DELAWARE DEPARTMENT OF EDUCATION
EXCEPTIONAL CHILDREN RESOURCES

FINAL REPORT
ADMINISTRATIVE COMPLAINT RESOLUTION

DE AC 12-7 *(January 27, 2012)*

On November 28, 2011, Parent filed a complaint with the Delaware Department of Education on behalf of Student.[1] The complaint alleges the Capital School District ("the District") violated state and federal regulations concerning the provision of a free, appropriate public education to Student ("FAPE"). The complaint has been investigated as required by federal regulations at 34 C.F.R. §§ 300.151 to 300.153 and according to the Department of Education's regulations at 14 DE Admin Code §§ 923.51.0 to 53.0.

The investigation included the review of Student's educational records and independent evaluations, as well as on-site interviews with the school principal, Student's 4th grade teacher, the special education coordinator, the school psychologist, the guidance counselor, and the District's director of special education services. Interviews by phone were also conducted with Parent.

FINDINGS OF FACT

1. Student is eligible to receive special education and related services under the disability category of "Emotional Disturbance" as outlined in 14 DE Admin Code § 925.6.9.

2. Student is currently a 4th grade student at the Elementary School. Student has been attending school in the District since kindergarten, and Student has extensive social-emotional, behavioral, and mental health issues as reported by Parent and documented in recent evaluation results.

3rd Grade
2010-2011 School Year

3. In the 3rd grade, Student was placed in an inclusion classroom with one full-time general education teacher and one part-time special education teacher. Student worked with the same general education teacher in the 2nd and 3rd grades. The number of children in class with Student ranged from 14 to 25 depending on the time of the day and the day of the week.

4. At the start of the 3rd grade, Student was performing at or above grade level and meeting academic standards. However, his performance began declining mid-year, and his teacher noticed an increase in his anxiety and behaviors. According to school records, Student

[1] The Final Report identifies some people and places generically, to protect personally identifiable information about the student from unauthorized disclosure. An index of names is attached for the benefit of the individuals and agencies involved in the investigation. The index must be removed before the Final Report is released as a public record.

would constantly raise his hand in class, seek a lot of attention, speak very slowly, frequently go off task or get out of his seat, write off topic, withdraw from social interaction, struggle to complete writing tasks, and become overwhelmed during group discussions. His teacher used interventions to address Student's behaviors, but Student was also missing work due to absences from school for full or partial days.

5. In October, 2010, Parent requested the school to evaluate Student and determine his potential eligibility for special education and related services. Parent also requested the school conduct an evaluation for autism.

6. The school's instructional support team reviewed Parent's request, and sought additional information concerning Student's performance, the interventions used to date, and the effectiveness of the interventions. Once the information was reviewed, the school proceeded with the special education evaluation.

7. On January 19, 2011, the evaluation team convened and reviewed multiple information sources to determine Student's eligibility for special education and related services. Parent described Student as having several learning, personal, and behavior problems. She reported Student as nervous, uncoordinated, anxious, and often complaining of nausea. Parent reported her observation that Student bullies, hurts others, argues, gets mad easily, lies, and often withdraws. Student's 3rd grade teacher rated him as "clinically significant" in the areas of anxiety, depression, somatization, atypicality, and withdrawal. Student's records showed a reported history of diagnosis including Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Post Traumatic Stress Disorder, Oppositional Defiant Disorder, and Obsessive Compulsive Disorder. At the time, Student's medications included an antidepressant, two mood stabilizers, three medicines for anxiety and sleep, a stimulant, and medication for migraines. Student was also involved with two other Delaware agencies to address his mental health needs. School records show staff concerns with Student faking illnesses, and becoming frustrated and off-task.[2]

Achievement testing showed Student performing in the below average range in sentence composition, oral expression, and numerical operations. The school psychologist observed Student's sentence completion to contain many mechanical errors, often make no sense, and repeat "a theme of chain saws, masks, and breaking a student's leg." Assessment data also showed Student having difficulty with expressing himself orally, controlling his emotions, getting along with others, and organizing his thoughts and daily activities.

