XXXX XXXX, JR.	*	**BEFORE UNA M. PEREZ,**
STUDENT	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
HARFORD COUNTY	*	**OF ADMINISTRATIVE HEARINGS**
PUBLIC SCHOOLS	*	**OAH No.: MSDE-HARF-OT-14-16208**

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DECISION

STATEMENT OF THE CASE

On May 7, 2014, XXXX XXXX (Parent), on behalf of her child, XXXX (XXXX) XXXX, Jr. (Student), filed a Due Process Complaint with the Office of Administrative Hearings (OAH) requesting a hearing to review the identification, evaluation, or placement of the Student by the Harford County Public Schools (HCPS) under the Individuals with Disabilities Education Act (IDEA). 20 U.S.C.A. § 1415(f)(1)(A) (2010). Both parties waived an otherwise required resolution meeting and requested that a mediation be scheduled in this matter. The mediation took place on May 21, 2014, but was unsuccessful.

I held a telephone prehearing conference beginning on May 22, 2014. The Parent was present and represented herself. Manisha S. Kavadi, Esq., represented HCPS. I continued the Conference until May 28, 2014 because the Parent had scheduled a meeting to consult with an

attorney on the afternoon of May 22, 2014.[1] By agreement of the parties, the hearing was scheduled for June 26, June 30, and July 1, 2014.

Under the federal regulations, a hearing must be conducted and a decision is due within 45 days of certain triggering events. 34 C.F.R. § 300.510 (b) and (c); 34 C.F.R. § 300.515(a) and (c) (2013). In this case, the triggering event was the unsuccessful mediation held on May 21, 2014, which would require the hearing to be held and the decision to be issued on or before July 7, 2014. During the pre-hearing conference, the parties jointly moved to waive the time requirements for conducting the hearing and issuing a decision set forth in 34 C.F.R. § 300.515 and Code of Maryland Regulations (COMAR)13A.05.01.15C. The reason for that request was so that a hearing could be scheduled to accommodate their calendars while allowing sufficient time to render a written decision. 34 C.F.R. § 300.515; Md. Code Ann., Educ. § 8-413(h) (2014). After reviewing the parties' calendars and availability, I granted the joint motion. The parties requested that I issue a decision within 30 days of the close of the record.

By letter of June 17, 2014, counsel for the Parent requested leave to present testimony by telephone from five witnesses. *See* COMAR 28.02.01.20B. By letter of June 20, 2014, counsel for HCPS objected and requested a conference call, which took place on the record on June 23, 2014. I granted the Parent's request subject to several conditions, and on June 24, 2014, issued a letter to counsel setting forth my ruling and the conditions.

I held the hearing on June 26, June 30, and July 1, 2014. Kimm Massey, Esq., represented the Parent.[2] Manisha S. Kavadi, Esq., represented HCPS. By agreement of the parties, I held the record open for seven days to allow each party to submit a brief list of citations

[1] On June 3, 2014, Kimm Massey, Esq., entered her appearance on behalf of the Student.
[2] Co-counsel Vaughn Mungin, Esq., was present on June 26, 2014 only.

and propositions relied upon in their closing arguments. I received HCPS's submission on July 8, 2014 and the Parent's submission on July 15, 2014.[3] I closed the record on July 8, 2014.

The legal authority for the hearing is as follows: IDEA, 20 U.S.C.A. § 1415(f) (2010); 34 C.F.R. § 300.511(a) (2013); Md. Code Ann., Educ. § 8-413(e)(1) (2014); and COMAR 13A.05.01.15C.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act; Maryland State Department of Education (MSDE) procedural regulations; and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2009 & Supp. 2013); COMAR 13A.05.01.15C; COMAR 28.02.01.

ISSUES

1. Did the Individualized Education Program (IEP) developed by HCPS provide the Student with a free appropriate public education (FAPE) for the relevant portion of the 2013-2014 school year?[4]

2. If not, is the Student entitled to a non-public placement at HCPS's expense or other remedies afforded by law?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits (originally labeled "Petitioner's") on behalf of the Student:[5]

Student Ex. 1 The Student's IEP, November 22, 2013

Student Ex. 2 Progress Reports on IEP Goals and Objectives, June 3, 2014

[3] I afforded the Parent an additional seven days (until July 15, 2014) to respond to HCPS's submission. I considered both parties' submissions, but I am issuing the decision thirty days following July 8, 2014.
[4] The IEP covers the period November 22, 2013 through November 22, 2014.
[5] Any exhibit numbers not reflected on this list were not offered.

Student Ex. 3	[Hospital] ([HOSPITAL]) Center for Autism and Related Disorders (CARD) Speech and Language Pathology Initial Evaluation, August 29, 2012
Student Ex. 4	[HOSPITAL] CARD Speech and Language Pathology Evaluation, August 15, 2013
Student Ex. 5	[HOSPITAL] CARD Speech and Language Pathology Re-evaluation Note, June 10, 2014 [over HCPS objection]
Student Ex. 9	Harford County Infants and Toddlers Program (ITP) Speech/Language Evaluation Report, May 1, 2012
Student Ex. 10	Harford County ITP Speech-Language Assessment Report, September 3, 2013
Student Ex. 11	Initial Consult, DBP[6] Autism Assessment/Plan, XXXX Health System, February 1, 2013
Student Ex. 12	Letter "To Whom It May Concern" from XXXX XXXX, D.O., [Hospital 2], October 8, 2013
Student Ex. 13	[HOSPITAL] CARD Initial Evaluation, August 30, 2012
Student Ex. 14	[HOSPITAL] CARD Follow Up Evaluation, January 24, 2013
Student Ex. 15	[HOSPITAL] CARD Follow-up Evaluation Note, December 12, 2013
Student Ex. 16	[HOSPITAL] CARD Follow Up Evaluation, June 27, 2013
Student Ex. 17	Letter "To Whom It May Concern" from XXXX XXXX, M.D., [HOSPITAL] CARD, January 10, 2014
Student Ex. 18	[HOSPITAL] CARD, Research and Education for Autism in Children (REACH), Eligibility Testing Report, February 14, 2013
Student Ex. 19	Letter "To Whom It May Concern" from XXXX XXXX, P.A.-C, February 3, 2014
Student Ex. 20	[HOSPITAL] Feeding Disorders Clinic Initial Evaluation Note, February 4, 2014 [over HCPS objection]
Student Ex. 21	[HOSPITAL] Behavioral Psychology Evaluation, February 27, 2014
Student Ex. 22	[HOSPITAL] Behavior Psychology Outpatient Note, May 14, 2014 [over HCPS objection]

[6] The document does not show what this acronym stands for.

Student Ex. 23 [Center], [City] Observation Notes, June 10, 2014

Student Ex. 24 Report of Follow-up Visit, XXXX XXXX, M.D., June 16, 2014 [over HCPS objection]

Student Ex. 25 Student's Daily Schedule, Monday through Thursday

Student Ex. 26 Harford County ITP, Family Visit Notes & Suggestions, May 28, 2013 through June 20, 2013

Student Ex. 27 IFSP [Individual Family Service Plan] Meeting Summary, May 10, 2013

Student Ex. 28 Curriculum Vitae, XXXX XXXX, M.D.

Student Ex. 29 Curriculum Vitae, XXXX XXXX, Ph.D., BCBA-D

Student Ex. 31 Curriculum Vitae, XXXX XXXX, Speech-Language Pathologist

I admitted the following exhibits (originally labeled "H") on behalf of HCPS:[7]

HCPS Ex. 1 Prior Written Notice (PWN) re: Identification/Eligibility Meeting, October 1, 2013

HCPS Ex. 2 Notice of No Assessment Needed (Initial Evaluation), October 1, 2013

HCPS Ex. 3 Department of Special Education, Parent Input for Present Level of Academic and Functional Performance, October 4, 2013

HCPS Ex. 4 Documentation of review of [HOSPITAL] Reports on September 26, 2013; Parent's "opt out" of accessible copies, October 1, 2013

HCPS Ex. 5 PWN re: Initial IEP Team Meeting, November 7, 2013

HCPS Ex. 6 PWN re: Subsequent IEP Team Meeting, November 22, 2013

HCPS Ex. 7 PWN re: IEP Team Meeting on January 10, 2014, January 14, 2014

HCPS Ex. 8 PWN re: IEP Team Meeting, March 28, 2014

HCPS Ex. 9 The Student's IEP, November 22, 2013

HCPS Ex. 10 IFSP Meeting Summary, August 6, 2013

HCPS Ex. 11 IFSP Meeting Summary, May 10, 2013

[7] Any exhibit numbers not reflected on this list were not offered.

HCPS Ex. 12	Progress Report, XXXX Early Learners Classroom, October 25, 2013
HCPS Ex. 13	Progress Reports on IEP Goals and Objectives, June 17, 2014
HCPS Ex.14	Areas of Progress, May 2012—May 2014
HCPS Ex. 15	Student's Monthly Mands,[8] September 2013—May 2014
HCPS Ex. 16	Monthly Mand Items, 2013-14 School Year
HCPS Ex. 17	Biting Occurrences, August 2013—June 2014
HCPS Ex. 18	Graph, Percentage of Days Present Headbanging Occurred, January—June, 2014
HCPS Ex. 19	Raw Data collected by HCPS re: Student's behavior, progress on Goals and Objectives, 2013-2014 School Year
HCPS Ex. 20	Early Learner's Class Schedule, 2013-2014
HCPS Ex. 22	Harford County ITP, Developmental Evaluation Report, May 1, 2012
HCPS Ex. 23	Harford County ITP, Developmental Evaluation Report, July 17, 2013
HCPS Ex. 26	Harford County ITP, Occupational Therapy Evaluation, September 26, 2012
HCPS Ex. 27	Harford County ITP, Occupational Therapy Evaluation, July 18, 2013
HCPS Ex. 28	Report of February 12, 2014 Student Observation, March 6, 2014
HCPS Ex. 33	Notes and e-mails from XXXX XXXX, Special Educator, to the Parent(s), December 2013 and January—June 2014 re: items needed by the Student
HCPS Ex. 34	Staff notes re: the Student's needs at school (blanket, snacks, etc.), May and June 2014
HCPS Ex. 36	Curriculum Vitae, XXXX XXXX, HCPS Coordinator of Special Education
HCPS Ex. 38	Curriculum Vitae, XXXX XXXX, HCPS Coordinator, ITP
HCPS Ex. 39	Curriculum Vitae, XXXX XXXX, HCPS Behavior Specialist
HCPS Ex. 42	Curriculum Vitae, XXXX XXXX, Speech Language Pathologist, [School 1]

[8] A "mand" is a request by the Student, using pictures, for some action or item. Transcript (Tr.) 495 (XXXX).

