

**District of Columbia
Office of the State Superintendent of Education**

Child Hearing Office
810 First Street, N.E., Suite 2001
Washington, DC 20002

OSSE
Student Hearing Office
May 6, 2014

<p>CHILD¹, By and through PARENTS,</p> <p style="text-align: center;"><i>Petitioners,</i></p> <p>v.</p> <p>DISTRICT OF COLUMBIA OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION,</p> <p style="text-align: center;"><i>Respondent.</i></p>	<p>Impartial Hearing Officer: Charles M. Carron</p>
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HEARING OFFICER DETERMINATION

I. PROCEDURAL BACKGROUND

This is a Due Process Complaint (“DPC”) proceeding pursuant to the Individuals with Disabilities Education Act (“IDEA”), as amended, 20 U.S.C. §§1400 *et seq.*

The DPC was filed March 7, 2014, on behalf of the Child, who resides in the District of Columbia, by Petitioners, the Child’s parents, against Respondent, District of Columbia Office of the State Superintendent of Education, which is the Lead Agency responsible for implementing District of Columbia (“DC”) Early Intervention Services (“EIS”) for infants and toddlers with disabilities and their families, also referred to as

¹ Personally identifiable information is attached as Appendix A to this decision and must be removed prior to public distribution.

“Strong Start,” in conformance with District of Columbia law and federal law to ensure that all children with disabilities, ages birth through three years of age have EIS available to them. DCMR §5-A3199.1; Joint Exhibit 6, para. 1.

On March 10, 2014, the undersigned was appointed as the Impartial Hearing Officer.

On March 17, 2014 Respondent filed its Response, stating, *inter alia*, that Respondent has not failed to provide the Child with appropriate EIS or violated any provision of IDEA or its implementing regulations.

On March 19, 2014 the parties participated in a mediation session in lieu of a resolution session meeting but failed to reach agreement. The 30-day resolution period under 34 C.F.R. §303.442(b) expired April 6, 2014. The 45-day timeline for this Hearing Officer Determination (“HOD”) started to run on April 7, 2014 and will conclude on May 21, 2014.

The undersigned held a Prehearing Conference (“PHC”) by telephone on April 2, 2014, at which the parties discussed and clarified the issues and the requested relief. The undersigned issued a Prehearing Conference Summary and Order (“PHO”) the same date. On April 8, 2014, the undersigned issued a Revised PHO correcting two errors.

At the PHC, the parties agreed that five-day disclosures would be filed by April 22, 2014 and that the Due Process Hearing (“DPH”) would be held on April 29, 2014.

No motions were filed by either party. and the DPH was held on April 29, 2014 from 9:05 a.m. to 4:15 p.m. the Student Hearing Office, 810 First Street, NE, Room 2006, Washington, DC 20002. Petitioner elected for the hearing to be closed.

At the DPH, the following documentary exhibits were admitted into evidence without objection:

- (a) Petitioners’ Exhibits: P-1 through P-24;
- (b) Respondent’s Exhibits: R-1 through R-12;

- (c) Joint Exhibits: J-1 through J-6; and
- (d) Hearing Officer's Exhibits: HO-1 through HO-9.

The following witnesses testified on behalf of Petitioners at the DPH:

- (a) Petitioner/Parent #1; and
- (b) Clinical Psychologist, who was admitted, over Respondent's objection, as an expert in clinical psychology and developmental evaluation of children including recommendations for children's services.

The following witnesses testified on behalf of Respondent at the DPH:

- (a) Director of Therapy;
- (b) Therapy Manager, whose testimony by telephone was struck by the undersigned because she did not have access to Petitioner's disclosures as required by Paragraph 19 of the PHO;
- (c) Coach, who was admitted, over Petitioners' objection, as an expert in early intervention evaluation and services; and
- (d) Family Services Unit Supervisor.

The parties filed written closing arguments on May 1, 2014.

II. JURISDICTION

The DPH was held pursuant to the IDEA, 20 U.S.C. §§1415(f) and 1439(a)(1); IDEA's implementing regulations, 34 C.F.R. §§300.511 and 303.443, and the District of Columbia Code and Code of D.C. Municipal Regulations, *see* DCMR §§5-E3029 and E3030. This decision constitutes the HOD pursuant to 20 U.S.C. §1415(f), 34 C.F.R. §§300.513 and 303.445, and §1003 of the *Special Education Child Hearing Office Due Process Hearing Standard Operating Procedures*.

III. CIRCUMSTANCES GIVING RISE TO THE COMPLAINT

The circumstances giving rise to the DPC are as follows:

The Child is male, Current Age, and attends child care at Child Care Center #2.

At one time, the Child was determined by Respondent to be eligible for EIS under Part C of IDEA.

Petitioner claims that Respondent has violated Part C of IDEA by failing to evaluate the Child in all suspected areas of disability, by failing to provide all of the EIS that the Child needs, and by determining the Child to be no longer eligible for EIS, as more fully set forth in Section IV *infra*.

IV. ISSUES

As confirmed at the PHC and in the PHO, the following issues were presented for determination at the DPH:²

(a) Since on or about August 2, 2013, did Respondent violate 20 U.S.C. §1435-1436 or 34 C.F.R. §303.344 because the Individualized Family Service Plan (“IFSP”) developed for the Child was inappropriate because it did not include all necessary early intervention services and needed services for transportation, occupational therapy (“OT”), speech-language, psychology, and nutrition; and/or because it did not specify an appropriate location of child care effective from mid-November 2013?

(b) During February 2014, did Respondent violate IDEA or its implementing regulations by failing to obtain Petitioners’ fully informed consent

² On the record at the DPH, Petitioner withdrew the following issue: “From August 2, 2013 to date, has Respondent violated IDEA by failing to implement fully the services required by the Child’s IFSP dated August 2, 2013, specifically twice monthly OT?”

before performing evaluations and/or assessments in conformity with 34 C.F.R. §§303.7(a) and (b) and 303.420(a)(2)?

