

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

PARENT on behalf of STUDENT,

v.

SAN DIEGO COUNTY OFFICE OF
EDUCATION.

OAH CASE NO. 2012110566

DECISION

Administrative Law Judge Robert F. Helfand (ALJ), from the Office of Administrative Hearings (OAH), State of California, heard this matter in San Diego, California, on January 22 and 23, 2013 and February 11, 12, 13, 14, 15 and 28, 2013.

Thomas S. Nelson and Ashok J. Pathi, Attorneys at Law, represented Student and his parent (Student). Student's mother (Mother) was present during most of the hearing.

Sarah L.W. Sutherland, Attorney at Law, represented the San Diego County Office of Education (COE). Carolyn Nunes, Senior Director of Special Education for the COE, was present throughout the hearing. Timothy Glover, Assistant Superintendent for Student Services and Programs Division of the COE, attended parts of the hearing.

Student filed his due process request on November 16, 2012. At the December 21, 2012 Prehearing Conference, the parties moved for a continuance to permit them to obtain a number of documents which had been subpoenaed. On January 22, 2013, the due process hearing commenced. The COE orally moved for a continuance as the records under subpoena had not been produced. There was no opposition to the motion. The undersigned ALJ granted the continuance. Because Student's first witness had traveled to San Diego to testify, the continuance commenced after the January 23, 2013 testimony of the witness. At the close of the hearing, at the parties' request, the parties were given time to file written closing arguments. Closing briefs were submitted on March 19, 2013. The matter was deemed submitted upon receipt of the written closing rebuttal argument on March 25, 2013.

The following witnesses testified during the hearing: Natalie Jean Novick Brown, Ph.D.; Jeffrey K. Rowe, M.D.; Cynthia Cromer; Naomi Eddy; Michael Tramell, M.D.;

Tamara Peddie-Musser, L.M.F.T.; Brian Russell; Alan Young; Lida Ramos; Kurt Christopher; Greta Hulley; Mother; Wendy Vaughn Platt; and Samantha Meadows.

ISSUES¹

- (1) Since January 16, 2012, has the COE deprived Student of a free appropriate public education (FAPE) both procedurally and substantively by failing to offer:
 - (a) Appropriate mental health services including therapy and counseling;
 - (b) Appropriate academic services when COE offered 240 minutes of academic instruction daily; and
 - (c) Appropriate occupational therapy services?
- (2) Since August 21, 2012, did the COE deny Student a FAPE both procedurally and substantively by failing to offer Student an appropriate placement when it failed to offer him placement at a residential treatment center (RTC)², which was the least restrictive environment (LRE)?

PROPOSED RESOLUTION

Student requests an order directing the COE to place Student at a RTC and awarding him compensatory education.

INTRODUCTION

This matter involves Student who was detained in a juvenile detention facility on a charge of homicide of another child. It may be of assistance to have a basic understanding of the juvenile justice system and competency to stand trial.

In California, juvenile justice proceedings are referred as “delinquency” cases or “602” cases, referring to the jurisdictional statute (Welfare & Institutions (W&I) Code, section 602). Following an arrest upon a charge of the commission of a crime, the youth may be charged by a petition filed by the District Attorney’s office. In some cases, such as

¹ The issues, as stated in the Prehearing Conference order, have been re-framed for the purposes of this Decision.

² An RTC is a live-in health care facility providing a therapeutic component as part of its program.

the instant case, the youth may be detained in a juvenile detention facility (referred to as “juvenile hall”). After the youth appears in Juvenile Court, the petition, containing the allegations, is read and the youth admits or denies the allegations. If the competency of the youth is in issue, it is raised at this stage of the proceedings.³

In *Dusky v. United States* (1960) 362 U.S. 402 (*Dusky*), the United States Supreme Court adopted a two pronged test to determine competency to stand trial for a criminal defendant. The two prongs are the defendant has (1) sufficient ability to consult with his attorney with a reasonable degree of rational understanding, and (2) a rational as well as factual understanding of the proceedings against him. In *Drope v. Missouri* (1975) 420 U.S. 162, 171, the Supreme Court clarified the first prong enunciated in *Dusky* to specify that the defendant must be able to assist in the preparation of his defense. California codified the *Dusky* standard in Penal Codes sections 1367 through 1376.⁴ Section 709, subsection (a) of the W & I states:

A minor is mentally incompetent if, as a result of mental disorder or developmental disability or developmental immaturity he/she lacks sufficient present ability to consult with counsel and assist in preparing his/her defense with a reasonable degree of rational understanding, or lacks a rational understanding of the nature of the charges or proceedings against him/her.

“But while almost every state provides statutory guidance for the implementation of the *Dusky* standard as applied to juveniles, California provisions apply only to adults.”⁵ In *James H. v. Superior Court* (1978) 77 Cal. App. 3d 169, 175-176, the Appeals Court found that the statutory provisions applying to adult defendants did not apply to juveniles but could be used as guidelines for defining competency in delinquent proceedings along with the *Dusky* standards. (See also, *In re Alejandro G.* (2012) 205 Cal. App. 4th 472, 278.) In 2007, the Appeals Court added developmental immaturity as a factor to consider when adjudicating competency of a minor. (*Timothy J. v. Superior Court* (2007) 150 Cal. App. 4th 847, 859 (“[w]e see no difference between a condition that results from a developmental disability and one that results from developmental immaturity.”) Where the youth is not competent by reason to doubt that the youth is capable of understanding the proceedings, the court should stay the proceedings. (*In re Christopher F.* (2011) 194 Cal. App. 4th 462, 468.)

If the minor is found incompetent, the proceedings shall be suspended until competence is restored. During the suspension period, the court may order services which are appropriate to assist the minor in restoring competence. (W & I §709, sub. (c).) San Diego County’s

³ Burrell, Sue et al, *Incompetent Youth in California Juvenile Justice* (2008) 19 Stan. L. & Policy Rev. 198, 200-201.

⁴ *Ibid.*, at p. 206.

⁵ *Ibid.*, at p. 213.

juvenile court has adopted a protocol on procedures dealing with the issue of competency (see Factual Findings 85.).

FACTUAL FINDINGS

1. Student is a 12 year old boy who currently resides at the Kearney Mesa Juvenile Detention Facility (JDF) and attends the Sarah Anthony School, a juvenile court and community school operated by the COE.⁶ He has been eligible for special education and related services since October 24, 2004. Student has lived and will resume residing with his adopted mother after release from juvenile detention within the geographical limits of the Cajon Valley Unified School District (CVUSD).

2. Student's birth mother had a history of schizophrenia and substance abuse (including alcohol, PCP, cocaine, and methamphetamine as well as being prescribed psychotropic medications). Student was diagnosed on October 30, 2007 as suffering from Fetal Alcohol Syndrome Disorder (FAS). Immediately following birth, Student was placed in foster homes. At three weeks, Student suffered a fractured skull. Student was adopted by Mother, a special education teacher, at approximately six months of age. Student's developmental milestones were delayed.

Fetal Alcohol Syndrome

3. FAS is a medical condition caused by exposure to alcohol in vitro and effects the development of brain formation. People with FAS can have abnormalities in growth and facial features as well as central nervous system damage. The brain area most affected is the frontal lobe which controls self-regulation, executive functioning, judgment, and impulse control.

4. FAS is diagnosed when there is (1) a clear history of prenatal alcohol exposure; (2) dysmorphic features primarily in the face; (3) growth retardation below the 10th percentile; and (4) central nervous system dysfunction including developmental delay, hyperactivity, attention and/or memory deficits, learning difficulties, intellectual deficits, motor problems, neurologic signs and/or seizures.

Early Years through the 2010-2011 School Year

5. Student had a history of head banging, rocking side to side, and hand flapping. He had engaged in unusual behaviors since three years old. He was placed in early infant

⁶ Under Education Code Sections 48645 et seq., the local education agency responsible for establishing, administering and operating schools in any juvenile hall or other juvenile detention facility is the county board of education, which in San Diego County is COE.

head start and pre-kindergarten class because of his developmental, fine motor, language, and adaptive skills delays. In August 2001, Student began receiving services from the Regional Center as an “at risk” child. In October 2004, Student was initially found eligible for special education and related services by CVUSD under the category of speech and language impairment. Later, Student’s eligibility category was changed to other health impaired (OHI) based upon the diagnosis of FAS. Student’s cognitive abilities fell in the average range.

6. Student has had a history of psychological and psychiatric care since six years old. He was diagnosed by Rady Children’s Hospital with Disruptive Behavior Disorder-NOS (not otherwise specified), and FAS. Student has undergone numerous evaluations. In January 2007, Angela Mendez, M.F.T., diagnosed Student with Anxiety Disorder NOS. On October 30, 2007, Lynne Bird, M.D., diagnosed Student with FAS. On June 26, 2008, Student was diagnosed with Disruptive Behavior Disorder -NOS by Ann Garland, M.D. and Alisha Carpenter, M.A. On September 25, 2009, Maria De Luna, M.D., diagnosed Student with Attention Deficit Hyperactivity Disorder (ADHD) and Anxiety Disorder- NOS.

7. Prior to being in Juvenile Hall, Student attended the W.D. Hall Elementary School operated by CVUSD starting in kindergarten. Student was placed in general education. Student was a withdrawn and quiet youngster in his early years. Starting in the third grade, Student changed and became more irritable and defiant. Student appeared less and less motivated to complete school work. Incentives and consequences were less effective. Student would often “shut down” by putting his head down on his desk and refusing to do work.