HCPS Ex. 43 Curriculum Vitae, XXXX XXXX, Occupational Therapist, HCPS

Testimony

The Parent testified and presented the following witnesses:

- Dr. XXXX XXXX, accepted as an expert in psychology and behavioral programming for children with autism;
- XXXX XXXX, accepted as an expert in speech/language pathology, autism spectrum disorder, and early intervention;
- XXXX XXXX,[9] the Student's father;
- XXXX XXXX, a close family friend; and
- Dr. XXXX XXXX, accepted as an expert in developmental pediatrics.

HCPS presented the following witnesses:

- XXXX XXXX, Special Education Coordinator, accepted as an expert in speech/language pathology and special education programming for children with autism;
- XXXX XXXX, accepted as an expert in speech/language pathology;
- XXXX XXXX, accepted as an expert in special education, with an emphasis on behavioral analysis and methodology;
- XXXX XXXX, accepted as an expert in occupational therapy; and
- XXXX XXXX, accepted as an expert in special education, with an emphasis on infants and toddlers.

FINDINGS OF FACT

Based upon the evidence presented, I find the following facts by a preponderance of the evidence:

1. The Student was born on XXXX, 2010. His birth was uncomplicated and he is physically healthy.

[9] In this Decision, the word "Parent" refers to Ms. XXXX, who filed the Due Process Complaint. The word "parents" refers to both father and mother.

2. The Student has two sisters, ages XX and XX.

3. Until approximately four weeks prior to the due process hearing, the Student lived with both parents and his siblings. Tr. 292-93 (X. XXXX).

4. The Student, his mother, and his siblings now reside separately from the Student's father.

5. When the Student was approximately 14 months old, the Parent became concerned that he was not developing normally. She had concerns about his speech and attention; his unwillingness to play or be cuddled; and that he seemed to be "in his own world." Tr. 232 (X. XXXX).

6. On or about March 29, 2012, the Parent consulted the ITP regarding her concerns. Student Ex. 9.

7. On May 1, 2012, when the Student was 17 months old, the ITP conducted a Developmental Evaluation and a Speech/Language Evaluation of the Student. HCPS Ex. 22, Student Ex. 9.

8. XXXX XXXX, a Special Educator, conducted the Developmental Evaluation. Ms. XXXX used the Brigance Inventory of Early Development II (Brigance) and the Early Learning Accomplishment Profile (ELAP), as well as her own observations and input from both parents.[10] HCPS Ex. 22.

9. The Brigance assessment tool indicated that the Student was more than 25% delayed in the areas of fine motor skills and social development. His gross motor skills and activities of daily living were within normal limits. HCPS Ex. 22.

10. The ELAP indicated a greater than 25% delay in cognition. HCPS Ex. 22.

[10] The Brigance captures developmental age ranges in fine motor, gross moor, living and social-emotional skills. The ELP measures the cognitive skill sets of young children. Tr. 799 (XXXX).

11. Based on the assessments, the Student was found eligible for early intervention services from the ITP. The evaluator recommended that the Parent discuss her concerns about possible autism with the Student's pediatrician. HCPS Ex. 22.

12. XXXX XXXX, a speech/language pathologist (SLP), conducted the Initial Speech/Language Evaluation. Ms. XXXX used the Rossetti Infant-Toddler Language Scale (RITLS), as well as her own observations and input from both parents. Student Ex. 9.

13. Ms. XXXX found that the Student was more than 25% delayed in the areas of expressive and receptive language skills, pragmatics (social language such as greetings, farewells, and requests), and play and gesture skills. She determined that he was eligible for early intervention services in those areas from the ITP. Student Ex. 9.

14. The Student began receiving in-home services from the ITP in May 2012 under an IFSP. These services consisted of 30 minutes of speech therapy and 60 minutes of special instruction weekly.

15. On August 29, 2012, when the Student was 21 months old, XXXX XXXX, SLP, conducted an Initial Speech and Language Pathology Evaluation at [HOSPITAL], CARD.[11] Student Ex. 3.

16. Ms. XXXX used two assessment tools, the Autism Diagnostic Observation Schedule (ADOS),[12] and the Mullen Scales of Early Learning (Mullen Scales),[13] as well as her own direct observations and input from the Parent. Student Ex. 3.

[11] Ms. XXXX's report indicates that there was also an occupational therapy (OT) evaluation, but the record does not contain a separate report of that evaluation.
[12] The ADOS is a semi-structured, play-based assessment that looks for symptoms or contraindications of autism. Tr. 160 (XXXX); 367 (XXXX).
[13] The Mullen Scales constitute a developmental assessment that yields an overall cognitive score. Tr. 161, 190 (XXXX).

17. Results of the ADOS showed that the Student had impairments in social communication, reciprocal social interaction, and play skills, as well as restricted and repetitive behaviors. Ms. XXXX concluded that he met the ADOS criteria for autism. Student Ex. 3.

18. Using the Mullen Scales (Visual Reception, Fine Motor, Receptive Language, and Expressive Language), Ms. XXXX computed an overall cognitive score, the Early Learning Composite. The Student's composite score was 49, in the very low range for a child his age (average range 85-115). Student Ex. 3. The age equivalents on the four scales ranged from four months to 15 months. *Id.*

19. Ms. XXXX recommended weekly speech and language therapy and weekly special education instruction. She made extensive suggestions for the Parent to use at home to help the Student with language, social engagement, and play. Student Ex. 3.

20. On August 30, 2012, Dr. XXXX XXXX, a developmental pediatrician at [HOSPITAL], CARD, conducted an initial evaluation of the Student. Dr. XXXX had the benefit of Ms. XXXX's evaluation and the OT evaluation. Student Ex. 13.

21. Dr. XXXX's impression was a "clinical presentation of global developmental delay." She deferred a diagnosis of autism spectrum disorder (ASD) until the Student was older, and recommended a reevaluation using the ADOS in one year. Her diagnoses were XXXX; unspecified delay in development; and mixed receptive-expressive language disorder. Student Ex. 13.

22. On September 26, 2012, when the Student was 22 months old, XXXX XXXX, an occupational therapist with the ITP, conducted an OT evaluation to address parental concerns regarding fine motor skills and feeding skills. HCPS Ex. 26. Ms. XXXX used

an assessment tool, the Peabody Developmental Motor Scales 2,[14] as well as input from the Parent and her own direct observations. *Id.*

23. Although the Student was able to perform some motor tasks independently, he was difficult to engage and required hand-over-hand assistance to complete most tasks. He did not demonstrate a refined pincer grasp. Ms. XXXX recommended individual OT treatment and family education, once weekly for 45 minutes. HCPS Ex. 26.

24. The Student continued to receive speech/language therapy, OT, and special instruction through the ITP.

25. On January 24, 2013, when the Student was 26 months old, Dr. XXXX conducted a follow-up evaluation at [HOSPITAL], CARD. Student Ex. 14. She relied on the history provided by the Student's parents and her own observations. He continued to display lack of social engagement, restricted play, and delayed expressive and receptive language. He became easily upset when preferred items were taken from him, but did respond to redirection. *Id.*

26. Dr. XXXX suggested a dual diagnosis of developmental delay and ASD, subject to verification by an updated ADOS evaluation. Student Ex. 14.

27. On February 1, 2013, XXXX XXXX, D.O., of the Department of Pediatrics at XXXX Hospital, evaluated the Student at the request of his pediatrician. Student Ex. 11. Dr. XXXX took an extensive history from the Parent and observed the Student's behavior in her office.

28. Dr. XXXX found the Student's problem-solving age equivalent to be 11.3 months, and his language skills age equivalent to be 7.5 months. Using the Childhood

[14] This tool measures a child's ability to use his hands (eye-hand coordination and grasping with fine motor skills). Tr. 774-75 (XXXX).

Autism Rating Scale (CARS), the Student's total score was 35.5, which Dr. XXXX characterized as "mild to moderately autistic, close to the borderline of severely autistic." Student Ex. 11.

29. Based on his deficits in social communication and interaction, and his restricted/ repetitive behaviors (jumping, frequent mouthing of objects), the Student met the diagnostic criteria for autism. Dr. XXXX's diagnosis was ASD and developmental delay. Student Ex. 11.

30. On February 14, 2013, XXXX XXXX, Ph.D., of [HOSPITAL], CARD, evaluated the Student for eligibility to participate in a research study examining the effects of a blended treatment approach on the development of young children diagnosed with ASD. Student Ex. 18.

31. Ms. XXXX administered the ADOS and three of the Mullen Scales (Visual Reception, Receptive Language, and Expressive Language). She concluded that the Student met the research criteria for an ASD, but that his cognitive and language skills were below the level required for study eligibility. Student Ex. 18. She was aware that he was receiving services from the ITP. *Id.*

32. On February 14, 2013, the Student demonstrated limited social, communication and language skills (e.g., poor eye contact, difficult to engage in interactions, no response to name, vocalizations lacked communicative intent). Ms. XXXX recommended that he receive "autism-specific classroom based services" at [HOSPITAL] or autism-specific services from the ITP. Student Ex. 18.

33. In March 2013, the ITP introduced the Picture Exchange Communication System (PECS) to teach the Student functional communication skills. Student Ex. 10. Visits were scheduled three times weekly to train the family in using this system. *Id.*

34. On May 10, 2013, when the Student was 29 months old, the ITP held an annual meeting to review the IFSP. The Parent participated by telephone. Student Ex. 27, HCPS Ex. 11. The Student continued to exhibit a greater than 25% delay in the following skill areas: cognitive, communication, fine motor, and social-emotional. The family's continuing concerns were that he was not making eye contact, did not respond to his name, did not pay attention to language, and did not request things he wanted.

35. The team modified the IFSP by adding a new "priority outcome," using sensory input to help him better attend to play, fine motor, and visual motor activities. HCPS Ex. 11 at H-11n. The IFSP provided for three one-hour sessions of special instruction weekly; four 30-minute sessions of speech/language therapy monthly; and one 45-minute session of occupational therapy weekly. *Id.*, H-11o-q.

36. The ITP Service Provider (XXXX XXXX, a Special Educator) documented the Student's progress at each visit in May and June 2013 and provided suggestions for the parents to use in his daily routines, including practicing communication with the PECS system, using preferred reinforcer items, and practicing imitation. Student Ex. 26.