(c) During February 2014, did Respondent violate IDEA or its implementing regulations by failing to comprehensively reevaluate the Child and assess the Child’s family pursuant to 34 C.F.R. §§303.113 and 303.321 once Respondent decided to reevaluate the Child?

(d) On or about February 19, 2014, did Respondent violate IDEA or its implementing regulations by deciding to discontinue the Child’s identification as an infant or toddler with a disability under 20 U.S.C. §1432(5) or 34 C.F.R. §303.21?

V. RELIEF REQUESTED

Petitioner requests the following relief:³

(a) an Order that Respondent identify the Child as a child with a disability and find him eligible for EIS;

(b) an Order that Respondent conduct the following evaluations in order to determine the Child’s needs as an infant or toddler with an automatically qualifying disability⁴: (i) an OT evaluation, (ii) a nutritional evaluation, and (iii) a psychology evaluation; and

³ By email on April 15, 2014, Petitioner’s counsel advised that Petitioner has withdrawn, without prejudice, the request for compensatory EIS, reserving that request for a subsequent DPC if the Child is found still to be disabled and entitled to services and Respondent fails to offer compensatory EIS.

⁴ Petitioner asserts that the Child had low birth weight, was extremely premature, and has Intraventricular Hemorrhage (“IVH”).

(c) an Order that Respondent develop an IFSP that includes OT, speech-language pathology therapy, psychological services, nutrition services, child care placement, and transportation.

VI. FINDINGS OF FACT

Facts Related to Jurisdiction

1. The Child is a male of Current Age. P-1-1.⁵
2. The Child resides in the District of Columbia. P-7-2, testimony of Parent #1.
3. On January 28, 2012, the Child was determined to be eligible for EIS under Part C of IDEA as a child with diagnosed conditions with a high probability of developmental delay (P-9-1) but on February 19, 2014 was determined to be no longer eligible (Stipulation of counsel on the record at the DPH).

Early History

4. On Date of Birth, the Child was born extremely premature (25 weeks of gestation) with several medical conditions, including grade 3 Intraventricular Hemorrhage (“IVH”). P-1-5, P-8.
5. IVH is a neurologic disorder (J-1) that appears on the District of Columbia’s “List of Established Conditions” that have a high probability of resulting in a developmental delay or disability (J-6-1).
6. On September 23, 2011, a developmental evaluation of the Child was conducted by Clinical Psychologist and a Psychology Fellow at Children’s National

⁵ When citing exhibits, the third range represents the page number within the referenced exhibit, in this instance, page 1.

Medical Center (“CNMC”). P-2. At that time, the Child’s parents “did not express any developmental concerns.” P-2-1. The Child’s IVH was “resolving.” *Id.* This meant that no surgical or other intervention was required, but the injury was chronic and will last the Child’s life. Testimony of Clinical Psychologist. The Child was attending Child Care Center #1 and receiving speech therapy, Physical Therapy (“PT”) and OT. P-2-1. His gross motor skills and fine motor/problem-solving skills were within normal limits. *Id.*

7. On January 6, 2012, CNMC referred the Child to Strong Start. P-8.

8. On January 28, 2012, an initial evaluation of the Child for Part C eligibility was conducted by Respondent. P-5, P-9. The evaluators found that the child had prematurity (25 weeks gestation), a condition that has a high probability of resulting in developmental delay (P-9-1) and they concluded that the Child met the eligibility criteria for Part C.

P-9-2.

9. On February 9, 2012, an initial IFSP was developed for the Child. P-10.

10. At that time, no developmental concerns were reported by the family. P-10-3.

11. The Child’s initial IFSP prescribed PT. P-10-5.

January 25, 2013 Evaluation

12. On January 25, 2013, Parent #1 provided written consent for assessments of the Child and his family. J-5.

13. The Child was evaluated by Respondent on January 25, 2013. P-6.

14. The Child was found to have met some of his objectives and was making progress on others. R-10.

15. At that time, Parent #1 expressed concerns about the Child walking straight, being more focused, being independent and doing more activities. P-6-3.

16. The evaluators found that the Child's cognitive, social-communication, social, gross motor, fine motor and adaptive development were delayed. P-6-5 through -7.

17. The evaluators recommended PT twice a month for 60 minutes, speech therapy once a week for 60 minutes, and OT twice a month for 60 minutes. P-6-10.

February 25, 2013 IFSP

18. The IFSP developed for the child on February 25, 2013 noted that the Child was developmentally delayed with regard to cognitive functioning (P-11-4), communication (P-11-4 and -5), social-emotional functioning (P-11-5), adaptive functioning (P-11-5 and -6), fine motor skills (P-11-6), and gross motor skills (*Id.*).

19. The February 25, 2013 IFSP prescribed speech-language therapy once per week for 60 minutes (P-11-18), OT twice per month for 60 minutes (P-11-20), and PT twice per month for 60 minutes (P-11-22).

Child Care Center #1 Waiting List

20. On February 27, 2013, the Child was put on the waiting list for Child Care Center #1. P-18-7.

21. On March 5, 2013, Director of Therapy informed DSC #1 that Child Care Center #1 would have space for the Child beginning April 1, 2013. *Id.*

22. On March 7, 2013, DSC #1 emailed Director of Therapy asking whether therapy sessions could begin at Child Care Center #1 before April 1, 2013, to which Director of Therapy replied that therapy could begin March 19, 2013. P-18-5 and -6.

23. On March 8, 2013, Director of Therapy emailed DSC #1 that the family would have to apply for a voucher to cover the cost of child care. P-18-3.

May 7, 2013 IFSP Modification

24. On May 7, 2013, the Child's IFSP was revised to modify outcomes and to revise the Child's services to deliver them in more frequent short sessions, without changing the overall number of minutes per month. P-12.

June 14, 2013 Developmental Evaluation

25. On June 14, 2013, Clinical Psychologist and a Psychology Fellow at CNMC conducted a follow-up developmental evaluation of the Child. P-17-3.