Classroom and school based assessments showed Student's second marking period grades as: Reading - C, Math - B, Social Studies - B, Science - F, Weekly Spelling - A, and Writing - C. Student met the January 2011 benchmark on DIBELS for oral reading fluency. He scored an 80% (meets standards) on the Holistic Harcourt Theme Assessment, and in the 71% percentile on the Fall Gates-McGinities Reading Test.

[2] School staff also expressed concern about the amount of medication Student was taking, and discussed it with Parent. The school eventually received confirmation Student was being medically monitored with respect to any contraindications from the medications.

8. At the January 19, 2011 meeting, the team identified Student as a child with a disability under the category of "Emotional Disturbance".

9. At the time, Student had also been medically evaluated by a behavioral health specialist at a local children's hospital ("the Children's Hospital"), and the Delaware Autism Program ("DAP"). The school planned to review the medical evaluation and the DAP report when available, and also address Parent's request that Student be identified in the disability category of "Autism".

10. On February 10, 2011, the IEP team convened to develop Student's IEP. Parent attended the meeting and participated. Student's IEP includes a goal for written expression, and a goal for on-task behavior. Services and modifications include teacher and peer editing, use of graphic organizers, additional time, prompting, small group, as needed, redirection, close proximity to teacher, use of a card system to limit his questions and keep him on task, and use of headphones. The team identified Student as having behaviors that interfere with his learning, but did not complete a functional behavior assessment or a separate behavior intervention plan. The team did not determine Student's eligibility for extended school year services over the summer of 2011 noting on his IEP eligibility "to be determined".

11. Under his IEP, Student's 3rd grade placement continued in the inclusion classroom to provide Student with access to the general education curriculum and an opportunity to be educated with non-disabled peers.

12. DAP completed its assessment of Student and concluded Student's pattern of behaviors were not consistent with the eligibility criteria for a disability category of "Autism" under the IDEA.

13. On February 14, 2011, the school's evaluation team convened to review DAP's assessment report. A representative from the DAP program attended the meeting and described DAP's findings. Parent reported that Student tends to be a "loner" and withdrawn, began "hearing voices", frequently rolls on the floor at home, prefers to play with toddlers, and tends to parallel play rather than cooperatively plan. DAP agreed Student has significant impairments and behavior problems as noted by school and medical evaluations, but felt the impairments were not indicative of an educational classification of "Autism" and may be better accounted for by an emotional disorder. According to DAP's assessment, Student did not demonstrate a significant, qualitative impairment in reciprocal social interaction, communication or restricted, repetitive patterns of behavior. The evaluation team determined Student did not qualify as a student with a disability in the category of "Autism" under the IDEA.

14. In the interim, the Children's Hospital issued its medical evaluation of Student completed on December 15, 2010. The medical evaluation contains 25 pages of diagnostic information tailored to Student's areas of need. Records show DAP may have reviewed the medical evaluation as part of its autism evaluation in February 2011. According to the school, staff asked Parent to provide a copy of the medical evaluation, but it was not received until the following school year on September 14, 2011. When the IEP was developed in February 2011, the team did not review and discuss the specific recommendations from the Children's Hospital.

15. As the school year proceeded, Student made educational progress under his February 10, 2011 IEP. IEP progress reports show Student was meeting short-term benchmarks in March and June 2011. Student had an increase in anxiety-related behavior toward the end of the 3rd grade year, but staff was able to intervene and deescalate or redirect Student. On the DCAS, Student met proficiency standards at the 3rd grade level in reading and math. Between the winter and spring DCAS, Student's scores rose from 695 to 731 in reading and 663 to 675 in math.

16. According to Parent, Student's anxiety levels and behaviors at home escalated near the end of the 3rd grade year, and included some self-induced vomiting.

