some childhood illnesses between birth and December 2002. See, e.g., Pet. Exs. 3, p. 1; 4, p. 13.

On December 17, 2003, based on concerns raised by a family friend regarding S.A.'s speech and language development, S.A. was evaluated by Angela Ziehmke, a speech and language pathologist, and Mary Miller, a developmental therapist. Pet. Ex. 7, pp. 2-10. One desired outcome of this evaluation and further treatment was to help S.A. "to communicate verbally without frustration so that he can express his needs and desires effectively." *Id.*, p. 17.

According to parental reports recorded in the written evaluations, S.A. was "not putting 2 words together" and "does not always handle new people or new environments easily." *Id.*, p. 2. The Ashmans also reported some of S.A.'s unusual behaviors. They described him as a "picky eater," *id.*, p. 7, who does not like vegetables or messy food." *Id.*, p. 3. They noted that he "mouths objects and sucks on his blanket," though infrequently. *Id.*, p. 7. They added that S.A. "frequently cross[es] his fingers," *id.*, p. 7, and will cry, kick his feet, and/or kick and hit his brother when told 'no.'" *Id.*, p. 3.

During his evaluation, S.A. was observed engaging in solitary and physical play. *Id.*, p. 6. After jumping into the air and landing bottom-first on the hardwood floor, he laughed and appeared unharmed. *Id.* He was observed playing with his brother, "but there did not appear to be any reciprocity in the play." *Id.*, p. 9. Both evaluators noted that S.A. did not interact with them during the evaluation. *Id.*, pp. 3, 5. Ms. Miller noted that he made minimal eye contact with her. *Id.*, p. 9.

Ultimately, S.A.'s overall development was summarized as "atypical, with a variable delay." *Id.*, p. 5. Both evaluators concluded that S.A. qualified for an Early Intervention program based on a finding that he exhibited "30% or more delay in one or more area of development." *Id.*, pp. 4, 9. Both recommended intervention for "language, speech and communication development," *id.*, pp. 4, 9, and Ms. Miller also recommended intervention for "social-emotional development." *Id.*, p. 9. A hearing evaluation and an occupational therapy evaluation were also recommended. *Id.*, p. 4.

A hearing evaluation on December 23, 2003, found S.A.'s hearing "adequate for the development of conversational speech." *Id.*, p. 14. On January 21, 2004, Traci Tyler, a pediatric occupational therapist concluded that S.A. "presents with atypical responses in sensory regulation and processing indicating a >30% delay that is impacting his day to day activities." *Id.*, p. 24. S.A.'s therapist reported that "[h]e would often respond to his name after he was called 2-3 times." *Id.*, p. 20. Later that year,

S.A. was referred to a clinical psychologist for a developmental evaluation. Pet. Ex. 6, p. 36.

During an evaluation on February 13, 2004, another desired outcome of S.A.'s treatment was recorded. This time, the goal was to get S.A. "to be able to adjust to a variety of situations and environments." Pet. Ex. 7, p. 16. S.A.'s communication skills also remained a concern. During an evaluation on May 20, 2004, therapist Cynthia Gutierrez noted that S.A. "continues to have difficulty accepting a visual cue as a response without a verbal utterance," exemplified by the observation that [he] will repeated[ly] say 'dada' until Mr. Ashman responds with 'yea', even though he was giving [S.A.] visual focus the whole time." *Id.*, p. 40. Ms. Gutierrez added that S.A., who was nearly 32 months of age on the date of assessment, had the language skills "expected of a 22-month old child." *Id.*

On a special education referral form, filled out on June 1, 2004, a few behavioral concerns were noted. S.A. was reported to repeat "'DaDa' (or Nana, Mama) over and over to one step directions" and be incapable of carrying out multi-step directions. *Id.*, p. 48. In an occupational therapy report in July 2004, therapist Brandy Schaffel commented that "[a]lthough [S.A.] can follow simple one-step directions, multi-step directions are more difficult." *Id.*, p. 58. In a report resulting from a July 26, 2004 evaluation, psychologist Anne Remler also noted that S.A. "demonstrated some repetitive behaviors and routines and was not able to complete multiple step directions." *Id.*, p. 62. Ms. Remler added that S.A. "demonstrated delayed receptive and expressive language" and "experienced difficulty communicating." *Id.*