26. As of that date, the parents expressed no developmental concerns. *Id.*

27. The Child's parents stated he ate a wide variety of foods, had no difficulty with chewing, and drank from a straw and an open cup without assistance. The only concerns noted regarding eating were that the Child at times put too much food in his mouth and ate very fast. *Id.*

28. The evaluators administered the Bayley Scales of Infant Development – 2nd Edition (“the Bayley”), conducted a parent interview, and observed the Child clinically in unstructured play. *Id.*

29. The evaluators noted that the Child was “alert and interested in testing items, but somewhat frantic/disorganized in his approach and easily distracted.” *Id.*

30. The Child’s gross motor skills were within normal limits. *Id.*

31. The Child’s fine motor/problem solving skills were broadly within normal limits. *Id.*

32. The Child’s social foundations for language were well established with receptive and expressive language within normal limits. P-13-4.

33. The Child’s adaptive skills were variable. *Id.*

34. The Child was less well regulated than a typically developing child.

Testimony of Clinical Psychologist. He had problems with maintaining attention sitting at the table during his evaluation. *Id.* He had limited ability to soothe himself. *Id.*

August 2, 2013 IFSP Meeting

35. An IFSP meeting was held on August 2, 2013. J-3.

36. Parent #1 testified that the Child was not able to keep his food down and would throw up two or three times per day. Testimony of Parent #1. For the reasons explained in Section VIII *infra*, the undersigned does not credit this testimony.

37. Based upon the speech-language pathologist’s testing, the Child’s communication skills were well within normal limits. Testimony of Director of Therapy.

38. Based upon testing, the Child’s gross and fine motor skills were within normal limits. *Id.*

39. The IFSP Team determined to discharge the Child from speech and PT services because he had reached the functional outcomes in these areas, and to reduce his OT to two times per month for 30 minutes. J-3.

40. These decisions were based upon provider progress notes (R-7, R-8, J-4) and an OT assessment (J-4).

41. Parent #1 signed the first page of the IFSP Add/Change Form, which states, just above her signature:

I/We have been informed of my/our parental rights through the *Families Have Rights* Procedural Safeguards Notice and give permission ... to implement any IFSP revisions based on this review.

J-3-1.

42. Parent #1 signed the last page of the IFSP Add/Change Form, which states, just above her signature:

I/We understand the plan and parental rights and give permission to implement all services.

J-3-11.

43. Based upon the entire record, the undersigned finds that the August 2, 2013 IFSP was appropriate for the Child, and that Parent #1 agreed it was appropriate.

Change in Location of Services

44. Sometime after August 2, 2013, the Child ceased attending Child Care Center #1 and sometime thereafter he commenced attending Child Care Center #2.

45. There is no evidence in the record that the Child's IFSP was revised to reflect the new location of services.

November 1, 2013 Change in DSCs

46. On or about November 1, 2013, the Child's case was transferred from DSC #1 to DSC #2. P-15-1.

December 16, 2013 Evaluation

47. On December 16, 2013, Clinical Psychologist and a Clinical Psychology Extern conducted a developmental evaluation of the Child. P-3.

48. At that time, the Child's parents expressed concerns about the Child's hearing status and inattentive behavior. P-3-1.

49. The Child's parents stated that he ate a wide variety of table foods, primarily finger-feeding himself and using a spoon sometimes, and Parent #1 reported that the Child's "excessive vomiting 2 months ago was connected with him not completely chewing his food before swallowing." *Id.* It was noted that the Child did not drink milk. *Id.*

50. At the time of the December 16, 2013 evaluation, the Child had been attending Child Care Center #2 for two weeks. P-3-1.

51. During testing, the Child was easily distracted and inattentive. *Id.*

52. The evaluators found that the Child's gross motor skills were within normal limits. *Id.*

53. The evaluators found that the Child's other areas of development were about nine months delayed.⁶ P-3-1 and -2. At the age of the Child, it is difficult for evaluators

⁶ Respondent's counsel elicited testimony that when calculating a child's degree of developmental delay, results vary depending on whether a child born prematurely is compared with typically developing children of the same chronological age or the

to distinguish between cognitive and language skills. Testimony of Clinical Psychologist.

54. The Child's parents reported that his expressive language skills were higher than the evaluators observed. *Id.*

55. The evaluators remained concerned about the Child's "regulatory challenges." *Id.*

56. The evaluators recommended continuation of the Child's OT, perhaps once per week, and opined that speech therapy might be indicated given his language delays, or the Child's occupational therapist could seek consultation from a speech-language pathologist and incorporate language-based tasks into the treatment routine. P-3-2.

57. Clinical Psychologist recommended that the Child continue to receive these services in the setting of a therapeutic day care center, both to ensure consistency of the therapies and also to benefit the Child's development of language, social-emotional and adaptive skills. Testimony of Clinical Psychologist.

February 7, 2014 Head Injury

58. On February 7, 2014, the Child suffered a head injury, bumping his forehead on a dresser in his apartment. P-23-1.

59. The Child was seen by a physician and was found to have a contusion and prescribed treatment with ice and Tylenol or Motrin. P-23-2.

premature child's "corrected" age that takes into account his prematurity. Because, as discussed *infra*, the Child is eligible under Part C based upon his diagnosis of IVH rather than based upon the degree (percentage) of developmental delay, the accuracy of the Bayley scores from the December 16, 2013 evaluation is not material to deciding the issues in this case.

60. There is no evidence in the record that this injury had any effect upon the Child's development.

Direct Service Records

61. Monthly, Respondent sent Petitioners notes of therapy services provided to the Child. R-9, testimony of Family Services Unit Supervisor.