8. In February 2009, CVUSD school psychologist Tiffany Brewer conducted a psycho-educational assessment. In the Behavior Assessment System for Children-Second Edition (BASC-2), Student scored in the “clinically significant” range for anxiety, depression, withdrawal, adaptability, externalizing problems, and internalizing problems. The assessor administered the Cognitive Assessment System (CAS) test where Student received a Full Scale standard score of 85, which is in the below average range as the average range scores fall between 90 and 109. Student scored in the average range in simultaneous processing, which is problem solving that demanded integration of information into groups, with a standard score of 94; and in successive processing, which tests his ability to work with information in specific linear order, with a 100 standard score. Student scored low average in attention with an 82 and within the borderline range in planning with a 79. In academic areas, the assessor administered the Brigance Diagnostic Inventory. Student scored in the above average range in reading, decoding, reading vocabulary, word analysis, and spelling. He tested in the average range in written language and reading comprehension. Student scored in the low range in math, math computation, and problem solving. Student’s teacher related that he performed in the classroom at grade level and with good fluency in reading but below basic in written language. In math, his teacher reported Student had difficulties with place value and regrouping.

9. From September 2009 through October 2011, Student was under psychiatric care.

February 4, 2011 IEP Meeting and Spring 2011

10. During school year 2010-2011 (fourth grade), Student was in a general education class with one period of resource support. Student's annual IEP meeting was held on February 4, 2011. Attending the IEP meeting was Ms. Brewer, Victoria Jones, Student's general education teacher, and Jessica Smith, Student's resource teacher. The IEP document noted that Student's "diagnosis of FAS negatively impacts his task completion in all areas."

11. The IEP noted in Student's present levels of performance (PLP) that he was inattentive and tended to shut down; he tested below basic in language arts on the California Standards Test (CST); although reading at grade level, Student did not perform to ability in class or testing situations; Student's math scores were below grade level; and he had difficulty retaining learned concepts. It was also noted that Student was taking medication for depression.

12. The IEP team adopted four goals. The first goal addressed number sense which set as a baseline that Student could then perform addition and subtraction with multiple regrouping at a 60-70 percent accuracy rate and could perform division and multiplication with the use of a chart. The goal intended that Student, when given a list of three mixed whole numbers and decimals, could order/compare these numbers to one decimal point with 60 percent accuracy in three consecutive trials. Student's second goal was in task completion. The baseline stated: "Currently, [Student] is completing 40% of daily assignments in the classroom." This goal was for Student to "consistently complete 50-60% of modified assignments in class." Goal three was in the area of organization and focus. The baseline was that Student struggled with formulating basic sentences and cohesive ideas. The baseline indicated that Student's "[w]riting task completion has been minimal." The goal was for Student to write a basic three to four sentence summary paragraph on a given topic. The fourth goal was in the area of behavior. Student's baseline was that he "is currently avoiding tasks by shutting down and refusing to participate 3-5 times a week." Student's goal was that the number of times he shut down per week would be no more than two to three and he was to cooperate by participating in an assigned task.

13. The IEP provided that Student should continue placement in a regular classroom with specialized academic instruction (resource support) for 30 minutes weekly. Also, the District would provide 20 to 30 minutes per month of occupational therapy consultation to Student's teacher. The IEP also provided two accommodations-additional time for tests and completing assignments.

14. Mother agreed to the IEP, and CVUSD implemented the IEP.

15. Student appeared more irritable, defiant, and struggled academically as the school year proceeded. Student regularly failed to complete school work or participate in

school activities. Additionally, he was involved in fist fights with peers at school on March 3, 2011, May 27, 2011, and June 8, 2011.

Fall 2011 to January 16, 2012

16. At the beginning of school year 2011-2012, Student entered the fifth grade in a general education classroom. Student's behavior problems continued. On September 29, 2011, the IEP team reconvened. In attendance were Mother; two general education teachers; Colleen Newman, the school principal; Jessica Smith, Student's resource teacher; and Iman DeGano, a special education teacher. The purpose of the meeting was to discuss whether Student should be placed in a more restrictive environment because of his behavioral and attention problems. The IEP document made a change in Student's PLP under the category of social/emotional/behavior to add: "recently [Student] is acting out aggressively towards other students."

17. The IEP team agreed that Student's placement should be in a special day class (SDC) for emotionally disturbed (ED) students taught by Ms. DeGano and a Behavior Support Plan (BSP) would be developed within 30 days. The IEP team also added an accommodation to permit Student to utilize a calculator. Mother consented to the IEP.

18. Ms. DeGano's SDC comprised between eight and 14 students with a focus on behavior issues. Ms. DeGano was a special education teacher who was assisted by two behavior aides, Cynthia Cromer and Robert Bahrke, and a school psychologist. Several days each week, a licensed therapist would also be present in the class. Ms. Cromer, the therapist, and Mr. Bahrke were employees of New Alternatives, a nonpublic agency, which provided mental health services for children. The aides were specifically trained to handle students with escalating behaviors. The class utilized a rewards system to encourage good behavior which allowed Students to earn the right to attend recess. Students received behavior ratings with green for good behavior, yellow for average behavior and red for bad behavior. The SDC staff prepared Daily Point Sheets (DPS) for each student which rated the student's behavior and noted when the behavior was exceptional or inappropriate. Student introduced into evidence 40 DPS. Of these, Student received 17 greens (good), 13 yellows (satisfactory), and 10 reds (poor). On 12 of the "yellow" days, the rater noted that Student on October 5, 2011 Student had refused to participate in the second half of the day; had "limited participation" on December 12, 2011; had "poor attitude" on November 11, 2011; and refused to participate during various class periods on seven other days with Student refusing to work for four class periods on October 27, 2011. On six of the "green" days, there were notations that Student had refused to participate in class on three days; had threatened staff on October 21, 2011; had limited participation on December 9, 2011; and had minimal effort on December 12, 2011. Thus, on 18 days when Student was rated with satisfactory or good behavior, he had engaged in problem behaviors which caused him to miss instructional time.

19. Student would shut down and refuse to talk or do school work three to four times per day. The shut downs would last from 10 to 45 minutes each time which equated to 70 to 80 percent of his school day. These incidents would be precipitated by Student's

feeling that the required work was too hard. The SDC staff felt that Student's behavior was his attempt to avoid doing the task, gain attention and control the situation. The BSP set as goals that Student would decrease the time he was shut down and that he would participate in at least 50 percent of class activities. The Student would be given academic options and the tasks would be broken into small parts, Student would be permitted short breaks, and taught coping skills. Additionally, Student would be seated in close proximity and be verbally praised as he completes portions of the tasks.

20. Student appeared anxious, feared his peers did not like him, and worried about being excluded. On the playground, Student would play alone. He was overly sensitive to any criticism. Student would refuse to participate when the class was broken down to small groups. When Student became frustrated, he, like others in the class, was allowed to go to an adjoining conference room which was labeled the "stay away" area to permit him to calm himself down. Sometimes in this area, Student would bang the walls but these actions were not directed to staff. After a short timeout, Student would return and do much better. Student's behavior got progressively worse as the semester went on. He went from placing his head down to avoid work to pushing his books and papers on the floor, kicking his desk legs, and banging his head on the desk. Ms. Cromer estimated that Student would participate between 20 to 30 percent of class activities. On two occasions, Student was sent home after fighting with peers. The class had in place a system of rating each pupil's behavior. Student was constantly rated in the lowest rating for using foul language, defiance, and aggression. Attempts by staff to calm Student following a shut down were more and more unsuccessful. Ms. Cromer noted that Student could not stop his behaviors even when he recognized he was acting improperly. At no time did the SDC staff feel a need to restrain Student during his outbursts. Student began to issue verbal threats to staff and once threatened to kill Ms. Cromer. When staff spoke to him about the threats, Student often apologized. Ms. Cromer testified that she did not take Student's threats seriously and that it was not unusual for the SDC students to issue threats against staff when angry. Ms. DeGano, in a statement to an investigator of the District Attorney's Office, did not take the threats seriously as Student would later apologize and explain he was angry and did not mean what he said. Ms. DeGano said "that students said these things all the time." Ms. DeGano also stated Student "got along with the other students." Mr. Bahrke told the investigator that Student would accept punishment for the consequences of his behavior. Mr. Bahrke described Student's behavior as "up and down" although his behaviors worsened as time passed. Neither Ms. DeGano nor Ms. Cromer ever observed Student taking any violent actions towards peers.

21. Student began treating with Dr. Thomas Jensen, a psychiatrist, on November 11, 2011. Dr. Jensen noted that Student exhibited excessive anxiety, poor impulse control, and neurological issues. On November 11, 2011, Dr. Jensen diagnosed Student with FAS, frontal-subcortical issues, and Generalized Anxiety Disorder with possible Bipolar Disorder. Dr. Jensen prescribed various psychotropic medications for Student. Ms. DeGano was told by Mother that Student had started new medication just prior to winter break and Student's behavior seemed improved at home. Student attended school for two days following the winter break and his behaviors worsened.

22. On November 15, 2011, Ms. DeGano prepared a report card for the first trimester. Student received “Unsatisfactory” in showing “respect for rules, authority and peers” as he did not follow staff directions and used inappropriate language. He also received an “Unsatisfactory” in “work completion” due to not completing assignments due to lack of cooperation. He received “Needs Improvement” in “focusing on learning and staying on task” as he required constant prompting. In reading, Student was unable to be assessed on comprehension or analysis due to his lack of cooperation. His reading fluency was at grade level. In the area of writing, Student was working on simple and compound sentences. It was noted that he needed a great deal of staff assistance. Student was working on addition and subtraction of one and two digit numbers in math. Student struggled with regrouping and word problems. In social studies, Student did well working in cooperative teams.