17. The IEP team did not reconvene to determine Student's eligibility for extended school year services over the summer of 2011.

4th Grade
2011-2012 School Year

18. In the 4th grade, Student's placement continued in the inclusion classroom with approximately 27 students, one full-time teacher dually certified in general and special education, and one aide. In the 4th grade, Student was assigned to a different teacher than his teacher in the 2nd and 3rd grades. Parent feels this change was a major issue for Student.

19. Student's 4th grade teacher noticed Student struggling to stay on task and resorting to attention seeking behaviors. Student often commented he wanted to go home and be with Parent. On one occasion, Student told the principal he wants to go home with Parent because Parent "hugs me". School staff felt Student was experiencing a high level of separation anxiety from Parent. School staff regularly communicated with Parent regarding their concerns and the behaviors occurring in school. Parent feels the communication was not consistent.

20. By the second week of school, Student was causing himself to vomit in school. School staff estimate his self-induced vomiting started occasionally and escalated to 3 to 10 times a day or more (approximately). Staff observed Student using his finger to provoke vomiting usually consisting of saliva, mucus, and/or liquids.

21. Student also made several somatic complaints describing physical symptoms such as pain or headaches. Student used medical terms with school staff to describe himself or his mental health. For example, Student's teacher observed Student to whine and make crying sounds in class. The teacher described an occasion when Student stated he was in "agony" with "severe back pain" and proceeded to roll out of his chair and fall on the floor. On other occasions, Student would be sleeping on his desk. The school guidance counselor described an occurrence when Student came to his office stating "I am bipolar" and became "physically pushy" with the guidance counselor. Student's 4th grade teacher reported that most of Student's behaviors occurred during classroom instruction.

22. School staff initially responded to Student's behaviors by taking him to the school

nurse for medical attention and treatment. Student would frequently be sent home with Parent or removed from class. On some occasions, Student would speak to Parent by phone and Parent would reassure and comfort Student encouraging him to stay at school and return to class. School staff eventually noticed a pattern and felt they were reinforcing Student's behaviors if they always sent him home or removed him from class following a behavioral event or vomiting episode. Student told staff frequently he wanted to go home.

23. Staff eventually placed a trash can next to Student's desk in the classroom. If Student spit up in the trash can, he would empty it, and return to the classroom.

24. Staff also began sending Student to the guidance counselor following a behavioral incident. The guidance counselor would communicate with Parent and discuss the event with Student.

25. Student's teacher began some limited 1:1 instruction with Student and reduced his assignments by half in order to get some work completed. Student's teacher used a daily behavior checklist to keep him on task and gave him additional time for classwork. Student would check in with an administrator each morning. The guidance counselor would check on Student and his mood throughout the day. School staff told Student he could complete his work in the guidance counselor's office area. When Student needed a break, he was told to give his teacher a hand signal in class.

26. In late October 2011, the District's speech-language pathologist and occupational therapist evaluated Student to assess his potential need for related therapy services.

27. Parent reported that some of Student's vomiting episodes caused him to become dehydrated and require medical treatment and/or hospitalization. The vomiting occurred at home and in school. On October 21, 2011, Parent requested the school schedule an IEP meeting as soon as possible to discuss changes to Student's IEP.

28. On November 8, 2011, the IEP team convened and reviewed the results of the speech-language and occupational therapy evaluations. The team concluded Student was eligible for occupational therapy services, but not eligible for speech-language services. The team amended Student's IEP to add occupational therapy services and an annual goal addressing visual perceptual skills. The team also discussed Student's behaviors and his program and decided to conduct a functional behavioral assessment ("FBA") and a behavior intervention plan ("BIP"). Representatives from other public agencies (i.e., mental health) attended the November 8th meeting to coordinate services for Student and his family.