62. Petitioners did not contact Family Services Unit Supervisor to provide any feedback or to complain about the services provided. *Id.*

63. It is possible that Petitioners provided feedback to other representatives of Respondent, although Family Services Unit Supervisor believes she would have been made aware of such feedback or complaints. *Id.*

February 12, 2014 Evaluation

64. On January 30, 2014, DSC #2 informed Parent #1 that it was time for the Child's annual evaluation to determine whether he would remain eligible for EIS. R-12-1.

65. Parent #1 was not informed of the evaluation or assessment tools that would be used or of her right to participate in the evaluation. *Id.*

66. Parent #1 testified that as of February 2013, the Child was not keeping his food down. Testimony of Parent #1. For the reasons discussed in Section VIII *infra*, the undersigned does not credit the testimony of Parent #1.

67. The Child was tested on February 12, 2014. R-6, R-11.

68. The Child had achieved almost all of his objectives. R-11.

69. In response to the question, “Are there any activities that are challenging for the child and the family ... at home, in childcare settings or during community activities,” the family expressed no concerns. R-6-2.

70. The evaluators administered the Assessment, Evaluation and Programming System for Infants and Children II (“AEPS”) and the Battelle Developmental Inventory-2nd Edition. R-6-6 and -7.

71. The Child’s scores on cognitive development, communication development, social-emotional development, physical development and adaptive development all fell in the average range of typically developing children, with no concerns noted. R-6-3 through -7.

72. The evaluators concluded that the Child did not meet the eligibility criteria for Strong Start and recommended no continued therapy services. R-6-8 and -9.

73. The evaluators did not take the Child’s history. R-6.

74. The evaluators did not interview the Child’s parents. *Id.*

75. The evaluators did not gather information from the Child’s medical providers. *Id.*

76. The evaluators did not request or review any of the Child’s medical records and they did not have, or were not aware of, Clinical Psychologist’s report of his December 16, 2013 evaluation. *Id.*, testimony of Clinical Psychologist.

February 19, 2014 IFSP Meeting

77. On February 19, 2014, the IFSP Team met and determined that the Child no longer was eligible for EIS. Stipulation of Counsel on the record at the DPH.

78. This determination was based upon the Team's assumption that the Child's previous eligibility had been based upon his prematurity coupled with the Team's finding that the Child did not have a developmental delay of 50 percent or more in one developmental domain or 25 percent or more in two domains. Testimony of Coach.

79. According to Coach, who was admitted as Respondent's expert in early intervention evaluation and services, if a child has a diagnosis of a condition on the List of Established Conditions, other than prematurity, the child's eligibility continues automatically, *i.e.*, without a showing of developmental delay of 50 percent in one domain or 25 percent in two domains.⁷ *Id.*

80. Based upon the entire record, the undersigned finds that the IFSP Team, by not having reviewed the Child's medical records, was unaware that the Child had a diagnosis of IVH, which is a condition on the List of Established Conditions, and that the Team therefore determined that the Child was ineligible based upon its mistaken assumption that the Child had been eligible previously due only to his prematurity, requiring continuing evidence of significant developmental delays.

81. Parent #1 testified that at the meeting, she asserted that she did not agree that the Child was no longer as eligible, and that she did not agree to the elimination of EIS. Testimony of Parent #1. For the reasons discussed in Section VIII *infra*, the undersigned does not credit the testimony of Parent #1.

82. Parent #1 signed a consent form for the Child's re-evaluation that already had been conducted. J-2.

⁷ As discussed in Section IX, *infra*, this is a correct interpretation of the law. Had Coach expressed an incorrect interpretation of the law, it would not have been considered an admission because it is the responsibility of the Hearing Officer to determine and apply the law.

83. Parent #1 signed the first page of the IFSP Add/Change Form, which states, just above her signature:

I/We have been informed of my/our parental rights through the *Families Have Rights* Procedural Safeguards Notice and give permission ... to implement any IFSP revisions based on this review.

Stipulation of Counsel on the record at the DPH.

84. Based upon the entire record, the undersigned finds that all participants in the February 19, 2014 IFSP Team meeting agreed that the Child no longer met the eligibility criteria for Part C, and no longer required EIS, although this determination was based upon faulty assumptions regarding the basis for the Child's eligibility.

Events Subsequent to February 19, 2014

85. On February 24, 2014, DSC #2 sent Clinical Psychologist the Child's evaluation report. P-14-1.

86. Clinical Psychologist disagreed with the evaluation because he thought it overstated the Child's skills compared to what he had observed two months before.

Testimony of Clinical Psychologist.

87. According to Clinical Psychologist, many of the skills that Respondent's evaluators considered age-appropriate for a 27-month old such as the Child were actually appropriate for a child 12 to 15 months of age. *Id.*

88. Clinical Psychologist considered the conclusion of Respondent's evaluators that the Child's physical development was that of a four to five year old to be "beyond unlikely" for a 27-month old. *Id.*

89. Clinical Psychologist acknowledged that the Child's scores could be affected by the setting of the testing, *i.e.*, hospital versus his familiar day care center. *Id.*

90. Based upon the entire record, the undersigned gives more weight to Clinical Psychologist's evaluation of the Child in December 2013 than to Respondent's evaluation in February 2014, and the undersigned finds that the Child continued to have developmental delays⁸ as of February 19, 2014.

91. On March 4, 2014, Clinical Psychologist emailed DSC #2 stating that based upon the Child's December 2013 assessment, the Child was "more than 25% in several domains" and should have once-weekly OT and possibly speech-language therapy.

P-14-1.

92. On March 6, 2014, 15 days after the February 19, 2014 PWN, Parent #1 wrote a letter "To whom it may concern," stating, *inter alia*, that at the end of the February 19, 2014 IFSP meeting, she did not want to sign the IFSP Add/Change Form because she did not agree:

I told [Dedicated Services Coordinator #2] that I did not agree and I did not want to authorize that my son ... be terminated from Strong Start and his IFSP to stop. [Dedicated Services Coordinator #2] told me that I had to sign the form because I attended the meeting, that I had no choice but to sign it. Under such duress, I did sign the paper despite my disagreement and lack of actual consent for the changes.