37. On June 27, 2013, when the Student was 31 months old, Dr. XXXX saw him for a follow-up visit. Student Ex. 16. The Student continued to exhibit limited social engagement, limited use of eye contact, limited use of facial expressions, no response to joint attention, and lack of initiation of joint attention. Based on the history and her observations, Dr. XXXX's diagnosis was developmental delay and comorbid ASD. She

advised the Parent that the Student would make slow gains developmentally and that his overall progress would be more limited as compared to children his age. *Id.* at 3.

38. On July 17, 2013, when the Student was almost 32 months old, Ms. XXXX conducted a developmental evaluation in preparation for his transition out of the ITP at age three. HCPS Ex. 23. The Student continued to demonstrate a greater than 25% delay in the areas of fine motor skills (age range 13 months), daily living (age range 20 months), social and emotional (age range eight months) and cognition (age range 10 months). *Id.*

39. By July 2013, the Student had become familiar with the ITP home visit routine, although he still required highly reinforcing objects, frequent breaks and redirection to remain on task. He required physical prompting to complete most tasks. HCPS Ex. 23.

40. By July 2013, the Student was familiar with the PECS system, and had attained phase III-A of that system, enabling him to use the picture cards to request preferred items. HCPS Ex. 23. He had difficulty transitioning from a preferred to a non-preferred activity. *Id.*

41. On July 18, 2013, XXXX XXXX, an Occupational Therapist with the ITP, conducted an OT evaluation of the Student. HCPS Ex. 27. Ms. XXXX used the Peabody Developmental Motor Scales 2, as well as input from the Parent and her own direct observations. The Student was happy, active, interacted well with the evaluator, and enjoyed exploring the toys and activities presented. *Id.*

42. The Student continued to demonstrate delays in fine motor skills (especially grasping), and a need for hand-over-hand assistance with most fine motor tasks. Ms. XXXX described him as a "sensory seeker" who benefitted from sensory motor activities

(e.g., bouncing on a ball, chewing on a "chewy tube"). He needed frequent movement breaks between seated activities. HCPS Ex. 27 at H-27a.

43. On August 6, 2013, before the start of the 2013-2014 school year, the ITP held a team meeting to review and revise the IFSP. HCPS Ex. 10. The team modified the IFSP to reflect that ITP services would be provided in a preschool special education classroom, the XXXX Center/Class for students with disabilities. The IFSP called for the Student to receive individual special instruction four times weekly, for 150 minutes (2.5 hours) per session, incorporating individual speech/language therapy twice weekly, for 30 minutes per session, and individual occupational therapy twice weekly, for 15 minutes per session; and bus transportation to and from school. *Id.* at H-10f-h.

44. The Student's "home school" (i.e., the one nearest to his residence) is [School 2]. HCPS has XXXX Center classrooms in four schools. The closest one of these to the Student's home is at [School 1] ([School 1]). Tr. 465 (XXXX).

45. On August 15, 2013, when the Student was almost 33 months old, XXXX XXXX, SLP, conducted a follow-up speech and language evaluation at [HOSPITAL], CARD. Student Ex. 4. Ms. XXXX again employed the ADOS and the Mullen Scales to assess the Student's behavior and developmental status.

46. On the ADOS, the Student demonstrated some strengths not seen previously, such as requesting behaviors, and heightened interest in activities he liked. He nevertheless continued to meet the criteria for autism. Student Ex. 4 at 3. The results on the Mullen Scales for Visual Reception, Receptive Language, and Expressive Language showed no change from the August 2012 assessment, and indicated severe impairment. *Id.* at 4; Tr.

164-65 (XXXX). Ms. XXXX recommended that the intensity of the Student's programming be increased.

47. The Student began attending [School 1] at the end of August, 2013. This was his first school experience. He transitioned well from home-based to school-based service. Tr. 477, 490 (XXXX).

48. On September 3, 2013, XXXX XXXX, SLP, performed a Speech/Language Assessment in connection with the Student's upcoming transition out of the ITP at age three. Student Ex. 10. Ms. XXXX relied extensively on the Parent's report of the Student's behaviors, but also observed him in the home. He was very self-directed and object-focused, and showed no interest in interacting with toys or the examiner; his eye contact was very limited. *Id.*

49. Using the RITLS and primarily Parent input, Ms. XXXX scored the Student's language skills at levels between three and nine months. She noted that the PECS system had been introduced in March 2013 and that the therapists had been in the home three times weekly to practice it with the Student and to teach the family. Student Ex. 10. Ms. XXXX found the Student to still be eligible for services based on a greater than 25% delay in expressive language, play skills, gesture skills, receptive language and pragmatics. *Id.*

50. On October 1, 2013, the Student's IEP Team (Team) at [School 1] held a meeting to determine his eligibility for special education and related services upon attaining the age of three. The Team considered all of the ITP assessments and evaluations, as well as evaluations form [HOSPITAL] and other outside sources. The Team determined that the

Student was eligible for preschool special education and related services through an IEP, as a student with autism. HCPS Ex. 1 and Ex. 2; *see also* HCPS Ex. 4.

51. The Team also considered written input from the Parent, in which she listed the following goals and her expectations of "significant progress":

- Language acquisition
- Point at things he wants
- Wave "bye"
- Increase eye contact and joint attention
- Use crayons
- Identify body parts
- Feed himself
- Use utensils
- Help dress himself
- Complete a three-piece puzzle
- Imitate others
- Clap
- Answer to his name
- Use PECS and/or sign language

The Parent reported that the Student was non-verbal, had no method of communication, did not point, and did not respond to his name. HCPS Ex. 3.

52. On October 8, 2013, Dr. XXXX XXXX saw the Student for a follow-up visit. Student Ex. 12. Dr. XXXX adhered to her earlier diagnosis of autism. On the CARS rating scale, his score was 41, falling in the range of "severely autistic." *Id.* Dr. XXXX assessed the Student's language skills age equivalent at 7.8 months. Dr. XXXX made several recommendations as to what an IEP should contain, emphasizing 25 to 40 hours of individual therapy in a structured developmental preschool program for children with an ASD. *Id.*

53. On October 25, 2013, XXXX XXXX, the Special Educator in the [School 1] XXXX Program, prepared a Progress Report describing the Student's progress on eight

"targets" since data collection began on September 16, 2013.[15] HCPS Ex. 12. As of October 25, 2013, the Student still required verbal and physical prompting for several tasks, and had only responded to his name once. He had made progress in using the PECS system and was able to sit throughout the duration of "Circle Time" [16] with the aid of sensory items to use as "fidget toys." *Id.* at H-12-12a.

54. Also on October 25, 2013, HCPS occupational therapist, XXXX XXXX, prepared an OT Progress Report. HCPS Ex. 12. At that time, the Student was using a "chewy tube" as a calming device, instead of biting and mouthing inedible items; was using other sensory calming toys during classroom activities; was consistently engaging in Circle Time for up to 30 minutes; and was using the PECS system to independently choose between a food item and a drink item. The Student was also making progress in using his hands to eat and drink (e.g., holding a spoon, scooping applesauce, drinking from a cup). *Id.* at H-12c; *see also* Tr. 767-772 (XXXX).

55. The Student continued to require hand-over-hand assistance to perform some activities, but not always in the same degree (e.g., minimal, moderate). He still required full hand-over-hand assistance to manipulate toys and to hold a crayon and make marks on a paper. HCPS Ex. 12 at H-12c.

56. On October 31, 2013, an "IEP Progress Report" was prepared relating to the Speech/Language Goal Area.[17] This report described the Student's progress in requesting preferred items from a field of three pictures; independently matching items in a field of

[15] The school year began on August 28, 2013. HCPS Ex. 12.
[16] This is a group activity where students sit in the front of the classroom and attend to instruction by the teacher, using a "white board," music, etc. Tr. 482 (XXXX).
[17] The preparer is not identified, but XXXX XXXX has been the Student's SLP since August 2013, and she participated in drafting this document. Tr. 619-20 (XXXX). The preparer used the "IEP Progress Report" format before the adoption of the IEP.

one; matching pictures in a field of two; following one-step directions; and following the "give me" command. The report noted that he needed visual and verbal cues, prompting or hand-over-hand assistance, depending on the task. HCPS Ex. 12 at H-12b.

57. On November 7, 2013, the Team met to develop an initial IEP for the Student and to consider his eligibility for Extended School Year (ESY) services. HCPS Ex. 5.

58. The Team approved an IEP providing that the Student receive special education and related services in a regional XXXX classroom, four half-days (10 hours) per week. The Team considered the parents' request for 40 hours of special education services but did not accede to it, based on the progress the Student was making and Team concerns that the Student might not be ready to participate in a full-day program. HCPS Ex. 5 at H-5. The Team agreed to schedule a meeting to permit review of the October 8, 2013 assessment by Dr. XXXX. *Id.* The parents withheld consent for the initiation of services through an IEP. HCPS Ex. 5 at H-5a.

59. The Team held a follow-up meeting on XXXX, 2013. HCPS Ex. 6. The Team reviewed Dr. XXXX's report of October 8, 2013, supporting the educational disability of ASD. In response to parental concerns, the Team amended the IEP to provide for 26 hours (four full days) of specialized instruction weekly. *Id.* at H-6. With this change, the Team approved the IEP. The parents continued to express disagreement. *Id.*

60. Both parents, as well as an attorney affiliated with [HOSPITAL], attended the November 7 and 22, 2013 meetings. HCPS Ex. 5 at H-5b; HCPS Ex. 6 at H-6b.

61. The Parent signed the Consent for Initiation of Services under the initial IEP on November 22, 2013. HCPS Ex. 9 at H-9ff.

62. The IEP [18] contains detailed summaries of the assessments and evaluations considered by the Team in the areas of speech and language; early literacy; social emotional/ behavioral; fine motor; independent living—feeding; independent community living—toileting, and self-help. HCPS Ex. 9 at H-9f-k.

63. The IEP provides for a number of supplementary aids, services, program modifications and supports directed to the Student's individual needs, including but not limited to: use of an augmentative communication system (gestures, pictures, or signs); systematic data collection to monitor progress; redirection to complete tasks, including a "most to least" prompt methodology to ensure positive task completion; use of highly motivating and reinforcing materials; reduction of distractions in his work area; adult facilitation of interactions with peers; frequent changes in activities and/or opportunities for movement; and the availability of sensory materials (e.g., balls, fabrics, fuzzy toys, "chewy tube") for calming and self-regulation. HCPS Ex. 9 at H-9o-q.