S.A. was evaluated again between November 24, 2004 and January 4, 2005. *Id.*, pp. 35-36. In a written evaluation dated April 15, 2005, Dr. Sharon Johnson noted S.A.'s "history of speech and language delays" and recorded the observations of S.A.'s parents. *Id.*, p. 36. According to the Ashmans, S.A. demonstrated tactile aversions, did not engage in imaginative play, and demonstrated repetitive behaviors, such as repeatedly pouring water. *Id.* Ultimately, Dr. Johnson opined that S.A.'s "behavior is more suggestive of an associated behavioral issue rather than a disorder with a neurological underpinning such as Autism." *Id.*, p. 40. She diagnosed S.A. with a "Mixed Receptive/Expressive Language Disorder." *Id.* On May 27, 2005, however, S.A. was diagnosed with autism by a team of specialists following an autism assessment conducted between March 15, 2005 and May 27, 2005. Pet. Ex. 5, pp. 1, 15.

### **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 OAP test case testimony<sup>9</sup> provided by three pediatric neurologists with considerable experience in

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<sup>9</sup> All of the evidence filed in the OAP test cases is available to any petitioner in the OAP, as well as to respondent. 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

diagnosing autism spectrum disorders [“ASDs”] for information regarding ASD symptoms and diagnostic criteria.

“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. 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.<sup>10</sup> The manual identifies the behavioral symptoms recognized by the medical profession at large as symptoms of ASD.<sup>11</sup> The DSM-IV-TR contains specific diagnostic criteria for autistic disorder (often referred to as “autism”<sup>12</sup> 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. See Fombonne Tr. at 1266A (explaining that the profile of a child’s symptoms can change as the child gets older, sometimes making the specific diagnosis and evaluation difficult to understand).

#### 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.

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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.

<sup>10</sup> 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).

<sup>11</sup> 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.

<sup>12</sup> I use the term “autism” to refer solely to the specific diagnosis of “autistic disorder.”

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*<sup>13</sup> 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 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.

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<sup>13</sup> *King*, 2010 WL 892296.

## 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* 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. *Id.* at 1594-96. To be diagnosed with autism (autistic disorder), the patient must have behavioral symptoms from two of the four subgroups. *Id.* 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. *Id.* 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. *Id.* 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. *Id.* 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*, 2010 WL 892250, 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. *Id.* 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. *Id.* 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. *Id.* 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 the 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. *Id.* 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. Statutory Requirements for Timely Filing.**

The Vaccine Act provides that:

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 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, 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 *Irwin v. Dep’t of Veterans Affairs*, 498 U.S. 89, 96 (1990)). 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 (citing *Pace v. DiGuglielmo*, 544 U.S. 408, 418 (2005)); see also *Irwin*, 498 U.S. at 96.

## V. Arguments and Analysis.

### A. First Symptom or Manifestation of Onset.

Petitioners argue that the first symptom or manifestation of onset of S.A.’s autism occurred on May 27, 2005, when he was diagnosed with autism. Onset Statement at 1.<sup>14</sup> They concede that even “their May 27, 2005 onset date is still outside the limitations period when considered against the December [10], 2008 filing date the petition currently bears.” *Id.* at 6. However, they argue “and continue to maintain, that the filing date of the petition is and should be considered to be November 20, 2007, the date the petitioners originally submitted their Petition to this Court.” *Id.* at 6.

Respondent argues that S.A.’s first symptom or manifestation of onset of his autism occurred on or before December 17, 2003, when S.A. was first evaluated for speech delay. Motion to Dismiss, filed Dec. 14, 2009, at 4; see also Part III.B.2 above.

Even utilizing a filing date of November 20, 2007,<sup>15</sup> the petition is untimely filed because the first symptoms of S.A.’s ASD occurred long before his diagnosis. Petitioners do not appear to dispute that S.A. was exhibiting speech and language delay prior to May 27, 2005, but rather argue that it does not qualify as a first symptom because a specialist such as Dr. Johnson knew of S.A.’s history but failed to diagnosis his autism. Onset Statement at 2. They also argue that because speech delay is not sufficient by itself to diagnose autism, it does not trigger the running of the Vaccine Act’s statute of limitations. *Id.* at 4-5. They assert that S.A.’s speech delay and other symptoms of autism that he may have exhibited only trigger the running of the Vaccine Act’s statute of limitations when they are sufficient and numerous enough to result in a diagnosis of autism.