23. Wendy Vaughn Platt has a M.S. in education and Ph.D. in educational psychology/instructional technology. Dr. Platt possesses numerous credentials including in special education, psychology, resource specialist, administrative and elementary teaching. Since 1989, she has been the Director of Special Education and Pupil Services for the CVUSD. She has held this position since 1989. From 1972 through 1979, Dr. Platt was a teacher or resource specialist. From 1979 through 1984, she was a program specialist with the West Orange County Special Education Local Plan Area and North County Special Education Local Plan Area (San Diego County). She served as the Director of the Santa Barbara Local Plan Area from 1984 through 1988. From 1988 to 1989, Dr. Platt was the director of the East County Local Plan Area which included CVUSD. Dr. Platt has developed specialized programs for CVUSD combining mental health components with education components. These include the SDC for emotionally disturbed students as well as a day treatment program which provides a therapeutic environment, including mental health workers, behaviorists, social workers, and counselors to augment the regular education program.

24. Dr. Platt reviewed Student’s records, including the DPS. Based on her review of Student’s behavior as reported on the DPS, Dr. Platt opined that Student’s behavior was not unusual for students in a SDC for ED students. She also testified that students threatening staff was also not uncommon in this SDC. Dr. Platt stated that CVUSD had in place a protocol when a staff member felt that verbal threats were serious. In this matter, neither Ms. DeGano nor her staff reported any such concerns. Dr. Platt also opined, based on her record review, that Student had made education progress while in the SDC as he had met or was in the process of meeting all his IEP goals. The ALJ discounted Dr. Platt’s opinion as she never observed Student at either Hall Elementary or JDF; the testimony of Ms. Cromer, the extent of Student’s behaviors reported on the DPS, and that Student’s behaviors became markedly worse as time passed in the SDC.

Placement in Juvenile Detention Facility

25. On January 16, 2012, Student was involved in an incident where Student caused the death of a 12 year old child. Student was at home playing with friends when he had an argument with a boy. Student ran into his house and retrieved a steak knife. After the

other boy ran home, Student ran around the house in an agitated state and he stabbed his best friend while Mother and the friend attempted to calm him.

26. Student was taken to the JDF and placed in Unit 200 which housed younger detainees. Student was the youngest in the unit. Unit 200 houses approximately 17 boys with 10 probation officers (POs) assigned there. All detainees attend academic classes which take place in the unit's Day Room. Student's room was right off the day room area. During all times, there are three POs on duty except during the shift when the detainees are asleep. Detainees' mental health needs are served by the Stabilization Treatment and Transition team (STAT) comprised of psychologists, psychiatrists, counselors and clinical social workers. When a detainee is prescribed psychotropic medications, he is assigned a psychiatrist for medication management and a psychologist for counseling. Additionally, Student was assigned a therapist who met with him on a daily basis. STAT personnel are available to intervene whenever a detainee has such a need. The STAT team consults with the educators on a regular basis.

27. A detainees' day is controlled by a structured schedule. Detainees are awakened and attend breakfast at approximately 7:28 a.m. After a 30 minute period of free time, the detainees attend school. From 8:00 a.m. to 9:00 a.m., they attend math class. From 9:00 a.m. to 10:00 a.m., the detainees participate in recreation (gym class). Detainees attend science/health class from 10:00 a.m. to 11:00 a.m., when they break for lunch. At noon, the detainees attend language arts instruction until 1:00. From 1:00 p.m. to 2:00 p.m., the detainees attend social studies class. The remainder of the day is broken down into 45 minute sections when activities such as free time, visiting, and programs presented by POs occur. Throughout the day, detainees may be pulled from assigned activities for medical visits, counseling or psychiatric treatment. Detainees are under constant monitoring from POs throughout the day.

28. Upon Student's arrival, JDF staff adopted an individualized protocol designed to assist Student in adjusting and participating in the JDF milieu. The staff recognized that Student's main issues were self-regulation and conforming his behavior to JDF rules. Student would engage in outbursts when frustrated. The plan was to have Student out of his room as much as possible and to use five to 10 minute time outs for disciplining him. Student met with his psychiatrist at least weekly, his psychologist at least weekly and with his therapist daily. Student's psychologist conducted supportive psychotherapy while his therapist conducted behavioral therapy.

29. At school, Student would attend class but mainly put his head on his desk and refused to do his school work. The teaching staff noted that Student was behind academically including reading and writing. He had a hard time coping and communicating his wants. At times, he would have an angry outburst when work was too difficult. It was also noted that he held his pencil incorrectly, which resulted in one of his teachers requesting that Student undergo an assessment in occupation therapy (OT).

Triennial Psycho-Educational Assessment by CVUSD

30. On December 2, 2012, CVUSD forwarded to Mother an assessment plan for a triennial assessment. Mother consented to the plan on December 5, 2012. From January 19, 2012 through January 31, 2012, Robert Metcalf, Ph.D., a school psychologist for COE, assisted by Kurt Christopher, a special education teacher who was one of Student's teachers at Sarah Anthony, conducted the three year re-evaluation. At the time of the assessment, Student was 10 years, 11 months old. Dr. Metcalf conducted a records review, classroom observations at the JDF, and interviews in addition to administering standardized tests. The standardized tests administered were the Woodcock-Johnson III Tests of Academic Achievement (W-J III), Beery-Buktenica Development Test of Visual-Motor Integration (VMI), and Draw-a-Person. Student refused to complete the Kaufman Brief Intelligence Test (KBI) and the Wide Range Assessment of Memory and Learning, Second Edition (WRAML-2) which is used to evaluate memory functioning.

31. Dr. Metcalf noted that initially Student was cooperative, motivated, and appropriately behaved. Student's initial reaction was reluctance when asked to complete a task. Student would refuse to complete tasks which were challenging. As the testing continued, Student exhibited increased inattention, boredom and fatigue. Student stated that he was afraid of being embarrassed. Because of these factors, Dr. Metcalf stated that the "[r]esults of the current assessment are seen as limited, but valid." The assessor noted that at the time of the assessment, Student was taking Abilify, Seroquel XR, Intuniv, and Lamical.

32. On the WJ-III, Student scored within the average range, with standard scores between 80 and 120, in letter-word identification (standard score of 98), spelling (97), writing sample (100), broad reading (83), and academic skills (94). He scored in the below average range in passage comprehension (78), calculation (79), reading fluency (76), math fluency (67), and broad math (75).

33. Student was unable to complete the verbal knowledge subtest of the KBI because he quit when the words began to be more difficult to him. Dr. Metcalf termed his performance as "indicative of a low average level of verbal knowledge." On the Draw-a-Person, Student was unable to sign his name in cursive. His drawing "suggests low self-efficacy and esteem." Student scored below average on the VMI with a standard score of 83 which placed him in the 13th percentile.

34. Student was observed on his first day of class at his desk with his head down most of the time. On ensuing days, Student interacted with his peers appropriately while at his desk. Student's teacher reported that he failed to do anything in class, and that he shuts down in the afternoon. It was noted that Student's manners were good and what writing he did was meticulous.

35. Dr. Metcalf noted that Student is "emotionally and socially immature," frequently has tantrums or whines to avoid tasks or manipulate situations, quick to anger, and exhibits inappropriate, sometimes aggressive, behavior. The assessor concluded that Student

“manifests multiple signs of emotional distress, including a sense of inadequacy, social stress, and school maladjustment.” Student’s ability to learn is adversely affected by depression and inappropriate types of behavior or feelings. Dr. Metcalf concluded that Student’s needs cannot be fully met in a regular classroom. He recommended that the IEP team consider “re-designating [Student] with a primary disability of Other Health Impaired (OHI), as it appears his emotional, behavior and cognitive problems stem from this condition [FAS].” Dr. Metcalf found that Student would also qualify under the category of ED as a secondary disability. Dr. Metcalf recommended that a classroom incentive program be established to address Student’s low motivation and achievement plus DIS counseling be made available on an “as needed” basis in light of Student receiving extensive mental health services from the STAT team.

February 15, 2012 IEP Meeting

36. On February 15, 2012, Student’s IEP team met. The team was comprised of Mother; Samantha Meadows, a paralegal with the Public Defender’s Office (PD); Jo Pastore, the supervising attorney for the Juvenile Delinquency Branch of the PD; Dr. Metcalf; Mike Thompson, a special education coordinator for COE who was the administrative designee; and Student’s three teachers- Alan Young, general education teacher; Greta Hulley, special education teacher; and Mr. Christopher. Dr. Metcalf reviewed his assessment. The team set Student’s PLP. In academic skills, Student’s PLP was that he was (1) working on the fifth grade level of the California state standards; (2) working on paragraph writing using a topic sentence, three supportive sentences and a conclusion; (3) studying western expansion in social studies; (4) learning tectonics and volcanoes in science; and (5) learning math concepts and doing addition and subtraction of one and two digit problems without regrouping and word problems. It was noted that Student “continues to struggle with math concepts,” and his behavior and work level “has shown improvement over the past two weeks.” As to gross/fine motor development, the PLP noted that Student’s motor skills were within normal limits but requested an OT assessment as Student received OT services on a consulting basis while at CVUSD.⁷ Student’s expressive and receptive communication skills were “within normal limits.” In the area of social emotional/behavioral, Student’s PLP stated:

[Student] is creative and enjoys the company of his peers. He is socially and emotionally immature. He will throw tantrums and whine to avoid tasks and manipulate. He has difficulty completing tasks, is quick to anger, exhibits inappropriate behaviors, is a worrier and experiences anxiety and depression. Motivation has increased, however, it is sporadic and he continues to need regular prompting. The IEP has agreed to write a Behavior Support Plan for [Student] using teacher’s and mother’s suggestions.”