64. The Team found the Student eligible for ESY services during the summer of 2014,[19] because of the nature and severity of his disability of autism. HCPS Ex. 9 at H-9r.

65. The IEP contains Goals in the areas of receptive language; expressive language; early literacy; early math literacy; social emotional/behavioral, including play; fine motor skills; independent living—feeding; and independent community living—toileting. HCPS Ex. 9 at H-9u-x.

66. Each Goal is broken down into two or more Objectives. The Objectives are expressed in specific, concrete terms with respect to the exact task, the number of trials,

[18] The IEP is in evidence as HCPS Ex. 9 (with page numbers) and Student Ex. 1.
[19] The ESY session was scheduled to begin on June 23, 2014 and end on August 11, 2014. HCPS Ex. 9 at H-9cc.

the degree of accuracy expected, the number of consecutive sessions necessary to indicate attainment of the Objective, and the amount and nature of assistance to be provided for the task (e.g., verbal and/or visual cues, adult facilitation, physical prompts, motivating pictures and objects, preferred toys). HCPS Ex. 9 at H-9u-x. The parents are notified of the Student's progress quarterly. *Id.* at H-9y.

67. All of the Student's special instruction and related services during the school year and ESY are provided outside the general education classroom, that is, in a self-contained special education classroom at [School 1]. HCPS Ex. 9 at H-9z-cc. This placement is the least restrictive environment (LRE) for the Student. *Id.* at H-9dd.

68. The Student began receiving services pursuant to the IEP on December 2, 2013. Tr. 684 (XXXX). He is in school for 26 hours per week, Monday through Thursday. Tr. 525 (XXXX). He continues to be provided bus transportation from home to [School 1].

69. On December 12, 2013, Dr. XXXX saw the Student in a follow-up visit at [HOSPITAL], CARD. Student Ex. 15. The parents expressed concerns about temper tantrums occurring at least twice a day, and difficulties falling and staying asleep. *Id.* The parents provided Dr. XXXX with a copy of the IEP, which indicated that they were seeking more intensive services. Tr. at 383-84, 386 (XXXX).

70. In her Evaluation Note, Dr. XXXX expressed the view that many of the Goals and Objectives on the IEP were inappropriate ("too far out of reach of where [his] skills are developmentally") and lacked focus on key skills. She opined that the Student needed "maximum intensity ABA [Applied Behavioral Analysis] programming, more specifically Discrete Trial Training in conjunction with evaluation and management of

maladaptive behaviors." She recommended that the parents consider a referral to the Neurobehavioral Unit (NBU) at [HOSPITAL]. Student Ex. 15.

71. On January 10, 2014, Dr. XXXX wrote a letter "To Whom It May Concern" on behalf of the Student's family, advocating for him to receive "special education programming geared toward children with autism," including additional 1:1 therapy, in a "structured special education preschool setting." Student Ex. 17.

72. On January 10, 2014, the Team held a meeting at the Parent's request. The Team considered Dr. XXXX's letter, but was not provided with any [HOSPITAL] report concerning the self-injurious behaviors referred to in her letter. HCPS Ex. 7. The Team declined to make any changes to the IEP because, it its view, the IEP already provided the structured classroom setting, daily routines, and clear expectations recommended by Dr. XXXX. In addition, the classroom teacher had not observed self-injurious behavior in the school setting. *Id.* at H-7.

73. The Team did consider data indicating that the Student's progress on individual targets was better during the morning session, and that he displayed some maladaptive behaviors in the afternoon even after a nap. The Team also provided a schedule for the Student when school opened two hours late due to inclement weather.[20] HCPS Ex. 7 at H-7a.

74. On February 3, 2014, XXXX XXXX, PA-C, of XXXX Pediatrics and Teen Medical Center (XXXX Pediatrics) wrote a letter "To Whom It May Concern" noting the Student's diagnosis of "severe autism" and recommending that the Student be placed in a "specialized school based setting around other children with similar learning disabilities."

[20] The winter of 2013-14 was particularly harsh, causing frequent school closings and delayed openings. Tr. 526 (XXXX).

Student Ex. 19.[21] She also recommended behavioral therapy to help control his temper outbursts, which she asserted she had recently witnessed in her office setting. *Id.*

75. On February 4, 2014, the Student, accompanied by his father, was seen by a speech language pathologist at the [HOSPITAL] Feeding Disorders Clinic. Student Ex. 20. The parental concerns were the Student's "food refusal, selectivity, and self-injurious behaviors, some of which stem from feeling hungry." The evaluator observed the Student eat some preferred foods (plantain, cracker, yogurt) and one non-preferred food (rice) with his father's assistance. The Student sat at the table and at one point, evinced a desire to feed himself by reaching for a cracker. The evaluator recommended that the Student participate in outpatient behavioral therapy for feeding. *Id.*

76. The parents did not provide the Feeding Disorders Clinic evaluation note to HCPS until the Due Process hearing disclosure.

77. On February 12, 2014, XXXX XXXX, HCPS Behavior Specialist, and XXXX XXXX, HCPS School Psychologist, XXXX Programs, conducted a classroom observation of the Student at the request of the Team. HCPS Ex. 28. The observation lasted from 9:40 a.m. until 1:30 p.m., and the evaluators documented their observations, using an "Antecedent-Behavior-Consequence" format. *Id.*

78. On February 12, 2014, the Student displayed three instances of bad behavior (hitting teacher, attempting to hit and bite, and vocalizing while lying on the floor) during the Student's IST (Individual Structured Teaching) time. These behaviors resolved upon providing the Student with the PECS system; providing him with the chew tube; and wiping his nose, respectively. HCPS Ex. 28 at H-28a.

[21] The Parent did not offer any evidence that this letter was provided contemporaneously to HCPS, but it was admitted without objection.

79. The Student did not display any behaviors during NET (Natural Environment Teaching) time or snack time. HCPS Ex. 28 at H-28a.

80. During the Art activity, the Student displayed several behaviors, including attempts to hit and bite the teacher, essentially resisting participation in the activity. The staff attempted to deal with these behaviors by ignoring them and redirecting the Student. HCPS Ex. 28 at H-28a.

81. At approximately 10:20 a.m., the Student fell to the floor and had a tantrum for approximately 50 minutes. The tantrum included attempts to bite, verbally protesting and crying. The staff first moved him to a corner and placed him on a bean bag for safety, but he hit his head on the floor three times. The staff then moved him to a carpeted area where there was a soft mat. The staff used several non-verbal de-escalation strategies in an attempt to calm him. When he remained calm for two minutes, he was offered a yogurt snack. He accepted the snack, ate it at the table, and was compliant for the remainder of the morning session. HCPS Ex. 28 at H-28b; Tr. 712-13 (XXXX).

82. The Student's father was present during part of the tantrum. He told the staff that the Student had awakened early and eaten breakfast early that day. HCPS Ex. 28 at H-28d. The observers made several suggestions, including providing additional substantial snack items throughout the day and a consultation with the occupational therapist regarding the Student's sensory needs and modifications to his "sensory diet." *Id.*

83. On February 27, 2014, when the Student was 39 months old, he and his parents were seen at [HOSPITAL] for a Behavioral Psychology Diagnostic Interview, from 2:00 to 4:00 p.m. Student Ex. 21. The parents reported that the Student was displaying "intense aggression" towards his parents and siblings, resulting in injury to family

members, as well as intense head-banging, resulting in self-injury. The parents rated the Student's problem behaviors as "severe," and indicated that the behaviors occurred all day. *Id.*

84. While the Student was in the [HOSPITAL] treatment room, he displayed tantrum behavior for approximately one hour and fifteen minutes, punctuated by five-to-ten-minute periods of calm. He displayed aggression towards his parents (biting, kicking, hitting) and self- injurious behavior (head-banging, heel-kicking). The therapist provided a cushion for safety; the Student eventually calmed down and fell asleep. This episode prevented the therapist from completing the intake evaluation. The therapist provided a referral to the NBU at [HOSPITAL]. Student Ex. 21 at 3.

85. On March 28, 2014, the Team held a meeting to review the behavioral observations and the parents' request for a change in placement. HCPS Ex. 8. The Team considered a January 19, 2014 evaluation at [HOSPITAL], CARD;[22] the February 12, 2014 observation conducted by Ms. XXXX and Ms. XXXX; and the February 27, 2014 Behavioral Psychology report from [HOSPITAL]. The Team also received input from the Student's HCPS teachers and therapists regarding the Student's progress on his IEP Goals and Objectives. *Id.* at H-8.

86. The Team documented the parents' concerns about the Student's progress and their desire for a full day, five days per week placement at [Center] for XXXX in XXXX, Maryland ([Center]). Based on classroom data indicating that the Student's self-injurious behaviors had decreased, and that he had acclimated to his placement, the Team declined to change the placement. HCPS Ex. 8

at H-8.

[22] This particular evaluation is not in the record.

87. On May 7, 2014, the Parent filed the Due Process Complaint.

88. On May 14, 2014, when the Student was 41 months old, he was seen by a psychologist at [HOSPITAL] to screen him for admission to the NBU. Student Ex. 22. His father was present; the appointment lasted 55 minutes. The Student's father reported the Student's aggressive, self-injurious and disruptive behavior, especially in the context of tantrums, as well as food refusal behaviors. He also reported that the tantrums were more frequent at night. The father expressed concern that the Student lacked basic skills, such as "pointing to something he wants." *Id.*

89. The [HOSPITAL] clinician diagnosed Disruptive Behavior Disorder Not Otherwise Specified (NOS), and recommended services through the NBU Outpatient Clinic. Student Ex. 22.

90. The parents did not provide the Behavior Psychology Outpatient Note to HCPS until the Due Process hearing disclosure.

91. The last day of school at [School 1] before the summer break was June 10, 2014. Tr. 55, 123 (XXXX).

92. On June 10, 2014, from 9:00 a.m. to 9:50 a.m., Dr. XXXX XXXX, the Program Director of [Center], observed the Student in his classroom at [School 1], accompanied by XXXX XXXX, HCPS Special Education Coordinator. Dr. XXXX had observed the Student once previously, in December 2013, in his home.

Tr. 28-29 (XXXX).

