

STATE OF RHODE ISLAND
AND
PROVIDENCE PLANTATIONS

ADMINISTRATIVE
DUE PROCESS HEARING
CASE #10-25

IN Re: N.F.

v

CHARIHO REGIONAL SCHOOL DISTRICT

DECISION

SUMMARY OF ISSUES AND DECISION:

ISSUES:

1. Did the District propose an appropriate clinical placement for N.F., to address his unique needs in the areas of sensory processing skills, behavioral skills, and emotional issues, in addition to his academic needs?
 - a. Does the proposed program include coordinated instruction and support by adequately trained personnel in all areas of diagnosed need, e.g., psychological, sensory-motor, gross and fine motor, social and academic?
2. Does the student require additional evaluation, i.e., Functional Behavioral Assessment with a concomitant behavioral intervention plan?
3. Is the current program providing adequate communication with the parents?
4. Is the facility appropriate for the provision of the program and supports needed by the student?

5. Is the clinical program at the Bradley School an appropriate program for the student?

HELD: FOR THE SCHOOL DISTRICT

1. The District did propose an appropriate clinical placement for the Student, to address his unique needs in the areas of sensory processing skills, behavioral skills, and emotional issues, in addition to his academic needs.
 - a. The proposed program does include coordinated instruction and support by adequately trained personnel in all areas of diagnosed need, e.g., psychological, sensory-motor, gross and fine motor, social and academic.
2. The Student does require additional evaluation, i.e., Functional Behavioral assessment with a concomitant behavioral intervention plan.
3. The current program is providing adequate communication with the parents.
4. The facility is appropriate for the provision of the program and supports needed by the Student.
5. The clinical program at the Bradley School is not an appropriate program for the Student.

HEARING OFFICER: Gloria S. Feibish

ATTORNEY FOR THE STUDENT: H. Jefferson Melish, Esq.

ATTORNEY FOR THE DISTRICT: Jon M. Anderson, Esq.

CASE #10-25

N.F. v CHARIHO REGIONAL SCHOOL DISTRICT

IDENTIFYING DATA

Student.....

Parents.....

LEXICON

For purposes of the Decision in the within Hearing and to ensure confidentiality of the student, the following Lexicon will be used in this decision.

Student: The Student

Mother: The Parent

LEA: Chariho Regional School District ("The District")

Director of Special Education: Kathleen Perry (Mrs. Perry)

Hearing Officer: Gloria S. Feibish (H.O.)

Student's Attorney: H. Jefferson Melish (Mr. Melish)

LEA Attorney: Jon M. Anderson (Mr. Anderson)

RYSE: RYSE School (Reaching Youth Through Support and
Education)

Witnesses:

For the Petitioner (Direct Examination by Mr. Melish):

The Parent

Chelsea Constantineau - Gateway Healthcare, Inc.
Autism Spectrum Disorders
Clinician - In-Home

Debra Dickson - Physical Therapist in Private
Practice; Consultant

Kathryn O'Connor, PhD - Educational Psychologist;
Director, Connecticut College
Children's Program (Laboratory
School)

For the District (Direct Examination by Mr. Anderson):

Barry Ricci -

District Superintendent

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| Eric Dauphinais, DPT- | Physical Therapist and Assistive Technology Coordinator for the District |
| Kathleen Perry - | Special Education Director of the District |
| Mark Dumas, PhD - | Clinical Psychologist; Director of Clinical Services at RYSE (Contracted; President, Behavioral Solutions, Inc.) |

LIST OF EXHIBITS

Petitioner's Full Exhibits Used in this Hearing (marked "P"-):

1. Request for Due Process Hearing (11/12/10)
2. Appointment Letter (11/15/10)
3. H.O. Letter (11/19/10)
4. Melish Letter to H.O. (12/21/10)
5. H.O. Letter to Counsel (12/24/10)
6. Resume of Mother
7. Resume of Dr. O'Connor
- 8A. Resume of Chelsea Constantineau
- 8B. Resume of Debra L. Dickson, RPT
9. IEP (11/5/10)
10. Memorial Hospital Evaluation (6/4/08)
13. Gershon Neuropsychological Evaluation (12/3/08)
14. S.E. CT Therapy & Wellness Center Evaluations (3/20/09 and 5/28/09)
16. Bradley Hospital Recommendations (8/16/10)
17. RI Hospital P/T Evaluation (5/13/10) (R-6)
18. Dr. Yatchmink Evaluation at Hasbro (4/9/10 and 5/28/10)
19. Bradley Hospital Recommendations (9/15/10) and Assessment (8/10/10)
20. Butler Hospital Aftercare Synopsis (11/30/10)
21. Bradley School Brochure and Summary of Available Services
22. Gateway Intake Assessment (10/5/10)
23. Gateway Treatment Plan (12/23/10)
- 24A. Physical Restraint/Hold Incident Report (10/22/10)
- 24B. Physical Restraint/Hold Incident Report (10/29/10)
- 24C. Physical Restraint/Hold Incident Report (12/23/10)
- 24D. Physical Restraint/Hold Incident Report (1/4/11)
- 24E. Physical Restraint/Hold Incident Report (1/6/11)
- 24F. Physical Restraint/Hold Incident Report (1/13/11)
25. Mother's Summary of Time-Outs/Restraints (from 10/12/10)

- through 1/14/11)
26. Communication Log Book Pages (from 10/22/10 through 10/29/10 and 12/2/10 through 1/13/11)
 27. Documentation of Verbal Agreement re: Time-Outs (10/26/10)
 - 28A. Mrs. Godbout's Schedule (10/19/10)
 - 28B. Mrs. Godbout's New Schedule (1/3/11)
 29. Team Meeting Minutes (5/14/09)
 30. Team Meeting Minutes (6/9/09)
 31. Team Meeting Minutes (10/27/09)
 32. Team Meeting Minutes (2/22/10)
 33. Team Meeting Minutes (6/8/10)
 34. Team Meeting Minutes (6/17/10)
 35. Team Meeting Minutes (9/16/10)
 36. Team Meeting Minutes (11/5/10)
 37. Mother's Chronology of Issues (No Date)
 40. Letter concerning compensatory Occupational Therapy sessions ((6/21/10)
 41. IEP (10/27/09 to 10/27/10) as Revised (6/17/10) **(R-10)**
 - 42A. Chariho Educational Observation (1/30/07) **(R-34)**
 - 42B. Chariho Psychological Evaluation (4/2, 4/9, 4/30/09) **(R-34)**
 43. Suspension Letter (2/4/10)
 44. Positive Behavior Support Plan (10/30/09)
 45. Mother's Proposed Positive Behavior Support Plan (11/20/10)
 46. Request to Home School (3/3/10)
 48. LEA Attorney Letter to Family Attorney (12/16/10)
 49. Dr. O'Connor's Report (1/14/11)
 - 50A. RYSE Observation by Dr. O'Connor (12/22/10)
 - 50B. RYSE Observation by Dr. O'Connor (1/6/11)
 51. Debra Dickson's Physical Therapy/Sensory-Motor Consultation Report (1/20/11)
 52. Butler Discharge Summary (1/1/11)

District's Full Exhibits used in this Hearing (marked "R-"):

1. Team Meeting Minutes (6/9/09) (P-30)
2. Team Meeting Minutes (10/27/09) (P-31)
3. Team Meeting Minutes (2/22/10) (P-32)
4. Letter to Susan Stuart, M.D. from Yvette Yatchmink, M.D.,
Ph.D. (4/9/10) (P-18)
6. Physical Therapy Evaluation (5/13/10) (P-17)
7. Letter to Susan Stuart, M.D. from Yvette Yatchmink, M.D.,
Ph.D. (5/28/10) (P-18)
8. Team Meeting Minutes (6/8/10)
9. Team Meeting Minutes (6/17/10)
10. IEP (6/17/10) (P-41)
11. Inpatient Neuropsychological Consultation Report
(8/10/10) (P-19)
12. Letter to Kathy Perry from Bradley Hospital (8/16/10)
(P-16)
13. Letter to Kathy Perry from Bradley Hospital (9/15/10)
(P-19)
14. Team Meeting Minutes (9/16/10) (P-35)
16. Document recording the Verbal Agreement with RYSE School
Staff and Parent (10/26/10) (P-27)
17. IEP (11/5/10) (P-9)
18. Memo to File (12/22/10)
19. Observation Notes (12/22/10)
20. Physical Restraint/Hold Incident Report (12/23/10)
(P-24C)
21. School-Based Physical Therapy Evaluation (12/23/10)
- 22A. Mrs. Godbout's Schedule Prior to 1/3/11 (P-28A)
- 22B. After 1/3/11 (P-28B)
23. Student's Report Card for the First Trimester/2010
24. IEP Progress Update (11/10)
25. Communications Log (10/22/10-1/14/11) (P-26)
26. Completed Behavioral Management Forms (10/27/10 through

- 1/14/11)
28. Authorization for Release of Information running between Gateway Healthcare, Inc., Cranston, Chelsea Constantineau and the Chariho Regional School District (11/5/10)
 29. Curriculum Vitae of Dr. Eric Dauphinais
 30. Curriculum Vitae of Dr. Mark C. Dumas
 31. Chariho Regional School District Assistive Technology Assessment (1/5/11)
 32. Transition Plan for Student (12/2/10)
 33. Observation of Student by Dr. Mark C. Dumas (1/6/11)
 34. Clinical Psychological Evaluation (4/30/09)
 35. Handnotes of Barry J. Ricci, Superintendent of Schools (2/23/10)
 36. Emails between Kathy Perry and Parent during summer of 2010
 37. Communication from RI Hospital to Kathleen Perry (2/7/11)
 38. Resume of Kathleen Perry
 39. Memorandum from Kathleen Perry to the File (1/6/11)

N.B. Joint Exhibits are marked in ()

TRAVEL OF THE CASE

A request for a Due Process Hearing in this matter was filed with the RI Department of Education on November 15, 2010 by Attorney Melish, on behalf of the Parent pursuant to 300.507-511, 300.521, 300.525-526 and 300.528 of the RI Regulations Governing the Education of Children With Disabilities (July 2010).

The Hearing Officer was appointed on November 16, 2010 by FAX, and by letter on November 19, 2010 from J. David Sienko, Director of the Office of Student, Community and Academic Supports.