37. The IEP team adopted four goals. Goal one was in the area of Comprehension. The baseline was Student’s standardized score of 78 on the WJ-III. The

⁷ Student had been receiving OT services to address sensory motor issues.

annual goal was when Student is given a fifth grade text, he would read the information and be able to discern the main ideas and concepts, draw inferences and conclusions, sequence events using textual evidence and prior knowledge with 85 percent accuracy in four out of five trials. Goal two was in the area of writing mechanics. Student's baseline was that he could write a paragraph using a graphic organizer with 60 percent accuracy. Student's annual goal was to construct a multi-paragraph composition with topic sentence, three supporting sentences using transitional expressions, and a concluding paragraph that summarizes important ideas with 85 percent accuracy in four out of five trials. The third goal was in the area of calculation with a baseline of adding and subtracting single and double digit terms. Student's annual goal was to compute correct answers when given 15 simple multiplication problems of single-digit numbers with 85 percent accuracy in four out of five trials. Goal four was in the area of coping skills with a baseline listed as "40%." Student's goal was "when faced with a stressful situation [Student] will use appropriate coping skills, (artistic expression, journaling, self-timeouts, breathing techniques), to minimize outbursts and regain focus on his classroom assignments with 70% accuracy, in each classroom period, as measured by teacher maintained records."

38. The IEP team also adopted accommodations to permit Student additional time to complete assignments, to provide preferential seating, and to use a calculator for math assignments and tests. The team listed placement for 240 minutes per day in specialized academic group instruction accompanied by one session of individual counseling for 30 minutes per week. The amount of counseling services was based upon Student also receiving services from the STAT team. As to Dr. Metcalf's recommendation for Student to be eligible for special education under OHI with a secondary disability of ED, the team opted to make Student's primary eligibility as ED and OHI as secondary. Mother consented to the IEP.

The OT Assessment

39. In March 2012, Student was given an OT assessment by Lida Ramos, OTR/L,⁸ which culminated in a written report dated March 27, 2012. Ms. Ramos received a B.S. from San Jose State University in 1999. She has worked as a OT therapist at Sharp Grossmont Hospital from January 2000 to August 2002, where she worked with adults who had been diagnosed with psychological disorders. From March 2002 to April 2006, Ms. Ramos was an OT therapist with the County of San Diego dealing with OT services to children and young adults up to 21 years of age. Since May 2006, she has been employed by COE as an OT therapist. Student was referred to her because of his triennial evaluation and due to his delays in fine motor and sensory motor skills.

40. Ms. Ramos reviewed Student's records, conducted clinical and classroom observations, interviewed Student's teacher, and administered four standardized tests-Quick

⁸ The "OTR" designation refers to national certification by the National Board for Certification in Occupation Therapy. The "L" shows that Ms. Ramos has received an OT license with the state of California.

Neurological Screening Test II (QNST), Sensory Profile, Bruininks-Oseretsky Test of Motor Proficiency, Second Edition (BOT-2), and the World Sentence Copying Test.

41. The QNST consists of 15 observable tasks to identify a student's maturity of motor development, skill in controlling large and small muscles, motor planning and sequencing, sense of rate and rhythm, spatial organization, visual and auditory perceptual skills, balance and cerebellar-vestibular function and attention disorders. Scores under 26 are considered in the "typical" range, 26 to 50 in the "moderate" range, and scores above 50 are "significant difference" for underlying neurological immaturities and having a potential impact on functioning in the educational setting. Student's overall score was 72. Student scored in the typical range in only two areas-distinguishing right from left verbally and asymmetry while skipping.

42. The BOT-2 standard scores of below 30 are in the "well below average" range while scores of 31-40 are "below average," 41-59 are "average," 60-69 are "above average," with 70 and above as "well-above average." Student scored well below average in fine motor control and manual coordination with scores of 29 and 39 respectively. Ms. Ramos observed that Student's hand did not appear to have developed the curvatures to complete fine motor tasks utilizing the smaller muscles of his hands.

43. In the Word Sentence Copying Test, Student was to copy a 110 word paragraph. Student wrote at a rate of 15 letters per minute which is below the second grade level. Results were consistent with written class assignments.

44. Sensory processing involves organizing and making sense of different kinds of sensation entering the brain at the same time. Sensory processing underlies the development of all motor and social skills as well as the ability to learn and perform complex adaptive behaviors. The Sensory Profile consists of questionnaires describing a student's responses to various sensory experiences. Mother completed the caregiver questionnaire, while Mr. Young completed the school questionnaire. In regulation skills, both were concerned with Student's tendency to be distracted. Visually, Student tended to find ways out of engaging in tasks involving paper and pencil. Student also tended to miss written or verbal instructions. He had difficulty adjusting body movements with his vision occluded, appeared unsteady in producing wide steps and had other proprioceptive and kinesthetic difficulties which lead to fidgeting while sitting. Student also was reported to seek all kinds of movement like rocking in his chair. Student also had difficulty performing rhythmic patterns with return motor output and oral sounds. He missed oral directions when a lot of noise was present. Student looked clumsy when walking and was unable to stand on one leg for a prolonged period of time.

45. Ms. Ramos recommended that Student would benefit from OT to improve his handwriting skills and to provide classroom strategies permitting to him to be more attentive. She recommended preferential seating, a graphic organizer with an outline of notes so he can read ahead of teacher instruction, allowing Student to write on every other line using single line paper to decrease visual distractibility, photocopying handouts and worksheets on light

blue or light green paper to lessen distractibility, allowing Student to practice his typing skills, provide small breaks, providing a fidget box, breaking down activities into smaller components, and working on finding the proper technique or modality to best fit his writing grasp.

Behavior Support Plan

46. On March 1, 2012, a BSP was implemented. The targeted behaviors were Student's "shutting down, refusing to do work, whining, tantrums, pouting, putting head down." The need for behavior support was listed as "serious." The predictors listed were when Student feels the work is difficult and he has no other choice to avoid it. Changes suggested were seating Student close to the teacher, providing frequent breaks, chunking of work into small/short segments, verbal praise, and strategic seating with peers. Student's goals were to complete 75 percent of assigned classroom activities and decrease shut downs to no more than 25 percent.

April 12, 2012 IEP Addendum Meeting

47. On April 12, 2012, an addendum IEP meeting was held to review the Ramos assessment and to determine if OT services were required to meet Student's unique needs. Attending the meeting were Mother, Mr. Young, Ms. Hulley, Ms. Ramos, and Mr. Christopher, who also acted as the administrative designee. Ms. Ramos presented her report. The team agreed to add OT services to the February 15, 2012 IEP including two 45 minute individual OT therapy sessions per month and one 30 minute consultation between the OT therapist and teachers per month. The IEP team failed to adopt OT related PLP, baselines and measurable annual goals. Mother consented to the addition of OT services.

The Educationally Related Mental Health Assessment

48. Mother requested CVUSD conduct a mental health AB3632 assessment to determine whether Student required an educational placement at a RTC. CVUSD referred the AB3632 assessment to the Behavioral Health Division (BHD) of the Health and Human Services Agency (HHSA) of San Diego County.⁹ The assessment was conducted by Tamara Peddie-Musser. Ms. Peddie-Musser has a B.A. in behavioral sciences and a M.A. in counseling psychology. She possesses a state license as a marriage and family therapist. From 1990 through 1993, she was a program therapist at New Alternatives of Newport

⁹ An AB 3632 referral is for county mental health services under Government Codes 7570-7588, which delineates interagency responsibility for providing special education and related services to disabled students. AB3632 was the Assembly bill which set up the interagency responsibilities. On October 8, 2011, the Governor at the time vetoed funding for such services. The Governor's veto was upheld in *California School Boards Association v. Brown* (2011) 192 Cal. App. 4th 1507. County mental health agencies ceased providing such services on or about June 1, 2012. As of June 1, 2012, mental services as part of special education are the responsibility of the local education agency (LEA).

Beach where she worked with children from four years old to teenaged. Since 1993, she has been a licensed mental health clinician dealing with mental health services for children and adolescents who are in special education including conducting assessments for educationally related mental health services (ERMHS). She is currently the residential health case manager for COE which requires her to find RTC placements and monitor those students placed in an RTC.

49. Ms. Peddie-Musser, in her written report dated June 6, 2012, stated, “The purpose of this assessment is to determine if [Student] is in need of mental health services primarily to assist him in benefitting from his special education program and if so, the least restrictive and most appropriate level of care will be recommended.” In performing her assessment, the assessor conducted clinical interviews with Mother; Student; Dr. Platt; CVUSD program specialist Christine Egasani; Ms. DeGano; Student’s resource teacher at CVUSD (Jessica Smith); and three previous therapists who had provided services to Student. Additionally, Ms. Peddie-Musser interviewed Lea Zweig, Student’s therapist at JDF; JDF director Craig Stover and JDF Supervisor Weatherton. She reviewed records from CVUSD, Dr. Metcalf’s report; a discharge report from Rady Children’s Hospital dated June 26, 2008; plus records from Student’s three previous therapists. On May 17, 2012, Ms. Peddie-Musser observed Student in his class setting.

50. Ms. Peddie-Musser reviewed Student’s developmental and family history, educational history, home functioning, and treatment history. Of significance in the educational history, the assessor noted that Ms. DeGano reported that towards the end of 2011, Student engaged in more frequent emotional outbursts and appeared more anxious. Student refused to attend school on January 9, 2012, the first day after a three week Winter break. Student’s last therapist, Sam Bruno, reported that Student’s “behavior would improve and stabilize then after a period of time it would regress.” Student did not attend treatment for a few weeks in December and never returned. Dr. Jensen provided psychiatric services to Student starting on November 11, 2011. Dr. Jensen described Student as having “excessive anxiety, poor impulse control and neurological issues.” Dr. Jensen had diagnosed Student with Severe Generalized Anxiety Disorder which may prove to be Bipolar Disorder. Dr. Jensen described Student as aggressive and assaultive towards Mother but not to others. Dr. Jensen opined that Student was “in need of a residential program due to behavior in the home.”

51. Mother reported to Ms. Peddie-Musser that Student started a new medication, Anafranil, approximately one month prior to the incident. For the first month, Student’s “anger was gone.” After the first month, Student became more angry than normal and had rage outbursts, punched Mother, and cried excessively. One week prior to the incident, he did major damage to Mother’s car by kicking the door and fender as well as damage to the house.