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<sup>14</sup> I cite primarily to the Onset Statement despite the fact that virtually the same information is contained in petitioners’ response. Compare Onset Statement with Pet. Response.

<sup>15</sup> Special Master Golkiewicz ruled that the date of filing was December 10, 2008 (see Order, filed Jan. 27, 2009, citing *Mojica*, 287 Fed. Appx. 103). However, the judgment in *Mojica* was vacated and the petition was later reinstated based on the Federal Circuit’s decision in *Cloer* that equitable tolling could apply in Vaccine Act cases. See *Mojica v. Sec’y, HHS*, 102 Fed. Cl. 96 (2011). Therefore, for purposes of this decision on respondent’s motion to dismiss, I evaluated timeliness using November 20, 2007 as the filing date. Regardless of the date of filing used, the petition is untimely filed.

A diagnosis is not necessary to trigger the running of the statute of limitations. See *Cloer*, 654 F.3d at 1329 (citing *Cloer*, 2008 WL 2275574, at \*9, *aff'd*, 85 Fed.Cl. 141 (2008)). Developmental delay and speech delay are recognized by the medical community at large as being symptomatic of autism even though they are not sufficient, in and of themselves, to establish a diagnosis of autism. See *White v. Sec'y, HHS*, 04-337V, 2011 WL 6176064, at \*12 (Fed. Cl. Spec. Mstr. Nov. 22, 2011). Some form of impairment in communication is essential to an autism diagnosis. *Id.* at \*8 (citing *Wiznitzer Tr.* at 1602 A–1603). A delay in speech is often the first symptom of what is later diagnosed as an ASD or autism. See *White*, 2011 WL at \*8 (citing R. Luyster, et al., *Language Assessment and Development in Toddlers with Autism Spectrum Disorders*, J. AUTISM DEV. DISORD. 38: 1426–38, 1426 (2008)). Although petitioners argue that speech delay alone is insufficient to trigger the running of the statute of limitations, S.A. displayed other symptoms of autism on or before December 17, 2003, including impairments in social interaction (poor eye contact), lack of reciprocal play, and some stereotypical mannerisms (crossing fingers and mouthing objects). Since these symptoms existed on or before December 17, 2003, the petition must have been filed by no later than December 17, 2006, to be timely filed. Even accepting the filing date of November 20, 2007, the petition was filed eleven months too late.

#### B. Equitable Tolling.

Petitioners argue that the statute of limitations should be equitably tolled in this case. Pet. Resp. to SC Order at 1. Petitioners explain that Laura Ashman's father "passed away suddenly" on October 22, 2005, and her mother passed away on July 17, 2006. *Id.* at 1-2. Petitioners add that "[l]earning of [S.A.]'s speech delay and, subsequently, autism diagnosis, also negatively affected [S.A.]'s parents." *Id.* at 2.

Parents of autistic children frequently experience a huge amount of stress as they struggle to cope with the behavioral symptoms of ASD and learn to navigate the labyrinthine process of obtaining adequate therapy and treatment for the disorder. The additional stress accompanying the passing of Mrs. Ashman's parents during the period when S.A.'s problems manifested certainly impacted petitioners' ability to consider pursuing a Vaccine Act petition. Notwithstanding my sympathies for petitioners' situation, I do not find that these considerations constitute the "extraordinary circumstances" *Cloer* mandates. *Cloer*, 654 F.3d at 1344-45 (quoting *Pace*, 554 U.S. at 1344); see also *Irwin*, 498 U.S. at 96.

## VI. Conclusion.

Petitioners have the burden to show timely filing. Petitioners here 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 also failed to demonstrate any extraordinary circumstances warranting equitable tolling.

**Therefore, this claim is dismissed as untimely filed under the Vaccine Act’s statute of limitations. §16(a)(2). The clerk is directed to enter judgment accordingly.**<sup>16</sup>

**IT IS SO ORDERED.**

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Denise K. Vowell  
Special Master

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<sup>16</sup> This document constitutes my final “Decision” in this case, pursuant to § 12(d)(3)(A).