A pre-Hearing Conference was scheduled by the RI Department of Education for December 16, 2010, but with the agreement of Attorney Melish (for the Parent) and Attorney Anderson (for the District), this conference was instead held on December 14, 2010, there being no resolution to the issues of complaint during the Resolution period.

There was no resolution reached during the pre-Hearing conference. Hearing dates were scheduled, amended and held as follows:

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|---------|---------|
| 1/10/11 | 2/7/11 |
| 1/11/11 | 2/8/11 |
| 1/18/11 | 2/9/11 |
| 1/19/11 | 2/10/11 |
| 2/3/11 | 2/16/11 |
| 2/18/11 | |

and the Hearing Officer requested of the Petitioner, a more specific delineation of the issues.

A lengthy and specific listing, which included a listing prepared by the Parent, was received on 12/21/10, from which the Hearing Officer framed the agreed-upon issues as follows:

- Did the District propose an appropriate clinical placement for [the Student], to address his unique needs in the areas of sensory processing skills, behavioral skills, and emotional issues, in addition to his academic needs?
 - a. Does the proposed program include coordinated instruction and support by adequately trained personnel in all areas of diagnosed need, e.g., psychological, sensory-motor, gross and fine motor, social and academic?
- Does the [Student] require additional evaluation, i.e., Functional Behavioral assessment with a concomitant behavioral intervention plan?
- Is the current program providing adequate communication with the parents?
- Is the facility appropriate for the provision of the program and supports needed by the student?
- Is the clinical program at the Bradley School an appropriate program for the student?

Several motions were received from the parties:

- A Motion was received from Attorney Melish on 1/6/11, to issue a Witness Subpoena for Chelsea Constantineau, as

requested by her employer, and who appeared on his Witness List. An objection was made by Attorney Anderson on 1/7/11, stating that the witness Attorney Melish wished to call, was not qualified to be a "fact witness". The motion was approved by the Hearing Officer.

- A Motion was also received from Attorney Melish on 1/6/11, for the Hearing Officer to view and tour the RYSE building, as part of the Hearing. An objection with argument and accompanying citations was received from Attorney Anderson on 1/10/11. The motion was denied by the Hearing Officer on 1/10/11, citing the request as being premature, time-consuming, possibly highly disruptive and unnecessarily costly.
- A Motion was received from Attorney Melish on 1/10/11 for an Order approving a one-hour observation by his Sensory Integration Expert, Debra Dickson. There was no objection to the motion by Attorney Anderson, and the motion was approved by the Hearing Officer on the record, on 1/11/11 (Tr., Vol. II, pp. 4-10).
- A Motion was received from Attorney Melish on 1/14/11 for the second time, for the Hearing Officer to view and tour the RYSE facility at the close of testimony, or order the District to produce a floor plan. Attorney Anderson objected to the production of a floor plan on relevancy grounds. The Hearing Officer denied the motion on 1/24/11, citing no regulatory mandate, as well as being satisfied that the architectural and safety features of the RYSE school had been approved by qualified people, obviating

the need for her to inspect the facility, nor for a floor plan to be produced.

- A Motion was received by Attorney Anderson on 1/19/11, to issue a Witness Subpoena Duces Tecum, seeking all documents, not limited to educational records, relating to the Student, from Kingston Hill Academy in South Kingstown, RI, inasmuch as the Parent's expert witness, Dr. Kathryn O'Connor had referred to said school in her report. There was an objection to the motion by Attorney Melish, which is on the record (Tr., Vol.IV, pp. 102-109). The Hearing Officer approved the motion on 1/19/11. An Order was issued by the Hearing Officer to Attorney Melish, to obtain the documents, to be utilized for this Hearing only, and for the District to return said records to the Parent, at the conclusion of the Hearing. So ordered on 1/27/11.
- Lastly, a Motion was received from Attorney Anderson to strike the report of Dr. Kathryn O'Connor, in that she gives a legal opinion, which she is not qualified to present. Attorney Anderson provides citations for his argument, which were accepted by the Hearing Officer. The motion was approved in part, on 1/19/11, i.e., any legal opinion and legal references in the report, would be disregarded by the Hearing Officer. The remainder of Dr. O'Connor's report was allowed to be entered in evidence, and is, in fact, on the Petitioner's Exhibit List.

A Continuance was requested and approved on 1/27/11, because

of difficulties scheduling Petitioner's expert witnesses, as well as conflicts in the calendars of counsel. The Due Date for a Decision was then moved to March 3, 2011.

Another Continuance was jointly requested by the parties on 2/23/11, because of the limitations imposed on the witnesses due to snowstorms, difficulties scheduling the Petitioner's witnesses, the necessity of numerous witnesses to give testimony, and further conflicts in the calendars of counsel. This request was approved by the Hearing Officer on 2/23/11, and the final Due Date for a Decision was moved to April 2, 2011.

On 2/16/11, the District submitted their response to the Parent's 5-Day Rule Amended Statement.

POSITION OF THE PARTIES

THE PETITIONER (THE PARENT):

The Parent has numerous concerns about the RYSE program, which are expressed in her point-by-point analysis (Ex. P-4) keying in on: the lack of psychological services; absence of sensory integration therapy and technology to be provided by an Occupational Therapist (OT); absence of a strong OT presence in the classroom; the absence of a "motor room"; absence of Physical Therapy; the absence of a social skills-building program; the absence of on-site PhD level staff; absence of good communication with the parents, particularly as relates to "Time Outs"; the absence of contact by the School Nurse regarding her son's medical issues; the refusal of RYSE to provide clinical services to her son in school; the lack of a positive behavior

support plan; the use of too frequent and too lengthy "time-outs" (Ex.P-25; Tr. Vol. II, p.103) and an overall lack of appropriate information being communicated to the RYSE staff regarding behavioral techniques and therapy.

The Parent states that the RYSE program is not being implemented properly. She does not think it is a well-coordinated program. For example, she questions how the interdisciplinary team meetings are conducted, and that the results are not being communicated to the parents. She is critical of the staff for not following the therapy and other recommendations indicated in the reports of various evaluators and hospital teams that have interfaced with her son, particularly those that she obtained through independent evaluations. She does not feel that the RYSE staff are adequately trained and experienced, e.g., the special education classroom teacher (Tr., Vol. VII, pp.112-113).

The Parent is highly critical of the RYSE facility. She feels it is not conducive to educating emotionally disturbed children, because it does not offer an indoor gym, outdoor play equipment, and that there is not enough space for proper movement (Ex.P-4). She further believes that the facility is problematic because it houses mostly middle and high school students. She also believes it is not safe, because it may include juvenile delinquents (Tr.,Vol. VII, p.123).

The Parent emphasizes that she has only refused clinical services in the home, but not in-school (Tr.,Vol.II,pp.89-90).

In summary, the Parent does not believe the proposed program by the District, offers a FAPE, and that the District's programs have been "harmful" to her son (Ex. P-33 and Tr., Vol.X, pp. 63-64). She wants the best placement for her son (Tr.,Vol.II, p.65), is not concerned with LRE, i.e., the Least Restrictive

Environment (Ex. P-35) and seeks the Hearing Officer's ruling in this regard, for a placement at Bradley (Ex. P-4).

THE DISTRICT:

The District believes it offered the Student a FAPE, in fact, "...more than what was necessary for him to make educational progress academically, socially and psychologically...".

(District's Post Hearing Brief, p.1), and has determined that all of the Student's needs can be met at the RYSE school (Id., p. 11 and Ex. P-35), with the exception of psychiatric intervention recommended by Bradley Hospital (Ex. P-19), which the District contends is not their responsibility, as these are medical services.

The District feels it has been forthcoming with the Parent about all aspects of the RYSE program, and has engaged in ongoing, frequent communication (Ex. P-26 and R-25) in a variety of ways. The District has asserted that the Parent has been uncooperative by withholding information, not only to the District, but to other agencies interfacing with the Student, e.g., Bradley Hospital (Ex. P-35; Tr. Vol. VII, pp. 139-40).

In addition to the above, the District emphasizes that the Parent has sought to control the placement process by making demands for certain methodology to be used with her son (Ex. P-33; P-34; Tr., Vol. II, pp 97-98), and has pressed for the District to utilize recommendations made by the independent evaluators she obtained, particularly in the area of sensorimotor activities, where the District does not find the recommended activities to be appropriate, nor consistent with Regulations (District's Post Hearing Brief, p.25; pp. 37-38).

The District maintains that the Student has a Behavior Plan at the RYSE School, incorporated into data collection sheets (Ex. R-26), and that it wouldn't be appropriate to include it in the Student's IEP (Tr., Vol. XI, p.56). Further, the District concedes that, once sufficient data are collected, a Functional Behavioral Assessment would be done, but this would be contingent on the Student's attendance over a period of time, which has been affected by frequent absences over periods of time, due to hospitalizations (District's Post Hearing Brief, p.39).

The District claims that the Parent "...labors under numerous mistaken assumptions and erroneous impressions of the RYSE School" (District's Post Hearing Brief, p.38), especially in the area of staff qualifications. It is asserted that the RYSE staff are all appropriately licensed and/or certified, are well qualified for the jobs they perform, are well trained, and do, The District emphasizes, also, operate in a well-coordinated manner as a team, contrary to what the Parent says (Id., p. 38). The District also objects to the Parent's complaint about utilizing contracted personnel for the provision of clinical services (Parent's Post Hearing Brief, p. 28).

The District indicates it is going beyond reasonable expectations insofar as communicating with the Parent, and has tried to accommodate to her many requests, where appropriate and consistent with Regulations. The District states that the problem lies in a personality clash between the Parent and in particular, Mrs. Perry, as well as the other staff. They think this is so because the staff does not accede to, or necessarily agree with the Parent's demands (District's Post Hearing Brief p.40).

Regarding the facility—the District feels that the Parent’s claims have no basis in fact, and that her assertions amount to personal preference. The District also states that the Parent’s claims that the facility is unsafe because of the students enrolled at the High School and/or Middle School levels, is simply untrue and a result of the Parent’s mistaken assumptions concerning a particular methodology she heard about in a conversation with the Director of Clinical Services (Dr. Dumas) (Tr., Vol. VII, p. 123). The District also feels the Parent is expressing personal preference, when one considers the description of the facility given in testimony (Tr., Vol. XI, pp. 109-110).