52. The assessor reported on Student’s functioning at JDF. During the first month, Student was placed on “Safety Watch” as he had outbursts where he tore up his room and had feelings of hopelessness. He also made threats to harm himself and threatened staff. He

had nocturnal enuresis and had trouble sleeping. It was reported that Student's "behavior fluctuates but he seems to be getting better." Student's counseling was then reduced from daily to three times weekly. Ms. Zweig reported that Student responded to nurturance and consistency. She noted Student requires a lot of one-to-one attention. She recommended that Student continue individual therapy focusing on social skills and learning to express emotions. Ms. Zweig opined that Student required a residential program.

53. Ms. Peddie-Musser interviewed Ms. Hulley who reported that Student was not doing well in school. She reported that Student was not physically violent in school but he would bang his head on the desk when frustrated and make comments under his breath. Student was reported to do "ok" in the morning classes but have issues in the afternoon classes. When Student was doing well, he would follow directions and be cooperative. He spent about 30-40 percent of the time on non-preferred tasks. Student struggled with math and writing. The physical task of writing was difficult for him also. When a task was difficult, Student would "shut down" and ask to go to his room. Ms. Hulley believed that Student was in need of "a small, very highly structured and supervised educational setting." Ms. Peddie-Musser also interviewed Student's JDF therapist, Lea Zweig. Ms. Zweig observed and met with Student on a daily basis. She reported that when he first arrived, Student had difficulty staying in school. As of June 2012, Student was doing better. Ms. Zweig also characterized Student's behavior as "fluctuates but getting better," and that Student had responded well to "nurturance and consistently." Ms. Zweig felt that Student required "a lot of one to one attention and he is in need of residential program."

54. The assessor and Dr. Laura Viengles, a CMH psychiatrist, observed Student in class. During the class, the dayroom floor was being waxed, which distracted the entire class. Student appeared to fidget and received help during a task which was difficult for him. He was also seen conversing with a peer and engaged in laughter with him.

55. Student refused to be interviewed following the classroom observation. He was interviewed at a later date. Student was distracted by persons walking by the interview room. He would wave at those who passed by. Student did not make much eye contact with the assessor and appeared to have difficulty responding to open ended questions. Student said he enjoyed playing with his friends but that there were some kids who did not like him. He reported sleeping well but also having nightmares. Student did apologize for his poor behavior during the first attempted interview.

56. Ms. Peddie-Musser consulted with her supervisor, Francis Edwards, L.S.W.; Laura Colligan, M.F.T.; and Dr. Laura Vlegal, staff psychiatrist. All were in accord with Ms. Peddie-Musser's conclusion. She also spoke to Jeffrey K. Rowe, M.D., the supervising psychiatrist for children's mental health services of BHD. At the time, Dr. Rowe was in the process of completing a competency evaluation on Student for the Juvenile Court. Dr. Rowe, according to Ms. Peddie-Musser, was surprised that an ERMHS evaluation was being conducted.

57. Ms. Peddie-Musser summarized that Student, in the school setting, “had issues in the area of task completion and difficulties with emotional and behavioral regulation.” Student’s struggles with academics, impulse control, anger outbursts and poor frustration tolerance have continued at JDF. The assessor concluded that “Student does have mental health issues that impact his ability to benefit from his education” as “evidenced by his struggling with mood and behavior regulation issues at school.” As to his time at JDF, the assessor noted that since his arrival, Student continued to have frequent mood irritability, aggressive verbal outbursts, and impulse control issues. She also concluded that Student did pose a “safety risk in the community” in light of the incident. The assessor then commented:

It is important for [Student] to have treatment that will provide opportunities for him to learn strategies to manage his impulses, emotions, and behaviors. Mental health treatment will not ameliorate his underlying neuro-developmental issues. Previous treatment providers have expressed concern as to [Student’s] ability to benefit from mental health services due to neuro-developmental issues related to exposure to drugs/alcohol in-utero. These issues appear to impact his attention, cognition and impulse/behavioral control. This makes it difficult for him to retain and make behavior changes. Historically, there has been a pattern where he will progress in regard to behavior management and then regress quite quickly.

[Student] does need some type of mandated, highly structured and supervised residential treatment program. Yet when looking at the bigger picture, his needs are “beyond the scope” of the ERMHS program. The reason for this is that ERMHS is not a mandated program. He appears to need a program where he can be closely supervised by the Juvenile Justice System and treatment based on issues beyond his education.

It appears to be in the best interest of [Student] if the juvenile justice system were to take the lead in providing appropriate treatment/placement to address his needs in light of safety concerns, as this would provide the best level of supervision and protection of the child and community.

Ms. Peddie-Musser then noted that ERMHS are “voluntary” and not “mandated,” so that Student could leave a RTC placement.¹⁰ Additionally, she noted that placement decisions and monitoring are the province of the IEP team pursuant to education progress. She concluded: “The concern here is that ERMHS are not included to be utilized to address the more global issue of ‘public safety’ and ERMHS does not provide intensive monitoring or have any legal jurisdiction like the Juvenile Justice System would.” During her testimony, Ms. Peddie-Musser stated that Student required RTC placement although not for educational

¹⁰ Ms. Peddie-Musser noted that placement by the juvenile justice system would require that Student stay in the placement. Under special education placement, a parent can withdraw from special education or refuse consent to keeping Student in the RTC. Ms. Peddie-Musser disregards that the Juvenile Court can place mandatory restrictions on any placement order even when the placement is educationally made.

reasons. She did admit that it is important for Student to receive treatment that will provide opportunities for him to learn strategies to manage his mood and arousal levels which impact his attention, cognition, and behavioral control.

June 5, 2012 Observation

58. On the morning of June 5, 2012, Brian Russell, a school psychologist and program specialist at CVUSD, and Lisa Uribe, a CVUSD resource specialist, conducted a school observation at the JDF. Mr. Russell has been a school psychologist for 12 years and directs CVUSD's kindergarten through eighth grade day treatment program. Student's class consisted seven students aged 11 to 14, with Student the youngest. Prior to class commencing, Student was observed appropriately interacting with peers while playing a board game. During class, Student was in constant motion by rocking, fidgeting, and shifting. He often engaged in vocalizations by yawning, humming or singing. Student appeared "highly impulsive" and inattentive with the surrounding environment. The class was given an assignment to complete a writing web by finding three to four examples in a book followed by drawing pictures representing the written work. Student required frequent prompting by classroom staff to initiate and complete the assignment. Student was the last pupil to complete the assignment even with one-to-one assistance. The observers noted that during the one-to-one assistance, Student would attempt to engage the staff member in conversations unrelated to the task in an attempt to avoid the task. After completion of the assignment, Student was unable to articulate the theme of his work although he described his picture. The observers also noted that Student displayed poor penmanship and fine motor skills. During physical education, Student behaved appropriately and put forth good effort.

June 13, 2012 IEP Meeting

59. The IEP reconvened to discuss the ERMHS report and OT services. The IEP attendees were Mother, Student, Ms. Meadows, Mr. Thompson, Mr. Christopher, Dr. Platt, Ms. Ramos, Mr. Russell, Ms. Uribe, Dr. Colligan, Katherine Naples, a special education teacher; Ms. Peddie-Musser, and Sarah Sutherland, counsel for CVUSD and COE. Mr. Christopher reported to the team of Student's current status educationally. Mr. Christopher stated that Student has had "some success" but continues to struggle. The team reviewed Student's current psychotropic medications and the individual therapy services provided by the STAT team. Ms. Peddie-Musser presented her report and findings. Following the presentation of the ERMHS report, Ms. Meadows requested that the team reconvene after Student's attorney and experts were consulted. The team agreed.

60. Ms. Ramos reported that Student was not accessing the OT individual sessions as he refused to attend. Ms. Ramos recommended that OT services be changed to consultation only. The IEP team agreed. Mother consented to the change in OT services but not to the ERMHS report and recommendation.

August 3, 2012, August 23, 2012 and September 10, 2012 IEP Meetings

61. On August 3, 2012, the IEP met and heard a report from Mr. Christopher on Student's progress on meeting his annual goals. Ms. Meadows informed the team that the Juvenile Court will probably find Student not competent at a scheduled hearing on August 21, 2012 based on four expert reports. The team agreed to a suggestion from Ms. Meadows to reconvene on August 23, 2012. On August 21, 2012, Ms. Gaston emailed Ms. Sutherland and reported the juvenile Court had found Student not competent to stand trial.

62. On August 23, 2012, the IEP team reconvened. The team was informed by Ms. Meadows that the Juvenile Court found Student incompetent and he would be released from JDF. She also reported that the court had directed Probation to send out packets to potential RTC placements as a "courtesy." Mr. Nelson, Ms. Edwards and Ms. Meadows stated that the ERMHS report demonstrated that Student required RTC placement for "educational purposes." Ms. Sutherland responded that the issue that drives Student's placement is his educational goals and not anything else. Ms. Meadows and Mr. Nelson stated that the RTC placement would be reviewed by the court in one year to determine if competency had been restored. Ms. Sutherland asked whether the only place that Student can be released to by the Juvenile Court is an RTC, which Dr. Edwards replied, "Yes." Mr. Nelson also stated that since the court determined that Probation is not responsible for placement, the responsibility of RTC placement falls on CVUSD and COE. Ms. Meadows agreed to forward to Dr. Platt copies of the competency evaluation reports for CVUSD and COE to review.¹¹ CVUSD agreed to coordinate with the Public Defender's office to recommend potential RTC placements to the Probation Department. It was agreed to reconvene on September 10, 2012.