I ... hereby revoke permission to implement any IFSP revisions based on the review on February 19, 2014, since I never intended to give permission for the IFSP to end and I do not and did not give my permission or consent for his IFSP to end....

HO-1-8.

⁸ As discussed in detail *infra*, the Child is eligible based upon his diagnosis of IVH, without regard to developmental delays; accordingly, the degree (percentage) of those delays is not material to determination of the issues in this case. However, the continued *existence* of those delays supports the continued need for EIS.

93. On March 7, 2014, Petitioner’s counsel wrote to Respondent stating, *inter alia*, as follows:

[Parent #1] is hereby revoking her signature on the IFSP Add/Change Form, pursuant to 34 CFR § 303.7(c)(1), which states that consent under Part C may be revoked at any time. Her signature was never fully voluntary, as required by law....

HO-1-7.

94. Based upon the entire record, particularly Parent #1’s lack of credibility (*See*, Section VIII, *infra*), the undersigned finds that Parent #1 did knowingly and voluntarily sign the IFSP Add/Change Form; however, the undersigned finds that Parent #1’s signature was motivated by Respondent’s incorrect explanation that the Child no longer qualified because he did not have evidence of significant developmental delays—evidence that was not required because of the Child’s diagnosis of IVH.

95. On March 25, 2014, Clinical Psychologist conducted a developmental evaluation⁹ of the Child based upon the Child’s parents’ concerns about ongoing developmental delay and behavioral challenges, *i.e.*, aggressive behavior, tantrums and attention difficulties. P-4.

96. Clinical Psychologist found that the Child’s gross motor skills were adequate for daily functioning and that his expressive language skills were within normal limits,

⁹ Respondent’s counsel elicited testimony from Clinical Psychologist that one of the assessment instruments he used—the Bayley—should not be administered more frequently than once every six months. Apparently the child’s scores may be skewed by the so-called “practice effect.” Because, as discussed *infra*, the Child is eligible under Part C based upon his diagnosis of IVH rather than based upon the degree (percentage) of developmental delay, the accuracy of the Bayley scores from the March 25, 2014 evaluation is not material to deciding the issues in this case.

but his fine motor/play skills and receptive language skills were approximately six months delayed, neither of which constituted a 25 percent delay. *Id.*

97. Clinical Psychologist testified that developmental delays of less than 25 percent still could require services although those services might not be provided under Part C. Testimony of Clinical Psychologist.

98. Clinical Psychologist recommended (a) a therapeutic daycare placement because of the Child's high risk for learning disabilities, (b) OT, and (c) a behavior management plan. P-4-3.

99. Clinical Psychologist did not recommend psychological services. *Id.*

100. Clinical Psychologist did not recommend speech-language pathology therapy for the Child's receptive language delay because he believed that delay was impacted by the Child's behavior and attention difficulties. Testimony of Clinical Psychologist.

101. Clinical Psychologist does not believe the Child needs nutrition services. *Id.*

102. Clinical Psychologist does not have specific concerns about the Child with regard to anxiety or depression. *Id.*

103. Based upon the entire record, the undersigned finds that, from August 12, 2013 to the date of the DPH, the Child has not required speech-language pathology therapy, psychological services or nutrition services, and that Respondent was not on notice of the need for assessments or evaluations in these areas.

VII. BURDEN OF PROOF

In a special education DPH, the burden of persuasion is on the party seeking relief. DCMR §5-E3030.3; *Schaffer v. Weast*, 546 U.S. 49 (2005). Through

documentary evidence and witness testimony, the party seeking relief must persuade the Impartial Hearing Officer by a preponderance of the evidence. DCMR §5-E3022.16; *see also, N.G. v. District of Columbia*, 556 F. Supp. 2d 11, 17 n.3 (D.D.C. 2008).

VIII. CREDIBILITY

The undersigned found Parent #1 not credible. Despite the repeated statements in Clinical Psychologist's reports that she had expressed no concerns about the Child's development, and despite documentary evidence that she concurred in the decisions of the IFSP Team at its various meetings, Parent #1 testified that she had continuing concerns about the Child's development and only signed the IFSP Add/Change Form on February 19, 2014 because she was told she had to. When the undersigned asked Parent #1 what the consequence of not signing the form would be, she testified that there would be no difference in outcome because the Child's services would be discontinued whether she signed or not. In response to another question from the undersigned, Parent #1 stated that she had on occasion refused to sign forms. When pressed to explain why, in these circumstances, she did not simply refuse to sign the IFSP Add/Change Form, Parent #1 had no answer. Parent #1 testified that the Child continues to have trouble chewing and vomits multiple times per day, but the report of the June 14, 2013 evaluation by Clinical Psychologist (P-17-3 and -4) recites that the Child's parents stated he ate a wide variety of foods, had no difficulty with chewing, and drank from a straw and an open cup without assistance. The only concerns noted regarding eating were that the Child at times put too much food in his mouth and ate very fast. Similarly, the report of the December 16, 2013 evaluation by Clinical Psychologist (P-3) recites that the

Child's parents stated that he ate a wide variety of table foods, primarily finger-feeding himself and using a spoon sometimes, and that Parent #1 reported that the Child's "excessive vomiting 2 months ago was connected with him not completely chewing his food before swallowing." It was noted that the Child did not drink milk. As of the March 25, 2014 evaluation by Clinical Psychologist (P-4) stated no concerns about chewing or swallowing, and the only reference to vomiting was from two months previous when the Child went to the emergency room. Clinical Psychologist does not believe the Child needs nutrition services. Apparently whatever feeding issues the Child had from birth have mostly resolved and do not support Parent #1's testimony of a serious eating disorder requiring nutrition services—another example of false or exaggerated testimony that reflects adversely on her credibility. Parent #1's demeanor and tone throughout her testimony on cross-examination was defensive. Parent #1 testified that before the Child first began to attend Child Care Center #1, Parent #1 was unemployed. Director of Therapy testified credibly that when the Child first began to attend Child Care Center #1, Parent #1 was employed and that three weeks later she was no longer working, which required Child Care Center #1 to change Petitioners' voucher. Director of Therapy testified that Parent #1 asked if she needed to put Parent #2's name on the voucher form, and asked what if he were deceased. Director of Therapy testified that she recently had met with Parent #2 and knew he was not deceased. Based upon all of the above, the undersigned found Parent #1 to be deliberately misrepresenting facts. Consequently, the undersigned has given no weight to her testimony.