Finally, the District feels that it should not be considered at fault for not providing mental health services to the Student, inasmuch as there was no informed consent for them, although said services were offered and refused by the Parent (Ex., P-36). The RYSE School can not only provide the same clinical services as the Bradley School and stands ready to do so, but goes beyond what Bradley School provides, in that a full range of mental health services are also provided to the students and their families beyond the school day, 24-7 throughout the year (Tr., Vol. XI, p. 18; pp. 19-25; and p.29). Additionally, the RYSE School has the same designation as the Bradley School on the Continuum of Services (Regulations, 300.115).

FINDING OF FACTS:

The Student is an 8-year old boy, who was adopted by the Parents at the age of three months, having lived with his adoptive parents as a foster child, first (Tr., Vol. I, pp. 18-19). He is described as having had a traumatic birth, and that little is known about his birth-mother, except that she had a history of drug and alcohol use. Despite this difficult beginning, the Student achieved developmental milestones on time, although there was some indication of gross motor delays (Ex. P-13). He is described as having had flat affect and difficulty being soothed as an infant (Ex. P-10). His early years were also problematic, with regard to behavioral issues (Tr., Vol. I, p.28).

Behavior difficulties began to emerge when the Student attended pre-school from age 3-months, where he had aggressive outbursts, but remained until he was ready to attend Kgn. (Tr., Vol.I, p.29).

The Student attended Kgn. at the Kingston Hill Academy, at which time he was being treated by a Psychiatrist (Dr. Robin) with Risperdal, for aggression. Despite the medication, the Student continued to have aggressive outbursts at school. While enrolled there, the Parent had the Student evaluated at Memorial Hospital (Tr.,Vol.I, p.31).

The Memorial Hospital Evaluation consisted of behavioral observations (he was cooperative for testing), a neurological evaluation, and developmental tests in the cognitive and theory of mind assessment areas. The neurological examination results were within normal limits, doing well on motor sequencing tasks,

with slow output on timed motor tasks. On the cognitive tests, the Student scored at age-equivalent to above age-equivalent on all tasks. The results on the theory-of-mind assessment, which measures the ability of the subject to ascribe thoughts, feelings, ideas and intentions to others in order to anticipate their behavior, was that the Student was age-appropriate in this area. In summary, the Student was found to have very strong cognitive skills, especially in perception and concepts, strong memory skills, but displayed difficulties with motor restlessness and impulse control. He also had some difficulty with expressive language. The diagnosis was ADHD (Attention Deficit Hyperactivity Disorder), combined type. Recommendations included: a Speech/Language evaluation, medication appropriate to the ADHD diagnosis, and parent counseling. The report was signed by Jill Crawford, Pediatric Nurse Practitioner and Viren D'Sa, MD, both of the Neurodevelopmental Center of the Dept. of Pediatrics at the Memorial Hospital (Ex. P-10). Over objection by the Attorney for the District, as to this report being Hearsay, and a request for the actual evaluator's reports, the Parent testified that the evaluations were done by Jill Crawford, the Nurse Practitioner (Tr., Vol. I, p.37), except that the neurological exam was done previously, by Dr. Mandelbaum (Ex. P-10).

The Student completed his Kgn. year at Kingston Hill ('07-'08), where he had no academic difficulties, but continued to have behavioral issues. He did not return to Kingston Hill for the first grade. There is controversy about whether the Student was not asked to return to Kingston Hill, which the Parent claims is false (Tr., Vol. VII, p. 9). However, many other reports in evidence, indicate that the Student was asked not to return because the school could no longer meet his needs (Ex. P-13, p-18, R-34, R-35 for example). The Parent refutes these statements

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(Tr., Vol. VII, p. 9) as "misinterpretation", but there were never any corrections made to the reports.

The Parents decided to home school the Student for the 1st Grade and to use the year to get the Student evaluated and to stabilize him (Tr., Vol. VII, p.27), for which they received School Board approval. A series of evaluations were completed during the '08-'09 school year. The Gershon Psychological Associates Neuropsychological Test Results were reported by Dr. Monarch on 12/08. Memorial Hospital's Speech/Language and Developmental Evaluations, Kingston Hill's Functional Behavior Assessment and Progress Reports, and an Educational Observation by the School District (Chariho) were reviewed. On intellectual functioning, the Student's scores ranged from low average (processing speed) to Superior (perceptual reasoning), with general functioning in the average range. However, it was felt this did not reflect his true abilities because of significant subtest scatter. Performance on academic tasks was low average (math), average (reading/spelling) and strong in reading fluency. Handwriting was legible. Verbal directions were followed with ease, and was rarely distracted during one-to-one testing. Most scores were average in the cognitive domain of attention/concentration. The Student's sensory-motor processing speed was average bilaterally, and no difficulties were noted on the gross tactile sensory and auditory sensory-perceptual examinations. The Student's verbal and language scores were generally intact. He was able to demonstrate higher level abstract thinking abilities, and overall, his cognitive executive skills were variable. The school reports indicated that the Student was very capable and a "quick learner". They also reported that the Student had poor emotional control, showed aggression and social withdrawal, as well as difficulty adjusting to new situations. He did not exhibit symptoms of Asperger's Disorder at school. The Parent and the School questionnaires were consistent. In

summary, the evaluation results indicated difficulties with emotional and behavioral regulation, oppositionality and aggression. He was diagnosed with an Oppositional Defiant Disorder and said there may be an undiagnosed sensory processing disorder. An evaluation by an occupational therapist was recommended. It was pointed out that the Student's prenatal health may have been compromised by the biological mother's drug/alcohol abuse, and that his genetic risk factors were unknown. Recommendations included: an Occupational Therapy Evaluation, continued Speech Therapy for a previously diagnosed Expressive Language Disorder, a Physical Therapy Evaluation (to rule out motor coordination delays), continued monitoring by a Neurologist, in-home services for the Parents with a family therapist, continued Special Education services (speech, occupation therapy, social/emotional/behavioral support and possibly additional classroom accommodations (a "sensory diet"), and individual or group social skills training. In addition, it was recommended that symptoms of a mood disorder should be monitored, and for the Parents to seek assistance to address the Student's sleep difficulties (Ex. P-13).

In March '09, the Parent had the Student evaluated by the Southeastern CT Therapy and Wellness Center, where a Physical Therapy Evaluation was performed. Physical Therapy was recommended for a defined period of time (6 weeks) with specific goals to increase overall strength, balance, coordination and advanced gross motor activities. It is noted that no standardized testing was done (Ex. P-14).

The Parent contacted the School District in the spring of '09 about the Student returning to school--public school. The District referred the Student for a clinical Psychological Evaluation, which was completed in 4/09 by Dr. Elizabeth Cantor of Psychological Centers, Inc. The Student was seen over three

sessions, in an effort to assist with diagnostic clarification (he had previously been diagnosed with ADHD, an Expressive Language Disorder and an Oppositional Defiant Disorder [ODD], with the possibility of a Pervasive Developmental Disorder [PDD]). The examiner said there did not seem to be a specific or single disorder that explained the Student's difficulties, and that he did not meet the criteria for a Pervasive Developmental Disorder, nor an Oppositional Defiant Disorder. She stated that mood difficulties should be considered and monitored, for a possible Mood Disorder. She recommended developing a positive behavior plan in his new, structured classroom, making accommodations for transitions and changes, and using information regarding his sensory functioning. She also recommended monitoring the Student's symptoms through ongoing communication with the home, prescribing physician and school (R-34).

In May '09, the Parent and the District staff met to determine eligibility of the Student for a special education placement. The variable diagnoses were discussed and the Team minutes indicate that the Student was found eligible for Special Education as Other Health Impaired (Ex. P-29). The Team met in June '09 to consider the Parent's request to have the Student repeat Grade 1, to which they agreed (Tr., Vol. I, p.49), and to review information available for the services to be included in the Student's IEP. An OT evaluation that had been done, was not available for this meeting, and there was otherwise not enough information available to include the OT services the Parent wanted. A release form was signed, but for the moment, the OT services would consist of consultation to the classroom teacher (Ex. P-30).

The Student began attending Charlestown Elementary School in September '09, in a 1st Grade regular classroom, however, an IEP wasn't developed until 10/09, inasmuch as the Parent had opted to wait until it was known who the 1st Grade teacher would be (Ex. P-29). The ensuing IEP (for 10/09-11/09) was for a regular classroom placement with language therapy, OT, special education consultation and many accommodations (Ex. P-41). The Parent consented to the IEP, even though it did not include PT services (Tr., Vol. I, p.50). The Student had a Behavior Plan (Ex. P-44).

The Parent requested another IEP meeting in 2/10 to discuss her request for an individual teacher assistant for her son (Tr., Vol.I, p.57), because the Student was exhibiting behavioral issues, and had been suspended (one day). The Team met and discussed the request and agreed to gather behavioral data for six weeks, then reconvene to review and plan accordingly. It was also agreed that the Student's behavioral plan would be revised to incorporate incentives. An individual teacher assistant was assigned to collect the data (Ex. P-32). The Parent was angry because she was of the opinion that the data she had collected was sufficient (Tr., Vol. X, P. 44). The Parent took her complaint emanating from the Team's denial of a 1:1 teacher assistant, as well as Mrs. Perry's perceived demeanor toward her, to the Superintendent of Schools on 2/22/10 (Tr. Vol. X, P.25) and again on 3/9/10 (Tr., Vol. VII, pp. 41-44), where the Parent couldn't recall exactly what was said by the District.

The Parent withdrew the Student from school on 3/3/10, to home school him again, for the remainder of the school year. In her request to the Supt. of Schools, she cites an inconducive learning environment, that the School will never address his sensory-integration issues, and that this is the only option she has, until she can move out of the district (Ex. P-46).

When the Parent visited the RYSE School in the Spring, she decried the facility, referring to it as a "warehouse" for emotionally disturbed children, and was critical of other things about the facility, as well (Tr., Vol. II, p. 67).