63. On September 10, 2012, the IEP team reconvened. Mother was absent but was represented by Attorney Thomas Nelson. Mr. Christopher reviewed Student's progress on his IEP annual goals. Student's progress was described as "slow, but consistent in all areas." Mr. Christopher stated that Student was reluctant to receive DIS counseling service as Student was "bombarded with various people talking to him." It was pointed out that Student receives therapy from the STAT team also. Mr. Nelson requested that an Independent Education Evaluation (IEE) be paid for by COE since Mother disagreed with the Peddie-Musser ERMHS report.¹² Ms. Sutherland stated that she would respond at a later time to the IEE funding request, which later was approved. Ms. Edwards and Ms. Meadows voiced concerns that Student's counseling services were not being provided at consistent time of day. It was agreed that the team would reconvene following receipt of the IEE report.

¹¹ Ms. Meadows never provided the competency reports to the IEP team even after numerous requests by COE, through its counsel..

¹² Mr. Nelson suggested that Dr. Mitchell Pearlman conduct the IEE. If he was not available, Mr. Nelson would contact another psychologist.

Juvenile Court finds Student Incompetent to Stand Trial

64. Student was assessed by four assessors as to whether he was competent to stand trial. On August 21, 2012, the Juvenile Court judge ruled that Student was not competent to stand trial. The court then scheduled a hearing to determine placement for Student. To date, the Juvenile Court has deferred ruling on placement.

September 20, 2012 Progress Report

65. On September 20, 2012, Mr. Young, Ms. Hulley, and Mr. Christopher jointly issued a “Student Progress Report” for Student. The report stated that Student was easily distracted in class and required one-to-one assistance to stay on task and complete assignments. Student “remains in class for the entire day 2 out of 5 days a week on average.”¹³ In science/social studies, Student showed “very little interest” although he completes assignments with graphic organizers with 60 percent accuracy. In physical education, Student participated and enjoyed all activities about 80 to 90 percent of the time. In language arts, Student could read at grade level; but it was difficult to determine comprehension due to Student’s lack of participation. He scored 80 to 90 percent on vocabulary tests when read to him. He found “40-50% of the errors in grammar, editing/proof reading exercises, and a few prompts from the teacher.” In math, Student was able to add numbers, knew greater than and less than symbols as well as using them. Student was commencing work on multiplication and subtracting.

The IEE by Dr. Kelin

66. The IEE was completed by Robert Kelin, Psy.D. who possesses a state psychology license and is a certified school psychologist. Dr. Kelin has a B.A. in psychology, an M.A. in educational psychology, and his Psy.D. in professional psychology. From 1978 through 1982, he was a psychologist at the Lakeland School for Emotionally Disturbed Adolescents. He opened a private practice in 1980, which he continues to maintain. He was a school psychologist from 1983 through 1984 for the Poway and San Diego districts. Since February 1984, Dr. Kelin has worked for the Health and Human Services Agency of San Diego County in the area of juvenile forensic services. Dr. Kelin was originally paid by Probation to conduct the assessment.¹⁴

67. Dr. Kelin conducted his evaluation on September 27 and 28, and October 11, 2012. He produced a written report dated October 11, 2012. He reviewed Student’s educational records from COE and CVUSD; the Metcalf evaluation report; the Peddie-Musser ERMHS report; the Brewer 2009 triennial assessment; a mental competency

¹³ The IEP provides accommodation for Student to end his school day early because of fatigue.

¹⁴ Probation was eventually reimbursed by the COE.

evaluation by Rahn Minagawa, Ph.D.; and the competency evaluation by Dr. Rowe.¹⁵ He also conducted interviews with Student, Mother, Mr. Christopher, Ms. Hulley, and Student's attorney, Deputy Public Defender Marian Gaston. Dr. Kelin administered standardized tests; Kaufman Brief Intelligence Test, Second Edition (KBI-2); Wide Range Achievement Test, Fourth Edition (WRAT-4); House-Tree-Person Kinetic Family Drawing; Thematic Apperception Test (TAT); Rohrschach Psychodiagnostic Technique Test (Rohrschach).

68. Dr. Kelin related that Student's current teachers, Ms. Hulley and Mr. Christopher, stated that Student often requires redirection and has a difficult time maintaining himself at his desk. Student would get extremely angry when given a challenging task. When angry, Student would throw paper and pencils, speak under his breath, and use inappropriate language. Ms. Hulley reportedly stated that when she tried to encourage him, matters would worsen. Mr. Christopher described Student as an "emotionally fragile" child who shut down at times. He also described Student as having peer issues resulting in verbal arguments and disruptions of class. Student would return to his room when angered and "tear paper, knock over things and yell."

69. Student's teachers, Mr. Christopher and Ms. Hulley both testified that the Dr. Kelin's report incorrectly reported what each stated. Both know Dr. Kelin as he frequently is in the facility. Mr. Christopher had no recollection of being interviewed by Dr. Kelin. He denied ever referring to Student as "emotionally fragile" nor having peer issues. In fact, Mr. Christopher noted that Student got along with most of the other boys on the unit. Although Student would shut down and refuse to do work when he first arrived, Student's behavior had dramatically changed. Mr. Christopher noted that the BSP had been successful in that Student attends the full morning classes with no issues and had learned coping skills. Mr. Christopher testified that some of the general education students in his class act up more than Student. Ms. Hulley admitted that Student initially had a difficult time adjusting. She testified that Dr. Kelin only reported what she had stated about Student when he first arrived at the JDF. As of October 2012, Ms. Hulley testified that Student, at the time of Dr. Kelin's assessment, was no longer engaging in behaviors compared to when he arrived 10 months earlier. She also pointed out that Dr. Kelin was incorrect in stating that she works with Student only one hour per day as she taught him for two hours daily. She also categorically denied ever stating Student became "extremely angry in class," as it was not correct.¹⁶ Ms. Hulley differed with Dr. Kelin's rendition of Student's earlier behaviors by testifying that Student did not bang his hand on the desk, throw items off the desk (at times he would push work off the desk), only rarely spoke under his breath, and was then able to maintain sitting at his desk as opposed to fidgeting as he had done upon arrival. Ms. Hulley and Mr. Christopher both stated that Student had never been violent in class nor had he issued any threats to staff. Mr. Young, Student's general education teacher, noted that Student's temper

¹⁵ The Minagawa and Rowe reports were for Juvenile Court purposes. These reports were not shared with the IEP team.

¹⁶ She stated that she told Dr. Kelin that she had observed Student become "extremely angry" in his room on occasion. .

tantrums while in his room usually occurred after he had been taken from class and escorted to Main Control where he would meet with his counselor, his attorneys, or assessors. Mr. Young felt that Student was not a behavior problem and had made slow progress except for math, where he made a lot of progress. As to peer relations, Mr. Young related that Student no longer thinks that other students are talking about him. Mr. Young disagreed with Dr. Kelin's conclusions that Student had a hard time maintaining himself at his desk and that he displays extreme anger in class.

70. Student's cooperation in the assessment was intermittent. Initially, Student refused to cooperate; but after coaxing by Probation Officer Naomi Eddy, Student agreed to answer 30 questions. After 15 to 20 minutes, Student would refuse to cooperate. Prior to the second session, Mother spoke to Student about his cooperation. Student then was more cooperative completing one hour of testing. He became frustrated when faced with questions beyond his ability. Based on his observation, Dr. Kelin believed that Student was oriented in all spheres, and does not believe he is psychotic, or "currently actively homicidal or suicidal."

71. Dr. Kelin opted to not report full standardized testing results in his report. Student scored a composite IQ standard score of 63 which placed him in the first percentile. He received a 73 on the verbal subtest and 63 on non-verbal. This places Student in the mentally retarded range, which Dr. Kelin believes "is not an accurate depiction of his intellectual abilities." Dr. Kelin cites that Student's score on the WRAT-4 was a 96 on reading recognition, which clearly indicates that Student is not mentally retarded. He did score 65 in the math subtest of the WRAT-4.

72. On the Thematic Apperception Test, Student related a story which reflected 'strong feelings of vulnerability,' which may lead to Student be over-reactive as he lacks emotional controls to deal with his feelings. Dr. Kelin interpreted the Rorschach as giving the same impressions. Dr. Kelin opined that the Rorschach also indicated difficulty in relationships. Dr. Kelin also observed that Student appeared frustrated during the assessment. He concluded: "Based on this information and based on his behavior that resulted in his detention in Juvenile Hall, the evaluator does not believe that he could be educated in a regular school setting, even a more restrictive setting, such as a classroom for emotionally disturbed students. He is easily frustrated and becomes explosive, which presents a danger to both school mates and family members."

73. Dr. Kelin diagnosed Student under Axis I as intermittent explosive disorder, mathematics disorder; relational problems, not otherwise specified; and ruled out bipolar disorder and anxiety disorder. Under Axis IV, Student was diagnosed with fetal alcohol syndrome, being adopted, possible skull fracture when very young, and legal problems. In summary, Dr. Kelin stated:

[Student] is an individual who previously tested in the Average range on intelligence testing. He showed some average potential on academic testing, but also demonstrated a severe weakness in math. He had been receiving

resource specialist services for a number of years, but his problem behavior has escalated and he was placed in a special day class for emotionally disturbed students in 2011. He has a very limited frustration tolerance and regardless of the outcome of his behavior, he seems unable to control himself. Despite extensive therapy and medication, he still presents as beyond the control of others.

Dr. Kelin recommended that residential mental health services are required to provide Student with a FAPE. Student “needs a very strict, supervised environment, therapy, and he needs to continue on his medication.” Dr. Kelin observed that “[i]t is not thought that he could be educated at a lower level of intervention without setting up a situation that is dangerous to others” including classmates and “the home environment, where he has been assaultive to his mother.”