The undersigned found all of the other witnesses to be credible, to the extent of their first hand knowledge or professional expertise.

IX. CONCLUSIONS OF LAW

Purpose of the IDEA

1. The IDEA is intended “(A) to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living [and] (B) to ensure that the rights of children with disabilities and parents of such children are protected...” 20 U.S.C.

§1400(d)(1). *Accord*, DCMR §5-E3000.1.

2. Part C of IDEA, covering early intervention for infants and toddlers with disabilities, has as its goal the provision of financial assistance to the States:

- (1) to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families;
- (2) to facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage);
- (3) to enhance State capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to infants and toddlers with disabilities and their families; and
- (4) to encourage States to expand opportunities for children under 3 years of age who would be at risk of having substantial developmental delay if they did not receive early intervention services.

20 U.S.C. §1431(b); *accord*, 34 C.F.R. §303.1.

Infant or Toddler with a Disability

3. Infant or toddler with a disability means

an individual under 3 years of age who needs early intervention services because the individual—

(i) is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in 1 or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or

(ii) has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay....

20 U.S.C. §1432 (5); *accord*, 34 C.F.R. §303.21 and DCMR §5-A3199.1.

4. It is significant that clauses (i) and (ii) above are joined by the word “or.” A child that meets one of these criteria need not meet the other. Thus, any policies or procedures that Respondent may have requiring a certain degree (percentage) of developmental delay for a Child to continue to be eligible under Part C even if the child has a diagnosed physical condition that has a high probability of resulting in developmental delay is invalid.

5. While Respondent may initially have determined the Child eligible based upon his prematurity, and subsequently based upon developmental delays, that does not preclude the Child from eligibility based upon his IVH.

6. Because the Child has been diagnosed with IVH (Finding of Fact 4), which is a physical condition that has a high probability of resulting in developmental delay (Finding of Fact 5), the Child is eligible under Part C without regard to whether he is experiencing developmental delays.

Evaluation and Reevaluation

7. When a child under the age of three is referred for evaluation or early intervention services and suspected of having a disability, the lead agency must ensure that, subject to obtaining parental consent, the child receives—

(i) A timely, comprehensive, multidisciplinary evaluation of the child in accordance with paragraph (b) of this section unless eligibility is established under paragraph (a)(3)(i) of this section; and

(ii) If the child is determined eligible as an infant or toddler with a disability as defined in §303.21—

(A) A multidisciplinary assessment of the unique strengths and needs of that infant or toddler and the identification of services appropriate to meet those needs;

(B) A family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler. The assessments of the child and family are described in paragraph (c) of this section and these assessments may occur simultaneously with the evaluation, provided that the requirements of paragraph (b) of this section are met.

(2) As used in this part—

(i) *Evaluation* means the procedures used by qualified personnel to determine a child's initial and continuing eligibility under this part, consistent with the definition of *infant or toddler with a disability* in §303.21. An *initial evaluation* refers to the child's evaluation to determine his or her initial eligibility under this part;

(ii) *Assessment* means the ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility under this part and includes the assessment of the child, consistent with paragraph c(1) of this section and the assessment of the child's family, consistent with paragraph (c)(2) of this section; and

(iii) *Initial assessment* refers to the assessment of the child and the family assessment conducted prior to the child's first IFSP meeting.

(3)(i) A child's medical and other records may be used to establish eligibility (without conducting an evaluation of the child) under this part if those records indicate that the child's level of functioning in one or more of the developmental areas identified in §303.21(a)(1) constitutes a developmental delay or that the child otherwise meets the criteria for an infant or toddler with a disability under §303.21. If the child's part 3 eligibility is established under this paragraph, the lead agency or EIS provider must conduct assessments of the child and family in accordance with paragraph (c) of this section.

(ii) Qualified personnel must use informed clinical opinion when conducting an evaluation and assessment of the child. In addition, the lead agency must ensure that informed clinical opinion may be used as an independent basis to establish a child's eligibility under this part even when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility under paragraph (b) of this section.

(4) All evaluations and assessments of the child and family must be conducted by qualified personnel, in a non-discriminatory manner, and selected and administered so as not to be racially or culturally discriminatory.

(5) Unless clearly not feasible to do so, all evaluations and assessments must be conducted in the native language of the child, in accordance with the definition of *native language* in §303.25.

(6) Unless clearly not feasible to do so, family assessments must be conducted in the native language of the family members being assessed, in accordance with the definition of *native language* in §303.25.

(b) *Procedures for evaluation of the child.* In conducting an evaluation, no single procedure may be used as the sole criterion for determining a child's eligibility under this part. Procedures must include—

- (1) Administering an evaluation instrument;
- (2) Taking the child's history (including interviewing the parent);
- (3) Identifying the child's level of functioning in each of the developmental areas in §303.21(a)(1);
- (4) Gathering information from other sources such as family members, other care-givers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs; and
- (5) Reviewing medical, educational or other records.

(c) *Procedures for assessment of the child and family.* (1) An assessment of each infant or toddler with a disability must be conducted by qualified personnel in order to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs. The assessment of the child must include the following—

- (i) A review of the results of the evaluation conducted under paragraph (b) of this section;
- (ii) Personal observations of the child; and
- (iii) The identification of the child's needs in each of the developmental areas in §303.21(a)(1).