29. On November 14, 2011, school staff met and completed a "draft" FBA and BIP. However, the draft FBA does not reflect lengthy direct observation by staff, objective data review and analysis, and contains a very limited description of Student's behaviors in relation to the activity, the space, the staff present, the students present, any other people present, the temperature of the room, the noise in the room, and other factors in the environment which may be preferred or non-preferred to Student in assessing the antecedent, the consequence, and the overall function of Student's behavior. In addition, the draft FBA generally refers to staff

observations apparently conducted in the 2nd and 3rd grade by Student's teachers when Student was much younger and interacted with different staff and students in another classroom environment. The draft FBA describes observations by the school principal and guidance counselor that were informal and not documented through specific data collection.

30. On November 16, 2011, the school psychologist was in Student's 4th grade classroom conducting an observation as part of the FBA. Student started crying and stating his throat hurt. Student was given the choice to stay and complete work or go with the school psychologist. He refused both options and held on to the desk. The school psychologist and guidance counselor gave Student a two person transport to the hallway. Student tried to kick and punch, and collapsed on the floor, vomited, and cried "leave me alone". Eventually, Student went into the time-out room with the guidance counselor. School records state the behavior started at approximately 9:40 a.m. and Student was relatively calmed down by 10:25 a.m. He was completely calmed down by 10:40 a.m., and returned to classroom and began to work.

31. In her complaint, Parent alleges Student was forced to clean up his vomit from the floor. Parent refers to the school's November 16, 2011 time-out log stating Student de-escalated, put his shoes on, and cleaned the trash and vomit from the floor. According to the school, the custodian cleaned the vomit from the floor, and as part of the de-escalation process, the school psychologist gave Student to an anti-bacterial cleaning wipe and directed him to wipe the area of the floor where he had vomited that had already been cleaned by the custodian.

32. Student has not returned to school since November 17, 2011. Student provided the school with a medical note from his private physician stating Student requires homebound instruction for at least 30 days due to a continued problem with hyperemesis (i.e., excessive nausea and sickness) and dehydration.

33. The school did not convene an IEP team meeting to review the doctor's prescription for homebound instruction. The District approved a change in Student's educational placement for homebound instruction and is now providing a prescribed 5 hours of instruction a week in Student's home.

34. Student has not received occupational therapy since determined eligible on November 8, 2011. According to the school, Parent declined occupational therapy services with Student until he completes a pending medical surgery.

35. School records show Student was removed from the classroom due to behavioral incidents or somatic complaints on at least 12 occasions between September 13, 2011 and November 16, 2011.

36. During the investigation, the school also confirmed the IEP team did not convene in the 4th grade to review the medical evaluation and recommendations from the Children's Hospital. As mentioned, the medical evaluation consists of 25 pages of diagnostic information concerning Student and specific recommendations for the school to follow to address Student's social-emotional skill development and mental health needs. The Children's Hospital recommended Student would benefit from an environment that can assist with behavior

management and social skills development, provide a safe environment for Student's anxiety, and help Student communicate and relate with better organization. The evaluators also encouraged the school to consider specialist involvement, high levels of structure and routine, and possibly the use of the aide.

COMPLAINT ALLEGATIONS

Parent claims the District failed to provide Student with positive behavior interventions in the manner required by the IDEA and denied Student a free, appropriate public education. Parent also claims the District failed to provide Student with the small group classroom environment he requires to address the management of his anxiety, behavior, and social skill development.

CONCLUSIONS

The evidence shows school staff were genuinely concerned about Student and attempting to respond to his behaviors thoughtfully. School staff were responsive to Parent's requests throughout the year, they sought additional information about Student when necessary, and kept Parent consistently informed. Communication with Parent was frequent, and often included contact with the school nurse. School staff regularly collaborated and discussed their observations about Student, his behaviors, and academic performance.

The evidence also shows Student's program does not meet his educational needs and a more restrictive placement is necessary.