93. On June 10, 2014, Dr. XXXX documented her observations, concerns, and overall impressions. Student's Ex. 23. A major concern was that responses to adult commands or questions by the students, including the Student, were heavily prompted. She opined

that the skills the Student was working on appeared "foundational" and that he had apparently not mastered simple skills such as "put in" or matching. She concluded that the Student would "greatly benefit from more than 20 hours per week of a one to one Applied Behavioral Analysis program" overseen by a certified Behavior Analysis professional. *Id.*

94. Also on June 10, 2014, at 1:00 p.m., XXXX XXXX, SLP,[23] conducted a speech and language re-evaluation of the Student at [HOSPITAL], CARD, at the request of the Student's attorney. Student Ex. 5. Ms. XXXX relied on the Parent's reports and her own observations and assessments, including the Mullen Scales. The evaluation took 45 minutes total; testing of the Student consumed 20 of those minutes. *Id.*

95. The results on the Mullen Scales for Visual Reception, Receptive Language, and Expressive Language were lower than those on the [HOSPITAL] assessment in August 2013, with age equivalents between three and nine months. Student Ex. 5 at 3, Tr. 168-69 (XXXX). The Student engaged in one self-injurious behavior (falling backwards and hitting his head on the floor) while the evaluator was giving feedback to the Parent. Student Ex. 5 at 2.

96. Ms. XXXX expressed the opinion that the tests did not show progress since August 2013, and that some of the Student's skills had declined. Student Ex. 5 at 4. She recommended placement in a "small, highly structured environment that provides redirection and close monitoring throughout all activities" and "extensive 1:1 individualized support and structure;" use of ABA or "other empirically supported instruction methods for children on the autism spectrum," "consistency across

[23] Ms. XXXX supervised this clinical fellow, but was not present during the evaluation. Tr. 141, 143 (XXXX); Student Ex. 5.

environments;" and speech and language therapy with a certified SLP trained to work with children on the autism spectrum "at a frequency and intensity to support receptive and expressive language gains." *Id.*

97. The parents did not provide the June 10, 2014 [HOSPITAL], CARD Re-evaluation Note to HCPS until the Due Process hearing disclosure.

98. On June 16, 2014, when the Student was 42 months old, XXXX XXXX, M.D., his pediatrician at XXXXX Pediatrics, saw the Student for a follow-up visit. Student Ex. 24. The Parent provided Dr. XXXX with a detailed history and the June 10, 2014 [HOSPITAL], CARD Re-evaluation of the Student. *Id.*

99. Dr. XXXX's impression was that the Student had made "very minimal to no progress in his development since the last visit." She recommended an "autism classroom" where "instruction is ABA-based, communication is integrated throughout the day and he can have individual attention to meet his goals." She opined that "school needs to be 12 months per year" and that the Student needed occupational therapy for one to two hours per week for his fine motor and self-help skills. Student Ex. 24.

100. The parents did not provide Dr. XXXX's follow-up visit note to HCPS until the Due Process hearing disclosure.

101. The XXXX Center/Class (Program) is the only full-time self-contained special education program offered by HCPS for students with autism. The Program is offered in four regional locations, depending on where a student resides. [School 1] is one of those locations and is closest to the Student's home. Tr. 465 (XXXX).

102. The Student's program at [School 1] consists of morning and afternoon sessions, Monday through Thursday, for a total of 26 hours. Through June 2014, including the

Student, there were six students in the morning session and four in the afternoon. Most have the disability of autism, and have poor functional communication skills. Others have developmental delay or intellectual disability. They are three to four years old. The Student is currently the only HCPS student who attends the Program morning and afternoon, but there have been other such students in the past. Tr. 466, 467,472, 474-75, 535-36, 538 (XXXX).

103. The content and structure of the Program is the same across locations, but different staff members provide special instruction and related services in each location.

104. At the [School 1] location, the same instructional staff provides services in the morning and afternoon session. With the exception of the Student, who is XXXX, the children in the afternoon session are different from the morning session students.

105. The Program is staffed as follows: a Special Educator (teacher); an adult para-educator (1:1) for each student; and an occupational therapist, a speech-language therapist, and a behavior specialist, who provide services at the times and in the amounts prescribed by each student's IEP.

106. Each session is divided into group activities and individual activities, generally as follows: Arrival/Breakfast or Arrival/Table (group, 30 minutes); Circle Time (group, 30 minutes); IST/NET (individual, 30 minutes); Stations (individual, 25 minutes); IST/NET (individual, 30 minutes); Outside/Activity Room (group, 20 minutes); and Closing/Dismissal (10 minutes). HCPS Ex. 20.

107. The Student's individual schedule has a mid-day portion, consisting of lunch (30 minutes); IST/NET time (30 minutes); and Rest (30 minutes). HCPS Ex. 20 at H-20c.

His schedule also includes 90 minutes of individual speech instruction and 30 minutes of individual occupational therapy weekly. *Id.*

108. XXXX XXXX is the Student's SLP. In addition to providing direct services to the Student at specified times in her own room, she is in and out of the classroom regularly throughout the day. Tr. 645 (XXXX). XXXX XXXX is the Student's OT. She provides services directly to the Student and also instructs the adult paraprofessionals in the methods she is using. Tr. 766, 769, 773 (XXXX). XXXX XXXX is the Behavior Specialist in the [School 1] Program. She uses Verbal Behavioral methodology and Discrete Trial, which are components of ABA training, but she is not certified in the provision of ABA services. Tr. 666-667, 716 (XXXX).

109. The Student has an adult with him at all times throughout the school day. This is true of all the students in the Program.

110. The Special Educator, the SLP, the OT, and the Behavior Specialist collect data daily on the Student's performance and progress, and share information among themselves. This data collection forms the basis of quarterly progress reports, which are provided to the parents and incorporated into the IEP.

111. Most of the students in the [School 1] Program are on the autism spectrum, and are of a similar profile to the Student in that regard. Although some of the other students are capable of shouting out words, they are considered "non-verbal" because they do not use words to communicate their wants or needs. Tr. 562-63 (XXXX).

112. The Student's Team prepared Progress Reports for three marking periods, and shared these with the parents. HCPS Ex. 13. By June 2014, the end of the third making

period, the Student had made noticeable progress on his objectives[24] related to goals for Receptive Language (H-13b); Expressive Language (H-13c); Early Literacy (H-13d-e); Early Math Literacy (H-13e-f); Social Emotional/Behavioral (H-13f-i); Fine Motor (H-13i-j); Independent Living—Feeding (H-13j-k); and Independent Community Living—Toileting (H-13l-m).

113. The Student's rate of progress was not the same for all the objectives, and for many tasks, he continued to need adult assistance, ranging from visual and verbal cues to hand-over-hand prompting. Nonetheless, he began to exhibit independence in some tasks, for example in "manding" for preferred foods or motivating/reinforcing items (e.g., toys) using the PECS system; drinking from a "nosey cup;" holding a spoon and scooping foods; grasping a crayon and scribbling on paper; and following some verbal commands. HCPS Ex. 13; *see also* HCPS Ex. 14.

114. In addition, over time the Student demonstrated improved eye contact, self-awareness (identifying his own picture), awareness of and interest in others, and ability to sit still and attend during Circle Time. He was observed smiling and vocalizing during group songs. He also showed an improved ability to soothe himself by using a "chewy tube" or other sensory item that he found comforting. *See* HCPS Ex. 14. He continued to need more work and more adult assistance on abstract tasks (e.g., matching items, shapes and colors) and on imitating behaviors (e.g., waving, jumping, and twirling his hands around). *Id.*

115. From September 2013 through May 2014, the Student's average number of "mands" per month using the PECS system increased in number and/or the type of item

[24] Ms. XXXX testified that he had mastered 13 of 30 objectives, and was ptogressing on the others. Tr. 507.

requested. HCPS Ex. 15 and Ex. 16. Typically, the number of mands was higher in the morning, but the Student eats lunch between the morning and afternoon session. Later in the year the Student began to mand for more non-food items or actions (e.g., ball, doll, sock monkey, bean bag, hugs, singing). Tr. 627-30 (XXXX).

116. From August 2013 to June 2014, the incidence of observed biting by the Student in the school setting has decreased. HCPS Ex. 17.

117. The percentage of school days upon which the Student engaged in head-banging behavior has fluctuated over time. At its highest (February 2014) it was 63%; at its lowest (March 2014), 6%. HCPS Ex. 18. The most common frequency was 25% (January, April, and June 2014). *Id.*

118. The instructional staff in the Student's classroom employ Verbal Behavioral methodology under the guidance of Ms. XXXX. Tr. 715-16 (XXXX). They keep detailed records of the Student's behaviors, documenting the Antecedent, the Behavior, and the Consequence. HCPS Ex. 19. They also use a task analysis approach to break down the "targets" needed to achieve a particular objective into smaller steps, and keep data on the Student's progress on each step. *Id.*

119. The instructional staff regularly kept the Parent informed if the Student needed anything to be comfortable at school (extra snacks, a change of clothes, etc.) HCPS Ex. 34. There were occasions during the school year when the Student did not have certain needed items from home, and the absence of these items appeared to affect his behavior, including his ability to nap. HCPS Ex. 33. The staff noted an increase in the Student's tantrums at the end of May and during the first week of June 2014. HCPS Ex. 34.

120. Outside the school setting, especially in the home, the Student has not demonstrated the same types and degrees of progress that he has shown in the school setting.

121. The parents use the PECS system with the Student at home, with limited success. His siblings do not use it; close family friend Ms. XXXX uses it "about half the time," but more typically uses objects or words to try to determine what the Student wants. Tr. 282 (X. XXXX); 340-42 (X. XXXX); 359-61 (XXXX).

122. [Center] offers a MSDE-approved five-day self-contained special education program (9:00 to 3:30 daily) for preschool children with ASD. The exact classroom assignment depends on the intensity of services required by a student; Dr. XXXX believes that the Student needs the most intensive level. The special education and related services are provided by special educators, speech/language pathologists, occupational therapists, and behavior specialists certified in ABA. The students receive extensive 1:1 instruction from the different professionals. Currently, [Center] has four special educators to teach 29 students. Tr. 30, 50-51 (XXXX).

123. HCPS currently has three students in non-public placements at [Center]. Tr. 595 (XXXX).

DISCUSSION

Applicable Law

The identification, assessment and placement of students in special education is governed by the IDEA, 20 U.S.C.A. §§ 1400-1482 (2010), 34 C.F.R. Part 300 (2013), Md. Code Ann., Educ. §§ 8-401 through 8-417 (2014), and COMAR 13A.05.01. The IDEA provides that all

children with disabilities have the right to a free appropriate public education (FAPE). 20 U.S.C.A. § 1412(a)(1)(A) (2010).