(2) A family-directed assessment must be conducted by qualified personnel in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability. The family-directed assessment must—

- (i) Be voluntary on the part of each family member participating in the assessment;
- (ii) Be based on information obtained through an assessment tool and also through an interview with those family members who elect to participate in the assessment; and
- (iii) Include the family's description of its resources, priorities, and concerns related to enhancing the child's development.

34 C.F.R. §303.321; *accord*, DCMR §§5-A3101.1(b), A3102 and A3103.

8. Based upon the entire record, particularly the failure of Respondent's evaluators to take the Child's history (Finding of Fact 73), interview the Child's parents (Finding of Fact 74), gather information from the Child's medical providers (Finding of Fact 75) or review the Child's medical records (Finding of Fact 76), the undersigned concludes that the February 12, 2014 reevaluation of the Child (R-6) did not meet the requirements of IDEA and its implementing regulations.

Consent

9. The Lead Agency must obtain parental consent before conducting an evaluation of a child. 34 C.F.R. §303.321.

10. Consent means that the parent has been fully informed of all information relevant to the activity for which consent is sought. 34 C.F.R. §303.7(a).

11. Because Respondent did not inform the Child's parents what assessments or other evaluation tools would be utilized for the February 12, 2014 evaluation (Finding of Fact 65), and did not obtain the Child's parents' consent for that evaluation until after it had been completed (Finding of Fact 82), Respondent violated IDEA's consent requirements.

Early Intervention Services

12. Early intervention services means services that--

[a]re designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant's or toddler's development, as identified by the

[Individualized Family Service Plan]Team, in any one or more of the following areas, including—

- (i) Physical development;
- (ii) Cognitive development;
- (iii) Communication development;
- (iv) Social or emotional development; or
- (v) Adaptive development.

34 C.F.R. §303.13(a)(4).

13. Types of early intervention services include assistive technology devices and services; audiology services; family training, counseling and home visits; health services; medical services; nursing services; nutrition services; OT; PT; psychological services; service coordination services; sign language and cued language services; social work services; special instruction; speech-language pathology services; transportation and related costs; and vision services. 34 C.F.R. §303.13(b). This list is not exhaustive. 34 C.F.R. §303.13(d).

14. Appropriate early intervention services that are based on scientifically based research to the extent practicable “shall be available to all infants and toddlers with disabilities and their families who are residents of the District of Columbia....” DCMR §5-A3100.1.

Individualized Family Service Plan

15. Individualized Family Service Plan (“IFSP”) means--

a written plan for providing early intervention services to an infant or toddler with a disability under this part and the infant’s or toddler’s family that—

- (a) Is based on the evaluation and assessment described in §303.321;
- (b) Includes the content specified in §303.344;
- (c) Is implemented as soon as possible once parental consent for the early intervention services in the IFSP is obtained (consistent with §303.420); and

(d) Is developed in accordance with the IFSP procedures in §§303.342, 303.343, and 303.345.

34 C.F.R. §303.20; *accord*, DCMR §5-A3199.1.

16. An IFSP must include the following:

(a) Information about the child's status. The IFSP must include a statement of the infant or toddler with a disability's present levels of physical development (including vision, hearing, and health status), cognitive development, communication development, social or emotional development, and adaptive development based on the information from that child's evaluation and assessments conducted under §303.321.

(b) Family information. With the concurrence of the family, the IFSP must include a statement of the family's resources, priorities, and concerns related to enhancing the development of the child as identified through the assessment of the family under §303.321(c)(2).

(c) Results or outcomes. The IFSP must include a statement of the measurable results or measurable outcomes expected to be achieved for the child (including pre-literacy and language skills, as developmentally appropriate for the child) and family, and the criteria, procedures, and timelines used to determine—

(1) The degree to which progress toward achieving the results or outcomes identified in the IFSP is being made; and

(2) Whether modifications or revisions of the expected results or outcomes, or early intervention services identified in the IFSP are necessary.

(d) Early intervention services.

(1) The IFSP must include a statement of the specific early intervention services, based on peer-reviewed research (to the extent practicable), that are necessary to meet the unique needs of the child and the family to achieve the results or outcomes identified in paragraph (c) of this section, including—

(i) The length, duration, frequency, intensity, and method of delivering the early intervention services;

(ii)

(A) A statement that each early intervention service is provided in the natural environment for that child or service to the maximum

extent appropriate, consistent with §§ 303.13(a)(8), 303.26 and 303.126, or, subject to paragraph (d)(1)(ii)(B) of this section, a justification as to why an early intervention service will not be provided in the natural environment.

(B) The determination of the appropriate setting for providing early intervention services to an infant or toddler with a disability, including any justification for not providing a particular early intervention service in the natural environment for that infant or toddler with a disability and service, must be—

(1) Made by the IFSP Team (which includes the parent and other team members);

(2) Consistent with the provisions in §§ 303.13(a)(8), 303.26, and 303.126; and

(3) Based on the child's outcomes that are identified by the IFSP Team in paragraph (c) of this section;

(iii) The location of the early intervention services; and

(iv) The payment arrangements, if any.

(2) As used in paragraph (d)(1)(i) of this section—

(i) Frequency and intensity mean the number of days or sessions that a service will be provided, and whether the service is provided on an individual or group basis;

(ii) Method means how a service is provided;

(iii) Length means the length of time the service is provided during each session of that service (such as an hour or other specified time period); and

(iv) Duration means projecting when a given service will no longer be provided (such as when the child is expected to achieve the results or outcomes in his or her IFSP).

(3) As used in paragraph (d)(1)(iii) of this section, location means the actual place or places where a service will be provided.

(4) For children who are at least three years of age, the IFSP must include an educational component that promotes school readiness and incorporates pre-literacy, language, and numeracy skills.

(e) Other services. To the extent appropriate, the IFSP also must—

- (1) Identify medical and other services that the child or family needs or is receiving through other sources, but that are neither required nor funded under this part; and
- (2) If those services are not currently being provided, include a description of the steps the service coordinator or family may take to assist the child and family in securing those other services.