October 30, 2012 IEP Meeting

74. On October 24, 2012, Attorney Sutherland, representing both COE and CVUSD, wrote to Deputy Public Defender Gaston requesting the competency assessment reports. Ms. Sutherland also stated that the IEP team “had not been provided information that would suggest, much less show, that a residential treatment center is the least restrictive environment in which Student can receive an educational benefit.” She also pointed out “[h]e appears to need a program where he can be closely supervised by the Juvenile Justice System and treatment based on *issues beyond his education*.” (Emphasis in original.) COE never received the reports.

75. The IEP reconvened on October 30, 2012. Mother, Ms. Meadows, Mr. Nelson, Ashok Pathi, a law clerk to Mr. Nelson, and Dr. Edwards attended on behalf of Student and his parent. Among those attending for COE were an administrative designee, Carolyn Nunes, Senior Director of Special Education for the COE, Dr. Platt; Dr. Colligan, Mr. Russell, Mr. Thompson, Ms. Sutherland, and Student’s three teachers—Mr. Young, Mr. Christopher, and Ms. Hulley. Dr. Kelin was also in attendance to present his IEE to the team. The team reviewed Student’s progress on his annual goals. On his comprehension goal, the team was informed that Student’s MAP score¹⁷ indicated Student was reading at a fifth grade equivalence. Additionally, Student showed knowledge of reading material verbally and would read and participate in class “some days.” Student continued to be unwilling to do written work on his own. As to the mechanics goal, Student would complete a close sentence paragraph frame with individual words and phrases. Again, staff observed that Student would not initiate paragraph writing on his own. On his calculations goal, Student’s MAP score showed him at the third grade level. In class, Student was learning multiplication facts plus mean, median, and mode. He had memorized “1-3 facts” and could solve problems up to eleven. On his coping skills goal, it was reported that Student “has

¹⁷ MAP refers to the Measures of Academic Progress standardized test by the Northwest Evaluation Association. The MAP is designed to measure a child’s academic level.

shown improvement with coping skills...He will draw pictures, ask to get water and ask for a self-timeout when stressed or upset.”

76. Dr. Kelin presented his IEE and recommendations for placement “at a high level in a local San Diego county program to start with.” Dr. Kelin’s recommendation for RTC was based on Student’s “inability to control himself,” the “potential for him to go off,” and his being a danger to the community. Dr. Kelin declined to give specific as to the type of RTC but did say he would consider a locked facility, which would necessitate an out-of-state placement. Dr. Kelin said that “there is a safety issue but there is also the safety issue as it relates to school.” He admitted that the safety issue was his main concern. Mother stated that she had asked the court to place Student in an RTC as “I don’t believe he’s safe to come home,” and that it was her decision rather than the court, or “otherwise the court would be paying for it.” Mother further observed that Student is not assaultive.” Dr. Edwards recommended that the IEP team place Student in a RTC which was not a locked facility so that he could be located close to Mother. After a short break, Dr. Platt announced that the team upheld the recommendation of Ms. Peddie-Musser’s ERMHS report as Student was making progress on his annual goals and the recommendation for a RTC was driven by public safety concerns. Dr. Platt concluded, “And we believe that the court needs to make a placement in regards to the safety issues to the community.” The COE did agree to reimburse the third party (Probation) for the cost of Dr. Kelin’s report.

77. On October 31, 2012, Mr. Nelson sent a letter to Ms. Sutherland informing her that the Juvenile Court was detaining Student “pending a decision regarding educational placement by the appropriate educational agencies.” He also stated that Student would be released upon such determination. Mr. Nelson referred to Dr. Kelin’s opinion that Student required placement in a RTC as the least restrictive environment to meet his educational needs based upon Student’s long history of school-related problems including refusal to do work, and that he “has engaged in violent behavior towards others, including classmates and threatening teachers.” Mr. Nelson concluded that there was a nexus between Student’s mental health and educational needs in that “[s]chool records confirm he has engaged in ‘explosive behaviors towards staff members and peers.’”

78. On October 31, 2012, Ms. Sutherland emailed Ms. Gaston that Student is making progress on his goals and that the information available to the IEP team “does not indicate such a placement (RTC) is educationally driven, and needed to in order for [Student] to receive FAPE under the IDEA (Individuals with Disabilities Education Act).”

79. On November 1, 2012, Ms. Sutherland sent a letter to both Ms. Gaston and Mr. Nelson. Ms. Sutherland commented that CVUSD and COE “continue to be unclear as to the connection between an educational placement and the (Juvenile) Court’s willingness to release [Student] from detention.” In responding to the assertion by Dr. Kelin that there is a nexus between Student’s mental health and educational needs that requires COE and CVUSD to place him in a RTC, Ms. Sutherland responded that Student’s educational records do not indicate that he had a long history of school-related problems including “violent behavior to others” and “explosive behaviors.” Ms. Sutherland concluded:

Instead, [Student's] need for a restrictive, Court supervised and mandated residential setting is entirely driven by the incident in January, the public safety issues created by that incident, the public safety issues created by that incident, and the evaluations and assessments reviewed by Juvenile Court, but not provided to the SDCOE and CVUSD. Further, [Student's] educational needs are not intertwined with his safety or medical needs as [Student] was attending his neighborhood school and making progress on his goals prior to his detainment in Juvenile Hall, and continues to make progress toward his goals in his current setting.

Testimony of JDF Staff

80. Student's three teachers all agree that he made educational progress since his arrival at JDF. Mr. Young pointed out that Student is easily distracted and requires individual attention to remain on task. Mr. Christopher believes that the BSP has been effective as Student has learned coping skills. Student now voices to staff when he becomes frustrated and seeks to calm himself by asking to get a drink, taking a short walk down the hall, or going to his room. Mr. Young testified that Student is not a behavior problem and is mostly compliant although he does get frustrated at times. Ms. Hulley observed that although Student still engages in task avoidance, especially for writing assignments, he now has volunteered to go the blackboard during grammar lessons and read out loud to the class. If a written assignment seems to frustrate him, Ms. Hulley will permit Student to draw a picture in lieu of the assignment. Both Mr. Young and Ms. Hulley agree that Student is now able to better maintain himself at his desk; although he still requires frequent re-direction to stay on task. Ms. Hulley noted that Student has accomplished "amazing growth" with more consistent behavior in class.¹⁸ The three teachers acknowledge that Student requires a small, highly structured and supervised environment although not necessarily an RTC.

81. Naomi Eddy is a Deputy Probation Officer and has been at JDF since 1998. Ms. Eddy had been assigned to Unit 200 prior to Student's arrival. At arrival to Unit 200, Student had outbursts all day whenever he felt frustrated. It took time for Student to get used to the routine and structure in Unit 200. Although there are still times when Student will refuse to go to class, he is in class longer. As time has passed, Student will take timeouts to calm himself, which usually result in his returning to class within 10 minutes. Ms. Eddy is present during class time three days per week. During the past six months or so, Ms. Eddy has not observed Student shutting down by putting his head on his desk. Ms. Eddy estimated that Student is in a "good mood" 50 to 60 percent of the time and he engages in disruptive behavior 15-20 percent of the time, which is a great improvement since his arrival. Ms. Eddy did state that Student does still have tantrums in his room where he throws items or rips up the room when upset. Mr. Young observed that now these seem to occur after Student had been taken to Main Control to meet with counselors, therapists, his lawyer, or be

¹⁸ Ms. Hulley noticed that this occurred when Student started a new medication, Haldol.

assessed. Many of his class absences occur because Student was escorted to meet with attorneys, therapists, psychologists, psychiatrists, and numerous persons who conducted evaluations of Student for court purposes. After many of these appointments, Student would return to the Unit and tantrum which often included throwing items and tearing up his room.

82. Michael Trammel, M.D. has been a staff psychiatrist on the STAT team at JDF since July 2008. In addition to working at JDF, Dr. Trammel is on staff at Rady Hospital in Oceanside and maintains a private practice in Newport Beach. Dr. Trammel provides psychiatric services to Student mainly comprising medication management. He regularly confers with Dr. Joachim Reimann who provides psychological services for Student. Student has a history of extensive changes in medication in order to control his arousal levels. Dr. Trammel opined that Student's sleepiness could be resulting from the anti-psychotic medications which may be a reason that Student takes himself out of his afternoon class. During their weekly 15 minute meetings, Student discussed how he had done and what may be upsetting him, which allows Dr. Trammel to assess Student's affect and mood. Dr. Reimann engages Student utilizing behavioral therapy which has resulted in helping Student make better decisions and acknowledge the consequences of his actions. Over his time at JDF, Dr. Trammel opined that Student has improved somewhat as demonstrated by fewer outbursts and less severe outbursts when they do occur.¹⁹ Dr. Trammel labeled Student as a potential danger to himself and others if in the community.

February 8, 2013 IEP Meeting

83. On February 8, 2013, the IEP team reconvened for the annual IEP meeting. In attendance were Mother, Dr. Edwards, Ms. Meadows, Mr. Pathi; now an attorney representing Mother and Student, Student, Mr. Christopher, Mr. Young, Ms. Hulley, Ms. Ramos, Mr. Thompson, Ms. Nunes, Mr. Russell; and Amy Koers, attorney for COE and CVUSD. The IEP team noted Student's present levels of performance. Student's coping skills and behavior had "shown significant improvement in the past year," although he continued to struggle in stressful situations. Student's "motivation and task completion skills continues to need improvement." Although he had shown improvement, Student's motivation had been sporadic and depended on the subject matter. Student continued to struggle in stressful situations. To complete assignments, Student still required prompting. It was also noted that "rarely" does Student meet with his school psychologist for his weekly meetings.

84. The team was presented a progress report on Student's February 15, 2012 IEP annual goals.

¹⁹ An example of this occurred on October 31, 2012. Dr. Reimann visited Student on the unit after Student had returned from a court hearing which did not result in a court order permitting Student's release to a RTC. Staff reported that Student, although frustrated, was able to control his extreme acting out behaviors as opposed to similar occasions in the past. Dr. Reimann observed Student engaging in Halloween related activities, calm, and interacting positively with staff and peers.