In *Board of Education of the Hendrick Hudson Central School District v. Rowley*, 458 U.S. 176 (1982), the United States Supreme Court described FAPE as follows:

> Implicit in the congressional purpose of providing access to [FAPE] is the requirement that the education to which access is provided be sufficient to confer some educational benefit upon the handicapped child. . . . . We therefore conclude that the "basic floor of opportunity" provided by the Act consists of access to specialized instruction and related services which are individually designed to provide educational benefit to the handicapped child.

Id. at 200-01. *See also In re Conklin*, 946 F.2d 306, 313 (4th Cir. 1991).

Students with disabilities have the right to FAPE. The IDEA defines FAPE as follows:

> The term "free appropriate public education" means special education and related services that—
>
> (A) have been provided at public expense under public supervision and direction, and without charge;
>
> (B) meet the standards of the State educational agency;
>
> (C) include an appropriate preschool, elementary, or secondary school education in the State involved; and
>
> (D) are provided in conformity with the individualized education program required under section 1414 (d) of this title.

20 U.S.C. § 1401(8) (2010). Maryland law defines FAPE similarly. Md. Code Ann., Educ. § 8-401(a)(3) (2014).

The question of whether a student is receiving FAPE has a procedural and a substantive component. The Supreme Court set out a two-part inquiry to determine if a local education agency, such as HCPS, satisfied its obligation to provide FAPE to a student with disabilities. The Supreme Court noted that the first inquiry is whether a school district complied with the procedures set forth in IDEA. The second inquiry is whether the IEP, developed through the

IDEA's procedures, was reasonably calculated to enable a student with disabilities to receive appropriate educational benefit. *Rowley,* 458 U.S. at 206-07.

In this case there is no allegation that the IDEA's procedural safeguards were violated. The question presented here is whether the Student's IEP and placement are reasonably calculated to enable him to receive an appropriate educational benefit. The controlling law is as follows: While FAPE does not require "the best possible education that a school could provide if given access to unlimited funds," *Barnett v. Fairfax County School Board,* 927 F.2d 146, 154 (4th Cir. 1991), it does require the state to provide personalized instruction with sufficient support services to permit the disabled child to benefit educationally. In turn, "educational benefit" has been construed to mean more than "trivial or *de minimis"* educational progress. *In re Conklin,* 946 F.2d at 313; *Polk v. Ctrl. Susquehanna Intermediate Unit,* 853 F.2d 171, 182 (3rd Cir. 1988); *Alexis v. Bd. of Educ.for Balt. Cnty. Public Sch.,* 286 F. Supp. 2d 551, 559 (D. Md. 2003); *M.S. ex rel. Simchick v. Fairfax Cnty. Sch. Bd.,* 553 F.3d 315, 327 (4th Cir 2009).

Providing a student with access to specialized instruction and related services does not mean that a student is entitled to "the best education, public or non-public, that money can buy" or "all services necessary" to maximize educational benefit. *Hessler v. State Bd. of Educ. of Md.,* 700 F.2d 134, 139 (4th Cir. 1983) (citing *Rowley,* 458 U.S. at 200). Instead, FAPE entitles a student to an IEP that is "reasonably calculated to enable the child to receive educational benefit." *Rowley,* 458 U.S. at 177.

"Educational benefit" requires that "the education to which access is provided be sufficient to confer *some* educational benefit upon the handicapped child." *Rowley,* 458 U.S. at 200 (emphasis added). *See also MM ex rel. DM v. Sch. Dist. of Greenville Cnty.,* 303 F.3d 523, 526 (4th Cir. 2002) (citing *Rowley,* 458 U.S. at 192); s*ee also A.B. ex rel. D.B. v. Lawson,* 354

F.3d 315 (4th Cir. 2004). Thus, the IDEA requires an IEP to provide a "'basic floor of opportunity that access to special education and related services provides.'" *Tice v. Botetourt,* 908 F.2d 1200, 1207 (4th Cir. 1990) (quoting *Rowley,* 458 U.S. at 201).

An "appropriate" education, however, does not mean that a student is able to maximize his potential or to receive optimal services. *Rowley,* 458 U.S. at 200; *Burke Cnty. Bd. of Educ. v. Denton,* 895 F.2d 973, 980 (4th Cir. 1990). Clearly, no bright line test can be created to establish whether a student is progressing or could progress educationally. *In re Conklin*, 946 F.2d at 313. Rather, the decision-maker must assess the evidence to determine whether the student's IEP and placement was reasonably calculated to enable him to receive an appropriate educational benefit.

In addition to the IDEA's requirement that a disabled child receive some educational benefit, the child must be placed in the "least restrictive environment" to achieve FAPE, meaning that, ordinarily, disabled and non-disabled students should be educated in the same classroom. 20 U.S.C.A. § 1412(a)(5) (2010); 34 C.F.R. §§ 300.114(a)(2)(i) and 300.117 (2013). Yet, mainstreaming disabled children into regular school programs may not be appropriate for every disabled child. Consequently, removal of a child from a regular educational environment may be necessary when the nature or severity of a child's disability is such that education in a regular classroom cannot be achieved. 34 C.F.R. §§ 300.114(a)(2)(ii) (2013).

The Supreme Court has placed the burden of proof in an administrative hearing under the IDEA upon the party seeking relief. *Schaffer v. Weast,* 546 U.S. 49 (2005). In this case that is the Parent, who must show (1) that the Student's IEP for the 2013-2014 school year does not provide him with FAPE and (2) that the proposed nonpublic placement at [Center] is appropriate. *School Comm. of Burlington v. Dep't of Educ. of Mass.,* 471 U.S. 359 (1985).

Preliminary Issue—Admissibility of Student's Exhibits 5, 20, 22 and 24

At the hearing, the Parent offered four exhibits to which HCPS objected. These were:

Student Ex. 5 [HOSPITAL] CARD Speech and Language Pathology Re-evaluation Note, June 10, 2014

Student Ex. 20 [HOSPITAL] Feeding Disorders Clinic Initial Evaluation Note, February 4, 2014

Student Ex. 22 [HOSPITAL] Behavior Psychology Outpatient Note, May 14, 2014

Student Ex. 24 Report of Follow-up Visit, XXXX XXXX, M.D., June 16, 2014

The basis for the objections was that none of the documents had been provided to the IEP Team; indeed, three of them (Exhibits 5, 22, and 24) were not even created until after the filing of the Due Process Complaint. All of the exhibits were disclosed before the hearing as required by 34 C.F.R. § 300.512(b)(3) and 20 U.S.C.A § 1415(f)(2).

I admitted Student Ex. 5 provisionally and deferred ruling on the remainder until counsel provided me with the legal authority upon which HCPS relied, as well as other citations from closing argument. HCPS provided this authority in a brief post-hearing submission on July 8, 2014, and the Parent responded on July 15, 2014. I segregated Exhibits 20, 22 and 24 until I decided whether to admit them.

HCPS argues that these exhibits, which are in the nature of evaluations, should not be admitted because they were not considered in the first instance by the IEP Team. The cases cited by HCPS stand for the general proposition that a fact finder or a reviewing court must not review information not considered by the IEP Team and then substitute its judgment for that of the IEP Team, which is charged by law with the task of developing the IEP. *See, e.g.*, *Hartmann v. Loudon Cnty. Bd. of Educ.*, 118 F.3d 996, 1000-01 (4th Cir. 1997); *Springer v. Fairfax Cnty. Sch. Bd.*, 134 F.3d 659, 663 (4th Cir 1998); *MM v. Sch. Dist. of Greenville Cnty.*, 303 F.3d 523,

532 (4th Cir 2002); *A.B.*, 354 F.3d at 325-26.

The Parent argues that these exhibits are relevant and admissible, by analogy to Maryland Rules 5-401, which defines relevant evidence, and 5-402, which provides that relevant evidence is admissible unless otherwise provided by law. I note also that under Maryland law, an administrative law judge may hear "any testimony that it considers relevant." Md. Code Ann., Educ. § 8-413(e)(1)(iii) (2014).

Several times during the hearing, and again in closing, counsel for the Parent clarified that (1) the Parent was not alleging any procedural violation by HCPS; (2) the Parent was not challenging the content of the IEP per se; and (3) the alleged denial of FAPE is based upon the Student's asserted lack of meaningful progress. *See, e.g.,* Tr. 144-159; 431-32; 840-41. The Parent offered these exhibits as evidence of the Student's alleged lack of progress.

After considering the authorities cited by HCPS, I have decided to overrule HCPS's objection to these exhibits and admit them for the limited purpose offered, and to consider them to the extent they may be relevant to the Student's educational progress under the November 22, 2013 IEP. I do not disagree with the general premise of the cited cases, but I am not considering these exhibits to find flaws in the IEP or to second-guess the IEP Team. This is not my role. *See Schaffer v. Weast,* 554 F.3d 470, 477 (4th Cir. 2009) (an IEP's appropriateness is to be judged based on the information available at the time the IEP was written).

Nevertheless, as indicated by *In re Conklin*, I must determine whether the Student's progress has been more than "trivial" or "de minimis" before I can decide whether the IEP as implemented provides FAPE or not. In addition, I admitted on behalf of HCPS the Student's Progress Reports, which conclude with the June 2014 time period. *See* HCPS Ex. 13. I believe that fairness requires me to consider the contemporaneous exhibits offered on behalf of the

Student, and to give them whatever weight I think they are entitled to in assessing the Student's educational progress under the IEP.[25]

Introduction

The testimonial and documentary evidence shows that the Student, who will attain the age of four on XXXX, 2014, is a student with the primary disability of autism, or ASD, with co-occurring developmental delay. His autism symptoms, as assessed by speech/language pathologists and developmental pediatricians, are severe. He displays deficits in social interaction, non-verbal communication (expression, eye contact, and gestures), and initiating and maintaining relationships with others. He displays restricted or repetitive patterns of behavior, has difficulty in adjusting to change, needs routine, and is very focused on sensory stimuli such as fabrics and objects. He is described by his parents and others as being "in his own world."

He also has significant delays in receptive and expressive language relative to his chronological age. He is capable of vocalizing (making sounds, imitating some consonants) but he does not speak. He is "non-verbal" in the sense that he cannot use language to communicate his wants or needs. Although his gross motor skills are within normal limits, his fine motor skills are not, making it difficult for him to feed himself, pick up small objects, hold a crayon and the like. He also has difficulty with basic skills of daily living, such as toileting. When his needs are not met, preferred items are taken away, or demands are placed on him with which he is unwilling to comply, he becomes frustrated or angry, and may have a tantrum or display aggression or self-injurious behavior.