The Parent had the Student evaluated again, while he was being home schooled, at Hasbro Children's Hospital, by Dr. Yvette Yatchmink. An initial developmental pediatric consultation was completed on 4/9/10, as well as a physical examination by Dr. Yatchmink. All of the information (with the exception of the Dr.'s exam) that appears in this report for 4/9/10, was provided by the Parent. The Dr. ordered genetic testing, as well as some other medical tests, and wanted a PT and OT evaluation using standardized assessments. She also suggested that the Parent discuss the Resperdal with the Psychiatrist, as she thought it might be adversely affecting the Student. Her intent was to reconvene with the family following the PT and OT evaluations. Part of this document also included a PT Evaluation, completed in 5/10, indicating significant delay in gross motor skills, balance, coordination and core strength. It was recommended that he have direct physical therapy and a home exercise program. There was no OT Evaluation as part of this report. Dr. Yatchmink met again with the Parent in 5/10, and made the following diagnoses: Developmental coordination disorder, Phonological Language Disorder, a Sensory Processing Disorder, and Emotional behavioral regulation Disorder with a possible emerging Mood Disorder. She states that the Student needs therapeutic support within the academic environment, to include speech/language therapy and OT within the classroom, and PT or Adaptive PE. She also recommended ongoing psychiatric care and monitoring, and continued outpatient OT and counseling (Ex. P-18).

The Parent requested an IEP meeting to review Dr. Yatchmink's report, and one was held on 6/8/10. The Team carefully reviewed the report point-by-point. Questions arose regarding eligibility, i.e., medical needs vs educational needs. The Team recognized the Student needed OT and S/L therapy, and was being accommodated in the classroom for his sensory needs. Discussion ensued regarding medically-based PT vs educationally-based PT, inasmuch as the PE Teacher indicated that the Student was doing fine in regular PT classes, and did not observe difficulties. This did not satisfy the Parent, who wanted Adaptive PE included in the Student's IEP. The Parent and her Consultant (Dr. O'Connor) differed with the Team regarding the sufficiency of the supports provided the Student. The Team indicated that only "pieces" of the Student's day may have been unsuccessful from time-to-time, but not his complete day, and their data suggested he was able to regroup after having a difficult time. The option of a 1-1 Aide for the Student in the current placement at the Charlestown Elementary School, or a therapeutic placement at RYSE, was discussed. The Parent indicated that emerging diagnoses were occurring that she wanted to pursue, and also stated concerns about the RYSE program, specifically, that RYSE was inappropriate because there was no playground, and that her son was already evaluated (independently) to determine the cause of his behavior. She also stated that her son's sensory needs had not been met prior to his removal, to go on home schooling.

And the Parent wanted the meeting minutes to reflect that she felt that the school was harmful to her son's well-being, which is why she chose to home school him. This sentiment was not shared by the team. There was no conclusion reached, so the team agreed to reconvene to revise and edit the current IEP as necessary (Ex. P-33).

A continuation of the Team meeting of 6/8/10 was held on 6/17/10, at which time the Parent again requested that the minutes include her concerns: regarding RYSE (no playground); that the Student was being evaluated privately; that the Student was exhibiting overly anxious behaviors at home; and that the 1st grade teacher indicated increased behavioral difficulties (on a questionnaire requested for the Dr. Yatchmink evaluation- (Ex. P-18). The teacher described some of the Student's behavioral difficulties in that report (Id.), but did not say they had increased. These concerns do appear in the Team minutes. Recommendations emanating from this meeting were: to do a PT assessment; to include as a need, sensory activities to promote self-regulation; to list needs in the area of Speech/Language; OT consultation to all staff and parent; a PT to consult with the PE teacher; that any behavior plan incorporate input from all team members; to conduct an assistive technology screening; and to provide opportunities for the Student to learn social interaction skills. The Parent also wanted a small-class setting for the Student. The team iterated that they did not agree that the Student needed a more restrictive placement in order to implement his IEP, whereupon the Parent repeated that her son's physical symptoms (at home) are due to stress at school. The team, however, pointed out that these physical symptoms were present prior to the Student attending the Charlestown Elementary School. It is indicated that the team felt the Student did not meet the criteria to be in a self-contained special education classroom, and that strategies/interventions could be provided in the current setting, to help the Student be successful. The next steps to occur were: for the Student to receive compensatory OT services during the summer, with review of prior strategies and current recommendations; begin an assistive technology screening; provide the Student with an

"AlphaSmart" device, to use over the summer. All of the foregoing were to occur when the Student returned to school. And finally, the Parent was to meet with the school Principal and the Special Education Administrators during the summer to plan for the Student's return to school, and to discuss a modified school day. Placement was not definitely resolved (Ex. P-34).

The Parent expressed appreciation to Mrs. Perry for her caring attitude (at the Team meeting of 6/17/09), to which Mrs. Perry responded (in several email communications) that she hoped the Parent would trust the team to do whatever is necessary to assure the Student with a successful transition, and that she and her staff were ready to meet with her during the summer to discuss concerns and to plan for the Student (Ex. R-36).

OT was offered by the RYSE Asst. Special Ed. Director (Mrs. Durkin) during the summer, to compensate for services missed during the school year (the OT had left) (Ex. P-40). The Parent did not avail herself of these services, instead requested the money to pay for OT services that she would arrange privately. The District agreed to this with the proviso that: the services would be documented and that they would be in concert with the Student's IEP. However, the Parent did not choose to observe these conditions, so OT was not provided during the summer (Tr., Vol.II, p.44; Vol. VII, pp. 46-47).

Mrs. Perry contacted the Parent at the end of July 2010 (Ex. R-36), but the Student was hospitalized because of "increasing aggression and out-of-control behavior" and was admitted to Bradley Hospital on 8/4/10 (Parent's Post-Hearing Brief, p. 10).

The 8/16/10 letter from the Clinical Social Worker at Bradley Hospital to Mrs. Perry (SpEd Director) is her synopsis of information she took from the review of various evaluations and teacher reports given by the Parent, which did not include the District's Clinical Psychological Report (Ex. R-34). Conclusions stated: "...[the Student] failed in the regular education classroom... and [the Student] presents with a very complex constellation of difficulties, including learning disabilities..." (Ex. P-16) is not consistent with the Charlestown Elementary School Team Minutes of 6/8 and 6/17/10 (Ex. P-33 and P-34). In addition, this report makes educational recommendations, including the makeup of the school's multidisciplinary team, and the training requirements of the staff working with the student. Also, there is a reference to the *Health Guidelines and Frameworks of the RI Dept. of Education*, which applies to students in regular classes in Gr. 1-12 relative to a Health Education Curriculum (Ex. P-16). They didn't have it, but the Psychological Report of 4/09, done by the District's Psychologist, Dr. Cantor (Ex. R-34), specifically excludes the diagnosis of a Pervasive Developmental Delay Disorder, which is in conflict with the Bradley evaluation (Ex. P-19).

On 9/15/10, Bradley sent another letter to Mrs. Perry, repeating the letter of 8/10/10, but with additional requirements for the staff who would work with the student, which described the placement they thought the student needed. There was a warning that, unless these recommendations were followed, there would be a possible need for a residential placement for the student. There was no mention of any input from, or conversation with the School District's team at this point, regarding these recommendations (Ex. P-19).

Ex. P-19 also included an Inpatient Neuropsychological Consultation Report, which summarized the previous evaluations reviewed by the Bradley Team, as well as other tests administered, e.g., Behavioral observations and the Vineland Adaptive Behavior Scales. Some of the results indicated a qualitative impairment in social communication and reciprocal social interaction. The examiner felt that the combination of both current functional impairment history of developmental delay was consistent with a diagnosis of Pervasive Developmental Disorder (PDD-NOS), but that the delays existed in the context of many strengths in social settings. The recommendations included: continued consultation with a physician; clearly defined rules and expectations for behavior; addressing inattention and distractibility using environmental distracters; use of "time out" for elimination of unwanted behavior; breaking down large tasks into specific steps; a structured classroom with a low student-teacher ratio; psychopharmacologic monitoring; utilization of intensive behavior management techniques in the classroom; parent management training and family therapy; intensive social skills training; occupational and physical therapy within the school setting; individual therapy for the student; and a comprehensive diagnostic evaluation once the student was stabilized (Ex. P-19).

The IEP Team met on 9/16/10 to review the Bradley letters and recommendations provided by the parents. Bradley staff (Ms Witkin [SW] and Dr. Bareto [Psych.] participated via teleconference. The District stated that the Bradley letters had some inaccuracies, which indicated they did not have all District information. The Parent consented to forward missing information to Bradley. The team indicated that clinical

services are available at RYSE, and described them. Locked seclusion, which occurs at Bradley, was questioned by the District's Attorney (Mr. Anderson), and it was stated this is illegal in a school setting. The District asked about a discharge date, but were told that the Student was still not stabilized. Parents requested a referral to Bradley School. The team felt the RYSE program could meet the Student's needs. The Parents stated they were not comfortable with the RYSE program because: of the newness of the program; of the exposure to middle and high school students; there was no playground; of academic observations; they do not feel RYSE is a "community"; and the MST philosophy (Multi-Systemic Therapy). The District's Attorney, Mr. Anderson, questioned whether the parent was looking for the least restrictive environment, and she indicated, "No". The Parent's Attorney, Mr. Melish, stated that the Student would not be successful in an elementary school. It was agreed the current IEP would need revision, contingent on new information and placement changes needed. It was pointed out that the RYSE program offers home-based services that are not available at the Bradley school. The Parent raised a question as to whether she would have to drop the home-based services she currently has, and was assured that they would not be "forced" to do so. Bradley promised to keep the team informed about the discharge date. The Parent questioned whether Dr. Cantor (the District's Clinical Psychologist) was certified by the Dept. of Education, and it was explained that Psychologists are not RIDE certified. The Parent's Attorney also requested RYSE staff certification and experience, and the District's Attorney offered what is legally required to provide (Ex. P-35).

The Student was discharged from Bradley Hospital on 10/1/10. Mrs. Perry did not attend the Discharge planning meeting at Bradley, and said that was because she was not invited to do so,

although Bradley was to keep the District informed as to the discharge date (Ex. P-35; Tr., Vol. XI, p.41). The Parent indicated that she was told by Ms Witkin, the Bradley S.W., that Mrs. Perry was informed of the meeting, but refused to go (Tr., Vol. II, p. 73). Mrs. Perry declared this false, and had no information about what had been discussed at the Discharge Planning meeting, nor were able to participate in it (Tr., Vol. XI, p. 41).

The Student began school at RYSE for the first time, on 10/7/10. The Parent came to school at lunchtime, to take the Student home. She showed the teacher her transition plan (back to school), which included shortened days (Tr., Vol. II, p.83; p. 87).