(f) Dates and duration of services. The IFSP must include—

- (1) The projected date for the initiation of each early intervention service in paragraph (d)(1) of this section, which date must be as soon as possible after the parent consents to the service, as required in §§ 303.342(e) and 303.420(a)(3); and
- (2) The anticipated duration of each service.

(g) Service coordinator.

- (1) The IFSP must include the name of the service coordinator from the profession most relevant to the child's or family's needs (or who is otherwise qualified to carry out all applicable responsibilities under this part), who will be responsible for implementing the early intervention services identified in a child's IFSP, including transition services, and coordination with other agencies and persons.
- (2) In meeting the requirements in paragraph (g)(1) of this section, the term “profession” includes “service coordination.”

* * *

34 C.F.R. §303.344.

Procedures for IFSP Review

17. IFSPs must be reviewed every six months, or more frequently if conditions warrant, to determine the degree to which progress toward achieving the results or

outcomes in the IFSP is being made and whether modifications or revisions of the results, outcomes, or EIS identified in the IFSP are necessary. 34 C.F.R. §303.342(b)(1).

18. At least annually, an IFSP meeting must be conducted to review any current evaluations and other information available from assessments, to determine the EIS services that are needed and will be provided. 34 C.F.R. §303.342(c).

19. Based upon the entire record, the undersigned concludes that the determination of the IFSP Team on February 19, 2014 that the Child no longer required EIS was defective, and therefore must be voided, because the Child's parents had not been fully informed of the assessment and evaluation tools that would be utilized and their right to participate in the evaluation (Finding of Fact 65), they had not provided prior consent (Finding of Fact 82), and the evaluation did not comply with the requirements of IDEA (Conclusion of Law 8).

Summary

20. From August 2, 2013 through February 18, 2014, the IFSP developed for the Child included all necessary EIS and needed services for transportation, OT, speech-language, psychology, and nutrition.

21. Respondent's failure to update the Child's August 2, 2013 IFSP to reflect the change in location of services from Child Care Center #1 to Child Care Center #2 caused no harm to the Child.

22. During February 2014, Respondent violated IDEA and its implementing regulations by failing to obtain Petitioners' fully informed consent before performing

evaluations and/or assessments in conformity with 34 C.F.R. §§303.7(a) and (b) and 303.420(a)(2).

23. During February 2014 Respondent violated IDEA and its implementing regulations by failing to comprehensively reevaluate the Child and assess the Child's family pursuant to 34 C.F.R. §§303.113 and 303.321 once Respondent decided to reevaluate the Child.

24. On or about February 19, 2014, Respondent violated IDEA and its implementing regulations by deciding to discontinue the Child's identification as an infant or toddler with a disability under 20 U.S.C. §1432(5) and 34 C.F.R. §303.21.

X. ORDER

Based upon the above Findings of Fact and Conclusions of Law, it is hereby ORDERED:

1. Effective immediately upon receipt of this Order, Respondent shall (a) reinstate the Child's August 2, 2013 Part C eligibility and IFSP (changing only the location of services to reflect the Child's attendance at Child Care Center #2) and (b) suspend all actions taken at the February 19, 2014 IFSP Team meeting, including the determination that the Child is not eligible for Part C and the discontinuation of EIS services.

2. No later than May 16, 2014, Respondent shall deliver the following to Petitioners: (a) a consent form for a reevaluation of the Child, (b) a list of all of the assessment tools and sources of information that Respondent intends to employ in the reevaluation, (c) a statement that Petitioners have the right to participate in the evaluation and to provide the evaluators with any medical reports or other medical information that they wish the evaluators to consider, and (d) a consent form for the parents to consent to release of the Child's complete medical records from Children's National Medical Center. Emailing these documents to Petitioners' counsel shall constitute delivery.

3. No later than ten business days after delivery of the documents described in Paragraph 2 above, Petitioners shall return the consent forms described in Paragraph 2(a) and (d), signed by one or both of them, to Respondent. Failure to return either or both of the signed consent forms by that date shall constitute a waiver of all relief provided in this Order, in which event Respondent may reinstate the actions taken at the February 19, 2014 IFSP Team meeting, including the determination that the Child is not eligible for Part C and the discontinuation of EIS services.

4. No later than 15 business days after receipt of the latter of the consent forms described in Paragraph 2 (a) and (d) above signed by one or both of Petitioners, Respondent shall complete the Child's reevaluation, including but not limited to taking a complete history of the Child, interviewing Petitioners, reviewing records from Children's National Medical Center, and reviewing records from any other medical provider of the Child that may have been provided by Petitioners or for whom Petitioners may have provided consent for Respondent to obtain records.

5. No later than two business days after completing the reevaluation described in Paragraph 4 above, Respondent shall deliver a copy of the reevaluation report to Petitioners with a Letter of Invitation ("LOI") to an IFSP Team meeting no later than five business days after delivery of the report and LOI, to discuss, at a minimum (a) the reevaluation; (b) the Child's needs and services to meet those needs; (c) whether a behavior plan is appropriate, and if so, who should prepare it; and (d) transition when the Child turns three years of age. Emailing these documents to Petitioners' counsel shall constitute delivery. The Child's IFSP shall be revised at the meeting, as appropriate.

6. All written communications from Respondent to Petitioners concerning the above matters shall include copies to Petitioners' counsel by facsimile or email.

7. Petitioners' other requests for relief are DENIED.

Dated this 6th day of May, 2014.



Charles Carron
Impartial Hearing Officer

NOTICE OF APPEAL RIGHTS

The decision issued by the Impartial Hearing Officer is final, except that any party aggrieved by the findings and decision of the Impartial Hearing Officer shall have 90 days from the date of the decision of the Impartial Hearing Officer to file a civil action with respect to the issues presented at the due process hearing in a district court of the United States or a District of Columbia court of competent jurisdiction, as provided in 20 U.S.C. § 415(i)(2).