The Parent became concerned about the Student's development when he was about 14 months old. She was referred to the Harford County ITP, which first evaluated the Student in

[25] Of course, the IEP Team is not precluded from considering these items, if offered, as part of its regular and ongoing process during the school year.

May 2012 and found him eligible for services because of a greater than 25% delay in the areas of fine motor skills, social development, cognition, expressive and receptive language skills, pragmatics (social language such as greetings, farewells, and requests), and play and gesture skills. The ITP provided services (special instruction, speech/language therapy, and occupational therapy) to the Student in the home beginning in May 2012 under an IFSP. From the end of August 2013 through the end of November 2013, these services were provided in a preschool special education classroom at [School 1] for a total of 10 hours per week.

During this time frame, the Parent or parents obtained evaluations from developmental pediatricians (Dr. XXXX at XXXX Hospital, Dr. XXXX at [HOSPITAL]) and a speech/language pathologist (Ms. XXXX at [HOSPITAL]) with expertise in working with autistic children. These professionals consistently recommended that the Student receive special instruction and related services, including 1:1 instruction, in a small-group, structured setting with children of similar disabilities.

In October and early November 2013, HCPS undertook the process of determining the Student's eligibility for special education and related services under the IDEA and then developing an IEP for the Student, to be implemented after his third birthday. The Team conducted three meetings, and considered all the information and evaluations then available. The result was the IEP signed by the Parent on November 22, 2013, providing for 26 hours per week of special instruction and related services, to be provided in the XXXX Classroom at [School 1]. Although [School 1] is a regular elementary school, there are no non-disabled peers in this classroom.

The IEP exhaustively describes the Goals and Objectives for the Student, to be worked on during the IEP year (November 2013—November 2014.) The Goals and Objectives are

specific and concrete, and relate to both the Student's ASD and his developmental delay. The IEP requires monitoring of progress, data collection and analysis, and quarterly progress reports.

The Team prepared detailed Progress Reports covering three marking periods, through June 2014. These reports speak for themselves, but in general they indicate progress over time on many of the Objectives, and even mastery of some. The reports acknowledge that the Student's rate of progress has not been uniform across tasks. The reports also indicate that although the Student has begun to perform some tasks independently, he continues to need varying levels of adult assistance on other tasks. This assistance ranges from simple verbal cues all the way to hand-over-hand prompting, depending on the task.

The parents take the position that the Student has made virtually *no* progress between May 2012 and June 2014; that standardized tests show he has even regressed; that he cannot communicate or do anything independently; and that his behavior in non-school settings (aggression toward parents and siblings, self-injurious behavior such as head-banging and scratching) requires more intensive behavioral methodologies. They believe that a full-time non-public placement at [Center] is the only program that can meet his needs. HCPS takes the position that the Student has made meaningful progress under applicable law; that the IEP provides FAPE; and that he is not entitled to a non-public placement at HCPS's expense.

Specific Contentions of the Parties

A. The Parent

Based on the direct testimony of the witnesses on behalf of the Student, the Student's exhibits, information elicited on cross-examination of the HCPS witnesses, and legal authority

cited in closing argument, I understand the Parent to be making the following specific factual contentions:

- The Student has made no developmental or educational progress between May 2012 and June 2014, across all the domains affected by his disabilities, with particular reference to visual reception, receptive language, and expressive language;
- The afternoon session of the [School 1] Program is simply a repetition of the morning session, and does not provide consistency;
- The Program provided at [School 1] is characterized by an excessive level of prompting, such that the Student is not offered opportunities to learn and practice basic skills, such as imitation and matching, independently;
- At home, the Student does not function independently (feed or dress himself, cooperate with toilet training);
- At home, the Student does not functionally communicate, either by words, gestures, or use of the PECS system;
- The Student has deficits in social interaction, such as limited eye contact, and lack of interest in others;
- The Student increasingly exhibits maladaptive behaviors when he is frustrated or does not get what he wants, such as crying, tantruming, showing aggression toward parents and siblings, and engaging in self-injurious behaviors such as head-banging;
- The Student's educational progress described in the HCPS Progress Reports never happened, and the school system's accounts of that progress are not true;
- The educational progress described in the HCPS Progress Reports and testified to by the HCPS witnesses cannot be replicated outside the school setting;

- The Student is not well matched with the other students in the [School 1] Program, who appear to have more advanced skills than he does;
- HCPS has misled the parents by representing that the [School 1] Program is the only full-time HCPS program for preschool students on the autism spectrum, when in fact there are other such programs;
- [Center] is the appropriate placement because it is more intensive (30 hours weekly versus 26); the behavior specialists are ABA certified; the profile of the Student's peers would be more like his own; and the Student would receive 1:1 individualized specialized instruction, including speech/language and occupational therapy, throughout the day; and
- HCPS has placed other autistic students at [Center] at public expense.

B. HCPS

Based on the direct testimony of the HCPS witnesses, the HCPS exhibits, information elicited on cross-examination of the Parent's witnesses, and legal authority cited in closing argument, I understand HCPS to be making the following specific responses to the Parent's factual contentions:

- The Student has made significant, documented progress on many of the Objectives on his IEP, although he still requires adult assistance, in varying degrees, with many tasks;
- The IEP incorporates the concept of "errorless teaching," whereby prompting is used to ensure that the Student has a positive result on a task, and a "prompt hierarchy," meaning that the extent and manner of prompting is decreased as the Student becomes more successful;
- With the exception of Dr. XXXX, the Parent's expert witnesses have not observed the Student in the school setting;

- The Student has expanded his ability to functionally communicate his needs and wants using the PECS system, and has begun to generalize that skill by requesting more items and actions as his picture "vocabulary" expands;
- The PECS system, when used consistently, provides the Student with a mode of communication and is his "voice;" if he cannot communicate his needs and wants, he becomes frustrated;
- The [School 1] Program provides all of the elements that the Student's various clinicians have recommended—it is a self-contained, highly structured, language-based program for children with ASD, consisting of individualized special instruction, speech/language therapy, occupational therapy, and a behavioral component using Verbal Behavioral and Discrete Trial methodologies, which are components of ABA;
- The Student receives individualized instruction throughout the day, even during group activities, because he is working on the Goals and Objectives specific to his IEP;
- The Student has 1:1 adult assistance at all times during the school day;
- HCPS has only one full-time XXXX program for children with ASD, but it is offered in four different school locations, in self-contained classrooms;
- Assignment to one of the four locations is based on where a child resides in the county;
- "Full-time" for preschool students means 26 hours per week; for elementary school students it is 30 hours per week;
- Most of the Student's peers in the [School 1] Program have the disability of autism and poor functional communication;
- The Student's disability of autism is complicated by his global developmental delay, which is a chronic health condition that will not go away;

- Because of these co-occurring conditions, the Student's progress can be expected to be slow and incremental;
- HCPS is addressing the Student's maladaptive behaviors in the school setting; neither Dr. XXXX nor Ms. XXXX observed those behaviors on the days they saw the Student; and
- Standardized assessments, while they are valuable for diagnostic and eligibility purposes, are "snapshots" of a child and may be affected by familiarity with the examiner or setting; fatigue, hunger or other physical condition; and other factors.

Analysis

I have carefully reviewed the testimony (lay and expert) and all the exhibits in the light of the guiding principles of IDEA law, which were well articulated by counsel for both parties. In considering the demeanor of the witnesses, I have not accorded any more weight to the live testimony than to the telephone testimony.

What I conclude from the evidence is that as of June 2014, just over halfway through the IEP year, the Student's presentation, and what he can accomplish, is markedly different in the school setting and at home. The Student's parents are not seeing the gains in functional communication (largely brought about by the consistent use of the PECS system in school), fine motor skills, attention, and social-emotional skills that have been observed and documented in detail by his teacher and his related service providers. The Student's teachers and therapists, while they do not dispute that the Student is prone to maladaptive behaviors at times, have developed strategies to deal with the behaviors using ABA methodologies. With the exception of the tantrum observed on February 12, 2014, (HCPS Ex. 28) they have not seen in the school setting the extreme aggression and self-injurious behaviors described by the Student's parents,

Ms. XXXX, and the [HOSPITAL] behavioral psychologists (Student Ex. 21 and 22).[26] In addition, as of the March 28, 2014 Team meeting, the classroom teachers were reporting a decrease in unwanted behaviors.

On these issues, then, the Student's parents and Ms. XXXX, as well as Ms. XXXX, Ms. XXXX, Ms. XXXX, Ms. XXXX and Ms. XXXX were all credible witnesses; the two sides are seeing the child from completely different perspectives. The parents' testimony regarding the Student's level of functioning at home and the challenges he poses for them and their other children was indeed affecting; they (especially his mother) have been tireless advocates for him.

On the other hand, with the exception of Ms. XXXX, who is the Coordinator of Special Education, and Ms. XXXX, who is the Coordinator of Special Education for the ITP, the HCPS witnesses all work directly with the Student, and have personal knowledge of how he is progressing in the school setting. They have a duty to monitor his progress and to collaborate with each other in collecting and analyzing relevant data, which is then synthesized into Progress Reports. Most of these individuals have participated in the Student's IEP process and have special expertise in the methods of educating students on the autism spectrum.

The parents' testimony, however, failed to refute the evidence of progress made by the Student under the November 2013 IEP.[27] The Parent testified that the reported progress "never happened," that HCPS "made up excuses" and it was "not true." Tr. 265, 272 (X. XXXX). While this may be her opinion, it is hard to imagine that all these HCPS employees would expend the effort to fabricate classroom data and Progress Reports, much less perjure

[26] I have attached little weight to Student Ex. 24. While the IEP is concerned with teaching the Student the communication and motor skills necessary to request foods and to feed himself, it does not address the issue of "food refusal" or the Student's "picky eater" behavior. The Parent offered no evidence to suggest that the Student was malnourished, or that any such concern was brought to the attention of the Team.

[27] I note that the services received by the Student under the IFSP are not at issue in this proceeding. Both parties presented evidence, and I have found facts, because the Student's involvement in the ITP and the early interventions he received are part of the narrative. But the issues before me relate only to the IEP adopted on November 22, 2013, and the Student's educational progress thereunder.

themselves, to prevent the Student from receiving more services or being granted a non-public placement.