The RYSE School Social Worker contacted the Parent on 10/8/10, to make an appointment to discuss the RYSE program mental health services, which included home-based services. They met at a Dunkin Donuts, because the Parent did not want the SW at her house (Tr., Vol. II, p.89). The Parent told the SW (Mrs. Cronin) that she had an acrimonious relationship with the District, and that she was frustrated. Mrs. Cronin asked if they could do home services (which are part of the program), to which the Parent replied that she didn't want them, and that she was already getting these from Gateway (an outside provider, at the Parent's expense). Although Mrs. Cronin said she hoped the Parent would come to trust the RYSE staff and program, the Parent indicated that she had no basis for that, but the Parent assumed that the clinical services would be provided in school (Id., p.90).

The Parent communicated with the classroom teacher and the Behavior Management Assistant (Mr. Pirnie) every day, when she brought the Student to school. In addition, the teacher called her at the end of each school day, and later, there was a daily

communication log between them (Tr., Vol. II, p.84; p. 93 and Ex. R-25).

The RYSE program uses "time-outs", as does the Parent at home, as well as Bradley and Butler (Tr., Vol. VII, pp. 126-127), but she objected to the length of time in "time-outs" at RYSE, calling them "detrimental" (Tr., Vol. II, p.96). She wanted RYSE to use the same system she used at home (Id., pp. 97-98).

10/22/10 was the first time the Student had to be restrained in any school he had attended in the District, although he had been restrained at Bradley Hospital and at Butler (Tr., Vol. II, P. 130), to which the Parent did not object. However, she said this incident resulted in the Student becoming distraught, and that she was going to pull him out of school. She wanted a behavior plan in place, and that something had to be done about these time-outs. She called various administrators to tell them what she planned to do. The Parent spoke to the classroom teacher the following school day, and it was agreed she would develop a protocol, to be used until the IEP meeting was held. This was done (Tr., Vol. II, pp. 102-105; Ex. P-27).

The Student returned to school on 10/26/10, and had good days through 10/28/10 (Ex. R-25; R-26). However, on 10/29/10, the Student had a time-out after lunch, and had to be restrained for disruptive behavior prior to going home for the holiday weekend (Ex. P-24B; Ex. R-25 and R-26). The written documentation for the restraint did not reach the Parent until early January, but she did know about it from reading the communication log, and a telephone call from the teacher (Tr., Vol. X, p. 59).

The Student needed to be hospitalized on 10/31/10 because of a "major meltdown", and went to Butler Hospital the next day (Tr., Vol. II, p. 111), where he remained for one month.

The RYSE team met again on 11/5/10 in order to develop the Student's annual IEP. The team reviewed the Student's academic strengths and needs (he functioned at grade level in reading, math and written language). Need areas were in expressive language, grapho-motor and coping skills. His present levels of performance and goals were developed in expressive language, and grapho-motor skills. The Parent provided a list of services she wanted to be included. The team reviewed the classroom behavior system that was in place for the Student, and the time-out procedures, including the agreement that was reached between the classroom teacher and the Parent as to "processing out" from time-out. They also reviewed and discussed the Parent's behavioral plan, which they said would consist of the daily documentation sheet and the time-out protocol, and agreed-upon supplementary aids, and modifications were incorporated into the IEP. There was still disagreement about the time-out procedures; the Parent wanted a Psychologist and Nurse to monitor the Student while in time-out, but the District believed that the Student was adequately monitored by the trained Behavior Management Assistant. It was noted that the Student had attended the RYSE program for 15 days since being discharged from Bradley, with 5 time-outs. The Parent indicated she was not interested in receiving clinical services through the RYSE program, therefore, no clinical services were incorporated into the IEP, and the necessary informed consent form for these services was not presented. Speech/Language and OT services were included in the IEP, and it is noted that a PT and Assistive Technology screen would be performed when the Student returned to school. Also, school personnel were to consult with outside providers (Ex. P-9).

The Parent conceded that some of her suggestions had been accepted (Tr., Vol.VII, p.95) and incorporated into the new IEP (Tr., Vol. VII, p. 95). She still wanted sensory integration goals and activities included (Tr., Vol. II, p.146) for the OT. She also provided her own behavior plan, which she wanted used. There was a Positive Behavior Support Plan (Ex. R-26) created by the RYSE staff, already in place, but not part of the IEP. This plan included similar activities to what the RYSE program used, and what was also utilized at Butler (Ex. P-52 and R-26). The Parent also tape-recorded the 11/5/10 IEP meeting, but the recording could not be produced (Tr., Vol. X, p. 8), and although she stated that the minutes did not accurately reflect what occurred at the meeting, she did not provide any corrections that she wanted made to them (Tr., Vol. XI, p. 42), as she had done previously for the 6/8/10 IEP meeting.

At the 11/5/10 IEP meeting, Mrs. Perry stated that she would attend the Discharge Planning meeting at Butler (Tr., Vol. XI, p. 50), but the Parent refused to have her there (Tr., Vol. IV, p. 62-63; Vol. VII, p. 108). Also, when presenting her concerns at the 11/5/10 IEP meeting, the Parent used documents, of which she refused to give copies to Mrs. Perry, when asked (Tr., Vol. XI, p. 48).

A Due Process Hearing was filed by the Parent through Attorney Melish on 11/12/10. The Student was discharged from Butler Hospital on 11/30/10, but the District was not represented for the planning that would take place, because of the Parent's refusal to do so. A synopsis was given to the Parent at that meeting, of which the District did not receive a copy until this Hearing had begun (Tr., Vol. II, p. 122) on 1/10/11.

The Butler Aftercare Synopsis indicates a primary diagnosis of Mood Disorder (NOS), Developmental Coordination Disorder,

Developmental Language Disorder, Other Specified Childhood Psychoses, and Attention Deficit/Hyperactivity Disorder. It also indicates Hypotonia. When the Student was admitted, he was transferred from Hasbro with complaint of "worsening meltdowns" at home. It is stated that the Student, while at Bradley Hospital for two months, had a trial with several medications (Abilify, Ritalin), which increased his symptoms. He was discharged from Bradley on four medications (Risperdal, Zyprexa, Depakote and Tenex), on which he did well for about one week after discharge, with gradually increasing frequency and intensity of outbursts. Parent reported that triggers for his behavior are: changes in routines, sensory issues, and not getting his way. Outbursts had been occurring daily. The Parent wanted him at Bradley, but no beds were available. Chelsea Constantineau, the provider of Home Services (from Gateway Healthcare) met with the Dr. Tarnoff and the Parents on 11/8/10, at which time they primarily told the Dr., about their dissatisfaction with the school program. The Doctor went on to the in-hospital behaviors of the student and a discussion of their medical options. The Student was being monitored carefully, and various amounts and kinds of medication were being tried. The Parent asked the Doctor to test her son's blood sugars, as she believed his moods might be related to his sugar levels. The Doctor did as the Parent requested, although he thought it unlikely that that was the case, and no correlation was found after testing. The Student continued to have difficulty and aggressive outbursts, and on 11/24, became so aggressive, that he had to be put in the locked-door quiet room. The following morning, he had to be restrained after trying to throw a chair. The Doctor indicated that the level of aggression and violence had not abated since admission, and they wondered if this was an anxiety issue, since discharge had been discussed. They continued to work with medication changes and

felt that the Student should be in the protected environment of the hospital while this was occurring. So discharge was delayed. It was noted that, while at Bradley, discharge occurred without preparation because of an anxiety issue, and he was not out very long. The Doctor decided to try an antidepressant, because he thought that anxiety might be one of the components of his difficulty. There was a plan to try to decrease one of his other medications, but they didn't want to discharge him at that time. By 11/29/10, the Student had four days of safe behavior, after he was told he was not going home on the day planned the week before. At this time, the Student was acknowledging that he may have been anxious about going home. He also was now talking about other behaviors of concern, and was developing more coping skills. The Student was discharged on 11/30/10. Recommendations included: renewing program with Chelsea Constantineau for home-based services; Psychiatric follow-up with Dr. Hunt as soon as possible; Call Dr. Tarnoff in one week for a follow-up and planning meeting; Return to school on a gradual basis, starting with half days (Ex. P-20).

While the Student was at Butler, his Report Card for the first trimester was issued for the fifteen days he attended school. His attainment of skills in that time period was positive (Ex. R-23; Tr. Vol. X, p.52).

The Student returned to school on 12/2/10. The Parent put a transition plan in the Student's backpack for the RYSE staff to follow. She also specified that her son "...was not going into time-out for more than 20 minutes at a time..." (Tr., Vol. II, pp. 119-120; Ex. P-37).

The Student attended half days on 12/9/10-12/14/10, with no incident. On 12/20/10-12/21/10, he attended full days with no

incident. Also, the Parent wanted him to get back on track for full days, as he was to be observed by one of the Parent's witnesses that week (Tr., Vol. IV, pp. 70-71). The Student appeared to be tired by 12/22/10, and on 12/23/10, which was the day before school vacation, the Student had to be restrained for disruptive behavior, prior to going home (Ex. R-25; R-26; P-24C). While he was being restrained, the Student told the staff person that, "...my mother is gonna shut this school down.." (Ex. P-24C). De-escalation techniques were used as called for in the Student's IEP, which utilized one of the Parent's suggestions (a necklace of cards that contain pictures and words that help the Student to calm down) (Tr., Vol. X, pp.15-16; Ex. P-24C).

The Student returned to school on 1/3/11 with no incident (Tr., Vol. IV, p. 80), but during the next day, he had to be restrained again, but at the end of the school day, and again, on 1/6/11 (Ex. P-24E). When he could have returned to class, he refused to do so (Id.).

There was a Physical Therapy Evaluation performed on 12/23/10, which had been recommended at the 6/17/10 IEP conference. The delay in getting the Student evaluated, was explained by the PT, Dr. Eric Dauphinais, that, this type of evaluation is best done in the school, in order to make appropriate recommendations regarding functional access to the school environment (Tr., Vol. VIII, p.10), and because the Student had been hospitalized during the summer, during the first part of the '10-'11 school year, and again in 11/10, and then needed time to become acclimated to his return, is the reason for the delay. Dr. Dauphinais also performed an Assistive Technology Assessment on 1/5/11—delayed for the same reason (Tr., Vol. VIII. p.15).