The IEP team did not begin the development of an FBA and BIP for Student until approximately 8 months after his identification as a student with an emotional disturbance. Student demonstrated a need for a comprehensive FBA and detailed behavior plan (based on the results of an FBA) much earlier than November 2011. Student had difficulty remaining in the classroom during the day, and left early on several occasions. When Student remained in class, his behaviors often disrupted him from receiving consistent classroom instruction. This pattern has an adverse effect on Student's ability to meaningfully access educational services. Staff reported that Student began the self-induced vomiting early in the 2011-2012 school year combined with other anxiety-related and attention seeking behaviors. The FBA was not drafted until mid-November 2011, and it was developed internally by the school team. The draft FBA was given to Parent afterward for review and comment. This approach precludes the meaningful discussion and exchange with Parent that is necessary to develop the FBA, especially for Student given his complex needs. In addition, the draft FBA does not reflect adequate, direct observation by staff, objective data review and analysis, or a description of Student's behaviors in relation to the activity, the staff present, the space, the students present, the noise in the room, and other factors which may be preferred or non-preferred to Student in assessing the antecedent, the consequence, and overall function of his behavior. The draft FBA generally refers to staff observations conducted in the 2nd and 3rd grade by Student's teachers when Student was much younger and interacted with different staff and students in another classroom environment. The draft FBA lists observations by the school principal and guidance counselor that were informal and not documented through specific data collection.

While Student appears to be a bright child meeting grade level standards and able to pass his classwork, Student's behaviors caused him to be removed from classroom instruction for notable periods of time. School records show Student was removed from the classroom due to behavioral incidents or somatic complaints on at least 12 occasions between September 13, 2011 and November 16, 2011.

Further, Student's IEP contains only two behavior goals, and very few accommodations and interventions to address Student's behavior. While school staff explained there a number of interventions and strategies used to respond to Student, they are not documented in Student's IEP or a behavior intervention plan. A separate behavior plan would ensure staff are implementing the interventions consistently across settings and allow for data collection to track the effectiveness of the interventions. School staff should have also convened the IEP team to review and discuss the recommendations of the Children's Hospital upon receipt of the report, especially given the frequency of Student's vomiting events and attention seeking behaviors in the beginning of the 4th grade year.

Finally, State and federal regulations require a school district to determine on an annual basis whether a child with a disability requires extended school year services. In this case, the District acknowledges the IEP team did not convene to determine Student's eligibility for ESY in the 2010-2011 school year.

To the extent Parent claims Student was forced to clean up his own vomit and exposed to dangerous chemicals, there is insufficient evidence to support Parent's allegation.

CORRECTIVE ACTION

The District shall provide Student with a more restrictive educational placement consisting of a low student to teacher ratio in a small group setting with high levels of structure, routine, and consistency. The program must include pre-teaching, social skills training, behavioral and emotional support for Student.

The program must also include appropriate behavioral interventions, **including, but not limited to**, strategies to teach Student how to appropriately request and obtain adult and peer attention, how to request and take a break when needed, and how to communicate appropriately when he is feeling overwhelmed. The program must provide Student with acceptable behavior choices when Student's behavior is inappropriate, and assist Student in identifying his negative thoughts and his mood throughout the day. The program must also provide positive reinforcement for Student's appropriate behaviors.

Staff providing instruction to Student must have or receive training in working with students with emotional disturbances.

The District shall complete a comprehensive functional behavior assessment of Student and develop a positive behavior intervention support plan.

The District shall also ensure staff receives technical assistance from a qualified provider in both: (1) the use of positive behavioral supports for students with emotional disturbance; and (2) the development of functional behavior assessments and positive behavior intervention plans.

The District shall ensure Student's IEP team reviews and discusses the specific recommendations of the Children's Hospital and the independent educational evaluation by Dr. Schmidt at a team meeting with Parent, and revise the IEP based on any evaluator recommendations, if the team deems appropriate.

The District shall also convene the IEP team to develop a specific plan allowing Student to gradually transition from the current restrictive homebound setting to an educational placement with the District based on his social-emotional and mental health needs.

By: ***/s/ Jennifer L. Kline***
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