The Parent's expert witnesses, two of whom are clinicians, also did not refute the evidence of progress made by the Student under the November 2013 IEP. Dr. XXXX, the Program Director at [Center], expressed the opinion that the Student had not made progress in his current placement and that he would do so if placed in an intensive, full time autism program at [Center]. Tr. 41-42, 52 (XXXX), With all due respect to Dr. XXXX, whom I found to be a sincere witness, I do not believe her opinions, based primarily on two brief observations, are of sufficient weight to meet the Parent's burden of proof when considered in light of the evidence adduced by HCPS. At best, her testimony tends to show a difference of professional opinion regarding the proper use of a prompt hierarchy in working with an autistic and developmentally delayed child such as the Student. *See* Tr. at 34-35, 39-40, 99-100, 103-04 (XXXX).

Moreover, Dr. XXXX's own notes of the observation (Student Ex. 23) reflect positive aspects of the Student's presentation (*e.g.*, he was able to sit and attend for 30 minutes; he appeared engaged; the staff were using Verbal Behavioral style methodology and Discrete Trial type programming; the Student chose one of two proffered items independently). *See also* Tr. at 37-38, 86-102 (XXXX).

Dr. XXXX's testimony describing the program at [Center] (*see* Finding of Fact 122, above) suggests that the Student might receive somewhat more intensive behavioral programming there, since [Center] behavior specialists are certified in ABA and they are the individuals who would provide the bulk of the 1:1 instruction. Moreover, [Center] program is five days per week, not four. But the fact that [Center] program might be better than the HCPS Program does not compel the conclusion that the HCPS Program does not provide FAPE, unless

the HCPS Program provides no meaningful educational benefit. *King*, 999 F. Supp. at 767.

As with Dr. XXXX, I found Ms. XXXX a sincere witness who, although I could not observe her demeanor, seemed to be making an effort to testify precisely, particularly with respect to the Student's degree of progress. She conceded that in her second evaluation of the Student, she had observed "nice progress" on the ADOS, which is an assessment of the Student's behaviors that support a diagnosis of autism. Tr. 192-202, 209 (XXXX). She testified, however, that there had been no progress in the Student's cognitive development, as measured by the Mullen Scales. *Id.* at 164-65, 171, 176, 192, 227. Ms. XXXX agreed, however, with the "Validity Statement" on all three speech/language evaluations that:

> Young children do not always respond optimally when influenced by variables such as unfamiliar settings, hunger, minor discomfort, and shyness. It is possible for [the Student's] scores to vary across time or from one test administration to the next.

Tr. 181 (XXXX).

In this connection, the Student's undisputed diagnosis of global developmental delay becomes important. Dr. XXXX, the Student's developmental pediatrician at [HOSPITAL], testified that as of December 12, 2013, she could not document significant gains in the areas of cognition and receptive language "with the services that were present for him." Tr. 384 (XXXX). At that visit, she had been provided with a copy of the IEP. *Id.*

On cross-examination, Dr. XXXX testified that the Student's diagnoses of severe autism, global developmental delay, XXXX, and receptive and expressive language disorder were chronic health conditions that do not disappear. Tr. 395. In the report of her December 12, 2013 visit, she documented a "lengthy discussion" with the Parent to the effect that the Student would make "slow gains developmentally" and that his "overall progress will be more limited as compared to children his age." Student Ex. 16 at 3. On cross-examination, she offered the

explanation that the Student's developmental delay and his autism were "two different issues," that her comment did not mean that children with developmental delay should not be making progress at all, and that she was concerned that he was not further ahead with the services that had been provided to him before December 2013. Tr. 411-12. At that point, however, the IEP had only been in place for ten days; the earlier services were through the ITP.

I find this testimony by Dr. XXXX very significant. The Parent relies on the results of certain standardized tests, such as the Mullen Scales, to demonstrate a lack of educational progress. But the Mullen Scales, as well as another developmental progress assessment tool used by Dr. XXXX, measure cognitive development. Tr. 161-62 (XXXX), 377-78 (XXXX). The Student's global developmental delay could explain why, when the Student is compared by standardized assessments to typically developing children, he appears to have made no progress over time, when classroom progress reports comparing the Student to his own baseline show that in working towards the Goals and Objectives on his IEP, the Student has made progress in functional communication and other areas that relate primarily to his ASD.

The testimony of Ms. XXXX and Dr. XXXX is credible and helpful insofar as it conveys an accurate picture of the Student's current clinical presentation; he is a growing toddler and this presentation will undoubtedly change as he gets older. But these witnesses are not educators, they have not observed the Student in the classroom setting, and they must depend on parental reports for an accurate portrayal of the educational interventions that the Student is actually receiving.

By contrast, the HCPS witnesses provided a clear explanation of the structure of the [School 1] Program and the implementation of the Student's IEP there. Ms. XXXX, Ms. XXXX, and Ms. XXXX gave detailed accounts of the hands-on interventions they provide to the Student

daily, and many concrete examples of how he responds to them. They also described how the instructional staff monitors the Student's progress by data collection and collaboration, and how they respond when a particular strategy does not seem to be effective. They made appropriate concessions on-cross examination, and were careful to distinguish between tasks that were among the Objectives being worked on under the IEP and those that were not. Overall, I found their testimony compelling in its specificity and concreteness, and supported by the examples of their contemporaneous observations that are included in the record.

The HCPS witnesses testified credibly to several concrete examples of the Student's progress on his IEP Goals and Objectives:

- His "mands" have increased over time, in both the number and types of requests. Tr. 624-30 (XXXX); 675-77, 679-80, 722-23 (XXXX);
- At the end of the school year, he had attained Phase III-B on the PECS (discriminating between two objects), progressing from Phase I. Tr. 630-31 (XXXX);
- He no longer required hand-over-hand prompting to choose desired food items, using the PECS system. Tr. 644 (XXXX), 780 (XXXX);
- He showed improvement in his responses to routine commands such as "take off" or "put in," using pictures. Tr. 655-56 (XXXX);
- At times, he responds to his name; he walks to the speech/language room by himself. Tr. 656 (XXXX);
- He can sit and attend for 30 minutes at a time. Tr. 687 (XXXX), 772 (XXXX);
- He is beginning to initiate interactions with familiar adults. Tr. 692-93 (XXXX);
- With assistance, his cooperation with the toileting routine is improving. Tr. 730 (XXXX);
- He is independently scooping food with a spoon and feeding himself. Tr. 731-32 (XXXX), 769-70 (XXXX); and
- His mouthing of inanimate objects has decreased, with the aid of the "chewy tube," which he has both at school and at home. Tr. 781, 789 (XXXX).

Apart from the contention that the progress documented by HCPS instructional staff did not occur, the Parent's argument boils down to two propositions—first, that standardized tests show a lack of progress; and second, that the alleged progress has not been generalized to, or cannot be replicated in, other settings, especially the home.

To the first contention, HCPS responds, in effect, that standardized tests are used for the purposes of reaching diagnoses and for determining eligibility for services; they are standardized with respect to typically developing children. *See* Tr. 604 (XXXX), 814 (XXXX). For educational progress purposes, the relevant comparison is the Student to himself, or his own baseline. *See* Tr. 652, 658-59 (XXXX), 810 (XXXX). In view of the individualized nature of the education to be provided under the IDEA, I am persuaded by this argument. Moreover, courts have held that deference should be afforded to the testimony of instructional staff who have actual and daily experience with the child. *King*, 999 F. Supp. at 771; *see also A.B.*, 354 F. 3d at 328 (IDEA requires great deference to the views of the school system).

With respect to generalization or replication, the HCPS witnesses emphasized the critical role of the PEC system in providing the Student with a means of functional communications. Several witnesses acknowledged that the Student's progress should be capable of reproduction in other settings, but only if he had everything he needed and the PECS system was used consistently; otherwise, the Student would become frustrated. *See* Tr. 631-35, 648, (XXXX); 680-81, 695, 723 (XXXX). There is no dispute that with the exception of his mother, the Student's family does not use the PECS system consistently at home.

Ms. XXXX noted that generalization is a hard skill for this type of student; she had offered to come to the Student's home to help with it, but the parents did not accept the offer. Tr. 734, 755 (XXXX). Similarly, Ms. XXXX had offered the Parent the opportunity to observe

the Student's feeding behavior at school, but the Parent did not do so. Tr. 786-87, 790 (XXXX).[28]

Summary

In summary, I conclude that the Student is receiving appropriate educational benefit given his progress in the school setting. The placement of the Student in the XXXX program at the [School 1] location was made to provide a setting and program in which the Student could progress educationally, and he has done so. Because the November 22, 2013 IEP provided the Student with FAPE for the relevant portion of the 2013-2014 school year, and will continue to do so through November 2014, there is no reason to change his placement at this juncture.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Harford County Public School System developed an appropriate IEP and made an appropriate placement determination for the Student for the relevant portion of the 2013-2014 school year, through November 2014. *Sch. Comm.of Burlington v. Dept. of Educ. of Mass.*, 471 U.S. 359 (1985); *Board of Education of the Hendrick Hudson Central School District v. Rowley*, 458 U.S. 176 (1982); Individuals with Disabilities Education Act (IDEA), 20 U.S.C.A. §§ 1400—1487 (2010); 34 C.F.R. § 300.403; COMAR 13A.05.01.07-.09.

[28] This is not meant to blame the family. I cite these examples to the extent they support HCPS's response to the Parent's argument, and may explain the discrepancy between the Student's presentation at home and at school.

ORDER

I **ORDER** that the Parent's request that the Harford County Public Schools fund a non-public placement of the Student at [Center] be **DENIED.**

August 7, 2014
Date Decision Issued

Una M. Perez
Administrative Law Judge

UMP/da

REVIEW RIGHTS

Within 120 calendar days of the issuance of the hearing decision, any party to the hearing may file an appeal from a final decision of the Office of Administrative Hearings to the federal District Court for Maryland or to the circuit court for the county in which the Student resides. Md. Code Ann., Educ. §8-413(j) (2014).

Should a party file an appeal of the hearing decision, that party must notify the Assistant State Superintendent for Special Education, Maryland State Department of Education, 200 West Baltimore Street, Baltimore, MD 21201, in writing, of the filing of the court action. The written notification of the filing of the court action must include the Office of Administrative Hearings case name and number, the date of the decision, and the county circuit or federal district court case name and docket number.

The Office of Administrative Hearings is not a party to any review process.