The Physical Therapy Evaluation (Ex. R-21) assessed the Student by observing his behaviors in play and testing procedures, and

assessing range of motion, muscle strength/tone, sensation, reflexes/postural reactions, posture, and functional movement. In summary, Dr. Dauphinais found that the Student presented with some mild strength, coordination and motor execution deficits for his age, but that they did not impede his access to play, either with the evaluator or his classmates. The deficits were in form, not function. He noted that the Student seemed to enjoy movement and motor play, and did not become frustrated. Recommendations included accommodations for functional posture for extended periods of sitting, consultation with the Student's PE teachers to appropriately implement accommodations, and instruction in an exercise program to promote independent movement, health and ongoing community access with peers. No direct PT was recommended, because Dr. Dauphinais felt that the Student's needs could be accommodated and addressed by the PE teacher, with consultation from the PT (Tr., Vol. VIII, p. 14).

An Assistive Technology Assessment was also conducted by Dr Dauphinais on 1/5/11 for the purpose of providing and planning interventions that may be needed to aid the Student in his educational program. A record review and consultation with the classroom teacher was done, which included writing samples, a student interview, observation in the classroom and in the computer lab room working on projects, following instructions. Digital intervention trials using standardized assessments were also done. The results indicated that the Student demonstrated he had the skills needed to progress, using assistive technology, with his writing difficulties and facilitate his expressive work. Recommendations included, exploration using Co-Writer, Kurzweil 3000 on a trial basis, and Dragon Naturally Speaking on a trial basis to assess the Student's keyboard coordination vs. spoken output (Ex. R-31).

The RYSE program was explained to the Parent on several occasions, and was also described during the Hearing as a public school, housing two separate, but distinct programs: an alternate learning program at the middle and high school level, and clinical day program, which is a special education program for students in Kgn. through grade 12, which is designated as a Special Education Day School on the continuum of placements. It includes an elementary classroom for five students, which is where the Student who is the subject of this Hearing, is placed. The staff includes a special education teacher, behavior management assistants, and clinical services that are contracted through Behavioral Health Solutions, which include a clinical psychologist (Dr. Mark Dumas) who directs and supervises the program, two Master's level Clinicians, a Bachelor's level Case Manager, and a Doctoral level clinical Psychologist for direct services (Tr., Vol. X, p. 81 and p. 98). The services include: individualized programming, in-school therapeutic support that is coordinated with families, mental health services available 24/7 throughout the calendar year, case management, a coordinated clinical and educational team that meets regularly, positive behavioral programming, and small, structured classrooms with a low pupil-teacher ratio.

DECISION

RE: to Issue #1 - Did the District propose an appropriate clinical placement to [the Student], to address his unique needs in the areas of sensory processing skills, behavioral skills, and emotional issues, in addition to his academic needs?

In determining whether a school system has provided a free appropriate public education (FAPE) to a student with a disability, as required under the IDEA's procedures, as well as whether the Individual Education Program (IEP) developed through those procedures, was reasonably calculated to enable the student to receive educational benefits under IDEA (20 U.S.C., Chapter 33, 1400 et seq.) and R.I. Regulations Governing the Education of Children With Disabilities (July 10, 2010), when a Parent challenges their child's IEP, and requests an Impartial Due Process Hearing, the burden of proof is properly placed upon the party seeking relief (546 U.S. 49, 126 S.Ct. 528 [2005], Schaffer v Weast). Therefore, in this Hearing, the Burden of Proof rests with the Parent.

The Parent maintains that "the 11/5/10 IEP is woefully inadequate to address [the Student's] complex neuropsychological, psychiatric, sensory-motor, fine and gross motor, social and emotional needs" (Parent's Post-Hearing Brief, p. 24). It is further maintained that the IEP addresses only three areas of concern: expressive language, graphomotor skills and coping skills, and does not address his other needs (Id., p.27).

The Parent's most critical issues seem to center on the subject of: a Sensory Disorder, which she believes is the cause of her son's behavioral aggression and dysregulation, which requires sensory integration therapy; the lack of a Positive Behavior

Support Plan which would address her great concern with "time-outs"; and the lack of clinical services by adequately trained staff. These areas will be addressed next.

Sensory Disorder

This term can be seen in most of the Student's evaluations, and was especially expounded upon by the Parent's expert witnesses. However, the Regulations do not recognize "Sensory Disorder" as a disability (see R.I. Regulations, 300.8 [c]). There are no peer-reviewed articles in the psychiatric literature which recognize sensory-integration therapy as being an activity that is used with emotionally disturbed children to improve their educational outcomes (Dr. Dumas, Tr.Vol.IX, p.103). Dr. Dumas is a Clinical Psychologist with the RYSE program, and has years of experience in the field, including being Director of Evidence-Based Services at Psychological Centers, Director of the ADHD Clinic at Bradley Hospital, and teaching at Brown University School of Medicine in the Dept. of Psychiatry and Human Behavior (R-30). The Hearing Officer regards Dr. Dumas' statements with high credibility.

The Parent's expert witnesses: Chelsea Constantineau, Debra Dixon and Dr. Kathryn O'Connor also testified about Sensory Disorder and Sensory-Integration Therapy.

Chelsea Constantineau is an Autism Spectrum Disorder Clinician with Gateway Healthcare, who provides home-based family therapy to the Student and the Parents. She has not observed the Student in the school setting, and has had no experience other than an internship, working in a school setting (P8-A). Her Treatment Plan with the Student includes reaching out to the Student's school a minimum of twice per month, to "incorporate what he

is learning in the home, into the classroom" (P-23). The start date for this plan was 12/10/10, but there was only one attempt on this witness's part to contact the Student's teacher, after finding she had the wrong telephone number. Also, the Parent had limited her contact with the school to verbal only, so she had no opportunity to review the Student's records with any RYSE staff. Therefore, her only information source was the Parent and any meetings with other clinicians that she may have attended with the Parent. (Tr., Vol.III, pp. 70-71 and p.88). Ms Constantineau's Resume does not indicate any education courses dealing with sensory issues (Ex. P-8A). Any sensory activities that she may have undertaken at home with the Student, are not necessarily transferrable to the school setting, although a collaboration with the school could be beneficial to the Student. In her testimony and in her Treatment Plan, there is no indication of what, if anything she did with the Student at home, was successful. The Hearing Officer could not give this witness's testimony any weight.

Debra Dickson, another of the Parent's witnesses, is a Physical Therapist in private practice, who has taken a great interest in Developmental Disorders, neurological problems, and sensory integration, having taken many courses since getting her B.S. in Physical Therapy in 1978. She is primarily a consultant to families and schools, and frequently presents at workshops on the subject of sensory processing. She is also an instructor for Education Resources, a continuing education agency for Physical and Occupational Therapists, and provides services to the school that Dr. O'Connor (another Parent witness) directs (Tr., Vol.V, p.12). She has produced her own assessment and treatment protocols, which have not been peer-reviewed (Tr., Vol.V, p.94).

Ms. Dixon did not observe the Student in the classroom, nor contact anyone at the school, but did observe the Student in his home on one occasion (Tr., Vol.V, p.68). Ms. Dixon's report of

her Physical Therapy/Sensory-Motor Consultation lists the tools and process she used to assess the Student, which included her own protocols. She also reviewed and commented on assessments of others, i.e., reports which were provided by the Parent. Her report is replete with passages that she admitted were taken from medical and other texts, with no citations given (Tr., Vol. V., p.43 and p.61). She was not aware of any peer-reviewed studies on her methods or assessment tools (Tr., Vol.V, p.43 and p.94). Although she agreed that the Student was motorically functional, she still felt that the staff working with him needed to have ongoing consultation with someone with expertise (such as herself). and that that was the most important thing that could be done for this Student (Tr., Vol.V, p.98-99). She thought that sensory integration therapy should be included in the Student's behavior plan (Id., p.37). When pressed, she conceded that the medical industry (insurers) do not pay for "sensory integration therapy", but if billed under separate categories of the sensory system, e.g., vestibular, they will pay (Id., pp. 44-45). Ms Dixon conceded that sensory integration therapy is a methodology (Id., p.89). Although this witness has an impressive resume, the Hearing Officer found her testimony and report to be very theoretical, and her protocols and recommendations not to be evidence-based. To be an evidenced-based practice, efficacy must be established through peer-reviewed research in scientific journals. The RI Regulations require that IEP's contain aids and services that are based on peer-reviewed research (300.320 [a][4]) and *scientifically based research* as defined in the ESEA, Art.9101(37). The Hearing Officer did not find her recommendations to be credible for use with the Student.

Dr. Kathryn O'Connor is the Director of the CT College Children's Program in New London, CT—a laboratory school (Tr.,

Vol.IV, p.5), at which she has had Debra Dixon as a consultant. She is a personal friend of the Parent, and has acted as a consultant and advocate, when the Student was at the Charlestown Elementary School (participated at the IEP Conference in 2/10) (Vol.IX, p.59). Dr. O'Connor did two observations of the Student at RYSE. She is unfamiliar with RI Regulations, and had only reviewed records provided by the Parent. One of her observations of the Student, was when he was in time-out. It was the opinion of the Special Ed. Director (Mrs. Perry), who was there, too, that the Student was "putting on a show" for Dr. O'Connor (R-39). Dr. O'Connor was not observed to have taken any notes during her visit, and didn't provide her report until well after her visits (Tr., Vol.IV, p.22). She testified that she thought the Parent was the expert here, and that she held a bias toward using interventions that address sensory needs, and sensory dysregulation (Tr., Vol. IV, p.18 and p.24). Generally, she echoed the Parent's criticisms of the RYSE program and the IEP of 11/5/10, though she was not present for the meeting. In spite of her impressive credentials, the Hearing Officer found this witness to be completely biased, and could not regard her as credible.

Activities that help students to improve their ability to perform tasks for independent functioning if functions are impaired or lost, fall under the domain of the Occupational Therapist (Regulations, 300.34 [Related Services], (6)(ii)(B)) Sensory activities that would be undertaken with students needing this type of therapy, would then be the responsibility of the OT. The Parent did not have an Occupational Therapist on their Witness List. Instead, the Parent's Attorney attempted to elicit information about peer-reviewed methodologies within the domain of the occupational therapist, from other witnesses, e.g., Dr. Dauphinais (the District's witness), a Physical Therapist. The Hearing Officer did not allow questions of

this nature to be asked of that witness and told Mr. Melish that, since this was a key issue with the Parent, he could call in an Occupational Therapist as a witness, even though the Hearing was underway (Tr., Vol. IX, pp.62-63).

Positive Behavior Support Plan

The RYSE staff believe that the data collection sheets that are used with the Student, include specific goals, which had been identified when the Student was at Charlestown Elementary School, and which are kept updated daily, comprise a positive behavior plan for the Student, although not in the format that the Parent wanted. This data collection (R-26) begins on 10/7/10, continuing through 10/29/10. The Student was hospitalized from 11/1/10-11/30/10, and the data collection began again when he returned to school on 12/3/10. The Student had 11 timeouts in the 27 full and 4 half days that he attended with varying amounts of time spent, the shortest being 1hr. 5 min., and the longest being 3hrs.20min. Although some of these times do seem excessive to the Hearing Officer, one needs to know the circumstances (the Student fell asleep during one of these), before denouncing them. And they are an accepted method of dealing with the behaviors that are sometimes seen, when working with behaviorally disordered children.

Behavior Support Plans (Behavior Intervention Plans) are a requirement of the RI Regulations, only in those instances when a student is removed from school (RI Regulations, 300.530). However, it is not unusual for students who have mental health needs, and who are in special education programs, to have such a plan. In fact, one of the services provided in the RYSE program is positive behavioral learning

(see description of RYSE in *Finding of Facts*, p.39). The Parent doesn't agree with the methods being used in time-outs (Tr., Vol.II, p.153) and produced her own modified behavior plan (P-45), which she wanted included in the 11/5/10 IEP. She also presented her plan to the classroom teacher (Tr. Vol.IV, p.53 and p.56). There is clearly a disagreement between the Parent and the School over this issue, but the IDEA does not ensure that a FAPE will consist of the precise plan that the parent desires (*Shaw, 238, F. Supp.2d at 139*) and under *IDEA, Art. 602(a)(20), 20 U.S.C.A. Art. 1401(a)(20)*, parental preference alone cannot be the basis for compelling a school district to provide a certain educational plan for the child. When there is consent for the Clinical Services that RYSE offers, the Treatment Plan that is developed for each student, would include a positive behavior plan, into which there is input from the team and the parent. The plan is not made part of the IEP, because, as Mrs. Perry explained (Tr., Vol.XI, p.56), behavior plans are fluid documents, which should be amended/modified, as the student's behaviors change or improve. Lastly, Mr. Melish stated during questioning of Dr. Dumas (the Director of Clinical Services at RYSE), that there is a requirement that if restraints are used with a student (the Student has been restrained), a behavior plan should be in place (Tr., Vol. IX, p.121). The RIDE Physical Restraint Regulations, under Definitions: 10.0: Behavioral Intervention Plans, say "school personnel shall determine if the student requires a behavioral intervention plan as part of his program"... It is this Hearing Officer's belief that the RYSE staff have already determined that such a plan should be put in place, have been collecting data when the Student is in school, and if consent for clinical services is granted, would be completed, and made part of his Treatment Plan.

Clinical Services Staff

The Parent is of the impression that the RYSE clinical services staff are inadequately trained. The Staff that provide clinical services at RYSE, include a PhD Psychologist (Dr. Mark Dumas) who directs and supervises the clinical services and the staff who provide them. Dr. Dumas is President of Behavioral Health Solutions, a mental health agency that provides specialty services to school districts. He is very experienced and has had numerous professional affiliations, served on Advisory Boards, and has had several academic appointments (e.g., Brown, Emory), and is the author of published peer-reviewed research, plus a host of other accomplishments. He is eminently well-trained and well-qualified. The Parent has expressed dismay that he did not attend the 11/5/10 IEP, but another member of the clinical services staff was there as a representative (Jane Cronin). The other clinical services staff are also well-trained, supervised and licensed for what they practice. The exception is the Master's Level Clinician (Jane Cronin), who is trained, but is working on her license as an LIMHC, and is supervised by Dr. Dumas (Tr., Vol.IX, p.136). The other staff include another doctoral level clinical Psychologist who provides direct services, another master's level Clinician, a Bachelor's level Case Manager, and trained Behavior Management Assistants. The Hearing Officer believes these staff are adequately trained and supervised, and that they support the classroom teacher and other school personnel in a coordinated manner, through bi-weekly (or more often, if needed) team meetings, and daily consultation. Families are supported on a 24/7 basis throughout the calendar year, through frequent contact with the master's clinicians, who also coordinate the school-home partnership,

for all students whose parents have consented to their participation in the clinical services program.

RE: to Issue #1a. - Does the proposed program include coordinated instruction and support by adequately trained personnel in all areas of diagnosed need, e.g., psychological, sensory-motor, gross and fine motor, social and academic?

The sensory-motor, and adequately trained personnel facets of this issue have already been discussed, with respect to the clinical services personnel. The classroom teacher is RIDE certified as a special education teacher, and the Hearing Officer is satisfied that she is adequately trained for her position, or she would not have been certified. In addition, the clinical services staff work closely with her, providing daily support, and the work she does with her students is closely monitored by Administrative personnel. They all work together as a team, to coordinate services for the students. The proposed program does not include the clinical services component, because there is no signed consent to do so. The Physical Therapist, monitors the Student and consults with the P.E. teacher. The Hearing Officer believes that, when the Student returns to school, the PT will follow up with the P.E. and classroom teachers, to implement the recommendations he made in his assessments (R-21 and R-31). Social skills training, academics and speech/language goals and activities are being addressed by the classroom teacher. The Progress Report of 11/10 indicates that the Student is making progress achieving his annual goals in language, writing and coping/social skills (R-24), and despite his behavior issues, is achieving at or near grade level in reading and math. And finally, the Special Ed. Director (Mrs. Perry), is eminently well-trained and qualified to perform her varied tasks. She

has had experience in early childhood education and as a school psychologist. She has held other administrative jobs as an assistant principal, principal and special educator. She is RI certified in special education administration, elementary and middle school principal, school psychologist and special education teacher Kgn. - Grade 9. Additionally, Mrs. Perry has presented peer-reviewed research in the area of optimizing outcomes for students with special needs in the classroom, to the American Educational Research Assn. She earned a bachelors degree in combined special educ./elementary educ/psychology from Wheelock, an MA from RI College in educ. psychology and a Certificate in Advanced Graduate Study (CAGS) from RI College in School Psychology. She has spent a major portion of her work day administering to the RYSE program. In answer to Question #1a, the Hearing Officer says "Yes".

FAPE

Much has been said about "consent" in this Hearing. It is a subject of dispute between the Parent and the RYSE staff, inasmuch as the Parent claims she gave consent at the 11/5 IEP meeting, for clinical services in school, but not in the home, and the staff say she did not. The consent she said she gave, was verbal, though it was made clear that it is signed consent that is required. The Team Meeting notes for the 11/5/10 IEP conference corroborate what the staff say. The Parent did not correct these meeting notes, (she said she was mis-stated) as she had done for the 6/17/10 IEP meeting. She taped the meeting, and claimed that the tape would confirm her side of the story, but she could not produce the tape (said she couldn't find the software to print it out) (Tr., Vol.X, p.10, foll.). She also refused to meet with the clinician in her home, when an attempt was made to initiate a relationship between home

and school, which is a crucial part of the clinical services at RYSE (Tr., Vol. IX, PP.98-99). As a matter of record, the clinical services continued to be offered to the Parent, but the offer was not considered. The Hearing Officer agrees with the District's Attorney (Mr. Anderson) that the inability of the Parent to produce the tape, is suspect, and accepts the findings offered in *Nation-Wide Check Corporation, Inc. v. Forest Hills Distributors, Inc.*, 692 F.2d214, 217 (1st Cir.1982). In this case, it is pointed out that the general inferences to be drawn from the loss or destruction of documents are well established, and when the contents of a document are relevant to an issue in a case, the nonproduction of said document may be considered evidence that the party did so out of fear that the contents would harm.

The Parent had indicated as far back as the previous school year, that she wanted to visit Bradley. There was a request made at the pre-Hearing conference, for a referral to Bradley. There were other requests for a referral to Bradley (Tr., Vol. II, pp.69-71). When the Student was being discharged from Bradley Hospital at the end of September 2010, Mrs. Perry was not invited to attend or participate at the Discharge Planning meeting, although the Parent claimed that she was invited and didn't go. The Bradley team sent two letters to Mrs. Perry ahead of the 9/10 IEP meeting, which specifically state the personnel qualifications needed to work with the Student in a clinical setting, as well as the services that were needed. Both letters had the same wording, except the second letter was more specific than the first, as to the personnel, and contained a warning, that unless these things were provided, the Student was at high risk for a residential placement.

The Hearing Officer considers these letters to be a thinly veiled strategy to force a Bradley placement. All of the requirements that were laid out, could be provided in the RYSE program, with the exception of medical management services, which are not considered a related service in the Regulations, therefore not the responsibility of the District. However, medical management could be accommodated if the District, the Parent, and the Physician kept in close communication. If Mrs. Perry had participated at the Discharge Planning meeting, accommodations could have been worked out, and there might have been a different outcome. Instead the atmosphere at the meeting was charged with acrimony (Tr., Vol. II, p.64).

The Parent asserted that the RYSE staff ignored the Bradley recommendations at the 11/5 IEP Meeting. She also stated that she would not agree to the program unless it contained the Behavior Plan she wanted, sensory-integration therapy, and the other services she wanted added in, e.g., PT. The RYSE staff did not feel they were ignoring the Bradley recommendations, rather that they could provide for what was recommended, at RYSE, except for the medical management (same as in Sept.). They reiterated that this could happen if the Parent would give signed informed consent, for the clinical services to be added in. This did not happen, as it is known, but Mrs. Perry continued to offer the services, and even wanted to schedule another IEPC in December. The Hearing Officer believes that the Parent misconstrued what signed consent meant. The clinical services are contracted (Regulations allow this), and there is a legal requirement the clinical people have, before they can provide direct services to the students. In fairness to the Parent, this should have been explained at the 11/5 meeting. The staff did not present the consent form at that time, in light of the parent refusal for the services. However, when the Parent did see the consent form at the last

Hearing session, she said she would have a problem signing it (Tr., Vol. XI, pp.168-169). And judging from the criticism of the RYSE program and its staff, that the Parent had leveled since RYSE was suggested as a placement, it would be difficult to establish a working relationship between the two. Nevertheless, the clinical services continued to be offered.

The acrimony continued when the Parent refused to have Mrs. Perry attend the Butler Discharge Planning meeting when the Student was going to be discharged from his hospitalization in November. The reason given was that the Parent would find it "too upsetting to have them there on the day of her son's discharge" (Ex. P-37). The only information Butler had about the school was what was provided by the Parent. The Hearing Officer is struck by this attitude, in that the Butler evaluations and recommendations were critical for the District to know about and it was important for the well-being of the Student for them to be able to participate in the planning. The District could also have provided important information to Dr. Tarnoff, who felt the Student needed careful monitoring relative to the many medications that were prescribed. Instead the Parent took it upon herself to provide the school with a transition plan for her son's return, which she wrote out and put into his backpack for the teacher to see, upon his return to school. In fact, the District did not receive a copy of the Butler Synopsis until the Hearing was in progress.

The Parent denied she was "shopping", when the District stated it would not make referrals to other programs, in light of the fact that the District could provide for the Student's needs at RYSE. The Parent further stated that if the RYSE program were to provide the "correct" services and supports that she is seeking, she would be happy with RYSE (Ex. P-37).

In *Shaw v. District of Columbia*, 238, F.Supp.2d.127, November 22, 2002, it was ruled that, although the IDEA guarantees a FAPE, this does not mean that this education will be designed according to the parent's preference. The primary responsibility for designing the education for a child with disabilities, and for choosing the educational methods most suitable to the child's needs, was intended by the IDEA, to rest with the LEA, in cooperation with the parents of the child, but because loving parents think they can design a better program than the LEA, does not entitle them to prevail.

The Parent's Attorney (Mr. Melish) argues that the focus of this case should be on the 11/5/10 IEP, only, citing *Knable v. Bexley City School District*, 238 F.3rd, 755, 768 (6th Cir.2001). The Hearing Officer does not agree. The First Circuit (RI's) does not consider the advisability of that course of action. The Hearing Officer does not consider the 11/5 IEP to be a final IEP, especially: in light of the absence of information needed by the District and either withheld or not provided in a timely fashion; the refusal of the Parent to have the District participate in discharge planning after the Student had been hospitalized, and by so doing, not treating the District as equal partners in the IEP process; impeding the process by refusing to sign consent for the clinical services, unless all the other Parent preferences of methodologies (whether permitted by Regulations or not) were included in the IEP; and refusing to allow a "get acquainted" visit by the RYSE clinician to explore how the family and school could work together, and then claiming the inadequacy of the 11/5 document. By continuing to offer the clinical services, this Hearing Officer does not consider the 11/5 IEP, to be the last offer. The Hearing Officer is looking at the totality of the circumstances in the instant case.

The Supreme Court has established a two-part test to guide the analysis as to whether FAPE is provided: (1) has the LEA complied with the procedures set forth in IDEA; and (2) is the IEP developed through the IDEA's procedures, reasonably calculated to enable the child to receive an educational benefit (*Rowley*, 458 U.S. at 206-07). In *Lessard v. Wilton-Lyndeborough Coop. School District*, 518 F.3d 18, 49 IDELR 180 (1st Cir. 2/25/8), the *Rowley* standard was upheld, and has not been replaced by a maximizing standard. So all of the aforementioned notwithstanding, the District, on 11/5/10, proposed an IEP that does afford the Student an educational benefit. The District, however, as the Hearing Officer has pointed out, through its continued offers to provide clinical services with a signed consent, has acknowledged that more is need.

Issue #1 and #1a: Held for the District.

RE: to Issue #2: Does the Student require additional evaluation, i.e, Functional Behavioral Assessment with a concomitant behavioral intervention plan?

It has already been ascertained that when Restraints are used, a Behavior Intervention Plan is required. Mrs. Perry has acknowledged that a Behavior Plan is necessary, however, it would be appropriate to develop one after a Functional Assessment is completed. Data has to be collected for this, and the District has been collecting data since the Student began attending the RYSE program, but this has been interrupted by long absences while he was in hospital. It is necessary to start the collection of data again, each time that occurs, so that a clear picture of current behaviors can be seen. The Functional Behavior Assessment is a team effort, and would involve the clinical team professionals, as well as the classroom teacher.

The entire process, from assessment to the completed positive behavioral intervention plan, is complex and time-consuming. Since this is a team process, and since the Clinical Services component of that team must be involved, it would be necessary for the Parent to give her informed signed consent for the Student to benefit. Mrs. Perry and her staff have already begun the process by collecting some data. Data collection can begin again, when the Student returns to school. Both parties are responsible for this process to occur, however, the District cannot be held in fault for not completing the process, if it cannot obtain parental consent to have it completed in the proper manner.

In response to the question: does the Student require additional evaluation, i.e., Functional Behavioral Assessment with a concomitant behavioral intervention plan?---the answer is "Yes".

Issue #2: Held for the District

RE: to Issue #3: Is the current program providing adequate communication with the parents?

There is a great deal of communication that is occurring with the Parent: a daily log (the Parent's idea, which was accepted by the classroom teacher, and is being done); telephone calls; letters; notes; and sometimes, face-to-face meetings. It seems to the Hearing Officer, that most of the time, the communication with the classroom teacher is good communication.

At other times, it appears the communication is strained. For example, the Parent may have good ideas/suggestions, but in some cases, the relationship between the Parent and certain staff, is so acrimonious, that they may not be listening to each other.

When the Parent was concerned about transitioning the Student back to school after a hospitalization, she said she tried to contact the Principal of the RYSE program, but was unable to reach her, and left a message. According to the Parent, she did not get a return call right away, and time was of the essence in this case (Tr., Vol. IV, p.66). There may have been extenuating circumstances, but someone should have gotten back to the Parent.

At other times, the Parent attempts to control the methodology used in the program, e.g., she argues with the method the school uses for "processing out" from time-outs. The staff person feels she/he is being criticized, which results in a strained relationship.

The Parent has complained that Mrs. Perry is very "cold" toward her, at times. She has gone to the Superintendent to make this complaint (Tr., Vol. X, p.25). She has made other complaints about Mrs. Perry, e.g., that she says one thing, but does another (Tr., Vol. X, pp.31-32). She assigned blame to the District (read Mrs. Perry), of contributing to the Student's hospitalizations during 2010. Even the Parent's advocate (Dr. O'Connor) thought this was extreme.

It seems to the Hearing Officer that there is a personality clash between the Parent and Mrs. Perry. It is understandable that when someone is frequently criticized, blamed for causing harm to her child, and "reported" to the Superintendent for acting "cold" (in her perception), that that person might not feel too pleasantly disposed toward the accuser. However, it is this Hearing Officer's feeling that, in spite of any misperceptions or less-than-cordial behavior, the staff has tried to accommodate all of the Parent's requests, where

possible, and have executed their responsibilities in a very professional manner.

Issue #3: Held for the District

RE: to Issue #4: Is the facility appropriate for the provision of the program and supports needed by the student?

The Regulations contain no requirements for facilities housing programs for children with disabilities. It is assumed that architects and building engineers, together with city officials, build buildings that are consistent with building codes, safe and are maintained properly.

The Parent has been critical of the RYSE facility for a number of reasons: it has no playground; it contains no "motor" room; and it houses middle and high school children, which are of the most concern. Because of a conversation that the Parent had with Dr. Dumas, the Psych. Director, regarding a modified type of treatment used with some of the older children at RYSE, the Parent has assumed that the facility is unsafe. The treatment in question, is known as MST(Multi-Systemic Therapy). MST is a community-focused, ecologically-oriented service delivery model designed to provide services to children, adolescents and their families, according to Dr. Dumas (Tr., Vol.X, p.82). Dr. Dumas explained that the therapy plays a role in terms of the children's functioning. It is an evidenced-based practice. The Parent looked it up, and saw that it has been used with juvenile delinquents, so assumed, erroneously, that there are juvenile delinquents in the RYSE building. Dr. Dumas said that they have

had success with this treatment program.

The Parent has also complained that the facility does not have appropriate space for the kinds of activities needed in the Student's program. Actually, there are five classrooms, three for the high school, one for middle school, and one for elementary. There are five students in the elementary classroom, which is standard size. In addition, there are four common rooms, which are multi-purpose rooms, that serve as areas for various activities (e.g., lunch, assembly). The elementary classroom is set apart from the upper level classes, separated by a hallway and double doors. There are six time-out rooms that are 8x10 or 8x12. These are not furnished, and have an open door or doorway. Two of these rooms are used with the elementary class, and they are near their classroom. All of the staff have offices, which double as therapy rooms, when needed. There is no playground, but the students have access to all the fields and recreational areas on the campus. They have access to the middle school gymnasium, and they have access for field days and events at the other elementary schools (Tr., Vol.XI, p.35 and pp.109-110).

When the RIDE visited the school in the spring of 2010 for a three-year review, there was no citation for any violation in the facility (Tr., Vol.X, p.164).

There are many school buildings that use multi-purpose rooms, and house a range of grades within them. Caution and good planning have arranged the use of the building in a way that is conducive to the elementary classroom. The Hearing Officer finds the facility appropriate for the provision of the program and supports needed by the Student.

Issue #4: Held for the District

RE: to Issue #5: Is the clinical program at the Bradley School and appropriate program for the Student?

The District, through its Attorney, Mr. Anderson, has stipulated that, should the Hearing Officer rule in favor of the Petitioner, that the Bradley School *is* an appropriate program for the Student. However, Mr. Anderson says in closing, in his Post-Hearing Brief, that the Parent's request should be denied, based on the evidence presented in this case.

Under IDEA, parental preference alone cannot be the basis for compelling a school district to provide a certain educational plan for a child (20 U.S.C.A. Art. 1401(a)(20)). Also, *Rowley* indicates that parents, no matter how well-motivated, do not have the right under IDEA to compel a school district to provide a specific program or employ specific methodology in providing for the education of their child (*Lachman v. Illinois State Board of Education*, 852 F.2d, 290 297 (7th Cir. 1988)).

The Hearing Officer agrees with the closing statement of the District's Attorney (Mr. Anderson) above. The District in the instant case has the capacity to provide, and has offered an appropriate program for the Student.

Issue #5: Held for the District

In summary, this Hearing Officer is of the opinion that the Petitioner has not met his burden.

I, the undersigned Hearing Officer, hereby certify that on April 5, 2011, I mailed a copy* of the within to:

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Gloria S. Feibish

Hearing Officer