A. As to goal one (comprehension), Student was reported to have met the goal as Student can read and decode words at grade level (sixth grade), is able to comprehend main ideas using textual evidence, and can express orally this information. The annual goal called for Student to be given a fifth grade book from which he would discern main ideas and concepts, draw inferences and conclusions using textual evidence with 85 percent accuracy on four of five trials. Ms. Hulley testified that Student was reading sixth grade level books. Thus, Student exceeded this goal.

B. On Student's second goal in the area of mechanics, he did not meet this annual goal although he made progress from his previous year baseline. Student's baseline was that he could write a paragraph using a graphic organizer with 60 percent accuracy. The February 15, 2012 goal was Student, with a written prompt, "will construct a multi-paragraph composition with a topic sentence, three supporting ideas using transitional expressions, and a concluding paragraph that summarizes important ideas, with 85% accuracy in four out of five trials." Although Student failed to meet the goal, he "will write a paragraph, using a cloze frame graphic organizer, with 75% accuracy in four out of five trials."

C. Student met his third goal in calculations. Student's baseline was that he could add and subtract single and multi-digit terms. The annual 2012 goal was for Student would compute with 85 percent accuracy in four out of five trials of 15 simple multiplication problems of single-digit by multiple digit numbers. As of the IEP meeting, Student "knows his multiplication facts (1-6) by memory. He can multiply single digit by multi-digit numbers without carrying with 85% accuracy."

D. Student also met his fourth goal in coping skills. This goal required Student to use appropriate coping skills when faced with stressful situations, minimize outbursts and regain focus on his classroom assignments with 70 percent accuracy in each classroom period. As of the IEP meeting, Student used appropriate coping skills 85 percent of the time. To cope during stressful situations, Student utilized talking to an adult, taking timeouts, and/or drawing pictures to refocus on his classwork.

Juvenile Court Procedures for Competency

85. The San Diego County Juvenile Court has adopted a protocol dealing with adjudicating the competency of minors. If there is an issue of competency, the court will order the minor to participate in an evaluation by a court appointed evaluator. The evaluator will assess the minor and prepare a written report. The evaluator is required to reach conclusions in seven areas-including whether the minor has a mental disorder or a developmental disorder or is developmentally immature, can he understand the nature of the proceedings and assist his counsel in the conduct of a defense, whether the minor is a danger to himself or others and whether the minor can benefit from attempts at restoration of competency. If the minor is found incompetent, the proceedings shall be suspended until

competence is restored. During the suspension period, the court may order services which are appropriate to assist the minor in restoring competence. If the minor is deemed to require hospitalization through the mental health system, the minor will be referred to the Emergency Screening Unit or to another Lanterman-Petris-Short (LPS)²⁰ facility for evaluation or for a psychological or psychiatric evaluation which includes the recommendation of treatment options within San Diego County or elsewhere. The court will then receive a restoration plan and conduct a Placement and Treatment hearing. “If it appears that the minor may not regain competence, the court, and the minor’s attorney, the prosecuting attorney, and the Probation department will work to obtain appropriate services for the minor.” (Ex. 38, “Protocol for Competence Evaluations,” by the San Diego County Juvenile Court.)

Testimony of Student’s Experts

86. Student called as expert witnesses Drs. Natalie Novick Brown and Jeffrey K. Rowe. Both had performed evaluations and produced written reports regarding Student’s competency to stand trial. Neither report was ever provided to the IEP team, even after the COE and CVUSD made such a request, nor was either made available for IEP meetings. Thus, the IEP never had the benefit of these, as well as other such evaluations, in making their determination.²¹

Natalie Novick Brown, Ph.D.

87. Dr. Brown is renowned expert on FAS and is the author over approximately 20 articles in peer reviewed publications on the subject of FAS. She has a B.A. in sociology with psychology minor, master of library and information sciences, master in health administration, and Ph.D. in clinical psychology. She did post-doctoral studies in FAS at the University of Washington Fetal Alcohol and Drug Unit in 1995. Dr. Brown is a certified psychologist from the Association of State and Provincial Psychology Boards, a certified sex offense treatment provider from Washington State, and a certified evaluator for the Washington State Department of Corrections Division of Developmental Disabilities. From 1994-1995, Dr. Brown was a psychologist and on the faculty at the University of Washington in the Fetal Alcohol and Drug Unit. From 1994 through 2000, she was in private practice conducting adult and adolescent therapy involving multiple issues including sexual offending, developmental delay and FAS disorders. Since 2005, Dr. Brown has been a clinical assistant professor with the Department of Psychiatry and Behavioral Sciences at the University of Washington and has conducted recidivist assessments for King County, Washington Mental Health and Drug courts. Since 2007, Dr. Brown has been the program director and chief psychologist for Northwest Forensic Associates, LLC which conducts

²⁰ Welf. & Inst.Code, § 5000 et seq. The LPS was enacted in 1967 and set up the procedures to be utilized for involuntary commitment to a mental health institution.

²¹ In addition to the Brown and Rowe reports, there were reports by Dr. Minagawa and Stephen Greenspan, Ph.D.

pre/post conviction case reviews, assessments, consultations, and offers expert testimony. Since 1994, Dr. Brown has conducted numerous adult, adolescent and child psychological evaluations in the areas of competency, dependency, FAS disorders, developmental delay, Shaken Baby Syndrome, and abuse and neglect allegations, and Asperger Syndrome. Dr. Brown estimated that about 50 percent of the evaluations and testimony involves cases outside of Washington State. She also estimated that half of all her expert retentions were for the government side. She estimated that she has conducted between 100 and 150 educationally related assessments. She has testified in five previous due process hearings in Washington State. Dr. Brown originally was retained by Student's Public Defender to conduct a competency evaluation for Student's Juvenile Court case. Dr. Brown took the assignment on a pro bono basis. She was later retained by the Public Defender to conduct an educational review and to testify in the instant matter. Dr. Brown was an informed and effective witness. The ALJ gave great weight to her testimony.

Functional/Psychological Assessment Report by Dr. Brown

88. Student's Public Defender referred the matter to Dr. Brown to determine (1) whether Student's lifelong history is consistent with fetal alcohol spectrum disorder (FASD); (2) Student's current level of cognitive functioning in terms of judgment, insight, and reality orientation; (3) his current level of emotional and behavioral functioning; (4) whether Student meets the diagnostic criteria for any mental health conditions; (5) if Student is competent to stand trial; and (6) interventions and treatment services to address Student's mental health/medical conditions and reduce the probability of reoffending. Dr. Brown submitted a written report titled *Functional/Psychological Assessment* dated April 18, 2012.

89. Dr. Brown reviewed medical records from Sharp Chula Vista Medical Center relating to Student's birth mother; and those relating to Student from Rady Children's Hospital and Medical Center, Children's Primary Care Medical Group, and Student's psychologists, Dr. de Lima and Dr. Jensen. She also examined a diagnostic report from Kenneth L. Jones, M.D. dated April 17, 2012. Additionally, Dr. Brown also reviewed records from the Regional Center; CVUSD; Children's Protective Services; and the Metcalf and Ramos assessment reports. Dr. Brown conducted interviews with Mother, Student, Student's aunt who was also his nanny, Ms. Eddy and Jose Robles, another JDF Probation officer.

90. Dr. Brown rendered a detailed section entitled "Social/Functioning History" comprising over 19 pages which effectively summarizes her record review and portions of Mother's interview. Dr. Brown also has a section entitled "Standardized Testing" which reports selected testing results and omits the Cognitive Assessment System (CAS) administered by Ms. Brewer during the 2009 triennial assessment. Dr. Brown reported the results of the Kaufman Brief Intelligence Test, Second Edition (K-BIT2) which had been administered on February 28, 2012. The K-BIT2 is a brief test measuring verbal and non-verbal intelligence. Student scored a standard score of 72 for IQ composite with subtest scores of 72 for vocabulary and 79 for matrices.

91. Dr. Brown administered the Gilliam Autism Rating Scale (GARS) to Mother and Student's aunt (Aunt). Results from both rating scales "indicated the likelihood of autism." The Fetal Alcohol Behavior Scale (FABS) was also given to the Aunt and Mother. The results showed Student "displays behaviors consistent with FASD."

92. Of note in the interviews was that Ms. Eddy observed that when Student gets angry, he tantrums but that he is "getting better, probably because of the structure here." She also observed that Student was able to get along with his peers. Mr. Robles noted that Student occasionally threatened to kill peers and staff when upset although there had been "no incidents of physical aggression." Mr. Robles characterized Student as being respectful toward adults but bored easily. Mr. Robles also opined that Student had responded well to structure. He also noted that Student "knows right from wrong but doesn't understand severity."

93. Dr. Brown observed that Student had been diagnosed with FAS which is one of medical conditions under the umbrella of FASD. She also opined that "his FASD has had a pervasive and severe impact on his executive and adaptive functioning" as well as significantly impairing social functioning. Dr. Brown opined that the GARS result coupled with data from other sources (unnamed) "support a diagnosis of Autistic Disorder." Student's composite IQ of 72 plus "well-documented evidence of adaptive deficiency throughout early childhood meets the diagnostic criteria for Intellectual Disability or Mental Retardation."

94. Based on her conclusions, Dr. Brown recommended the following:

(1) Student should be placed in a structured residential treatment setting involving "24/7 supervision" and a "behavioral milieu." She also opined that Student would qualify for this placement as "he will qualify for developmental disabilities services through the State, which would provide ongoing case management throughout the remainder of his childhood and into his adult years."²²

(2) Student should be assessed by a neuropsychologist to identify strengths and weaknesses and to assist in treatment planning by the setting of baselines.

(3) The OT recommendations of Ms. Ramos should be adopted as part of Student's treatment plan.

²² Thus, Dr. Brown opines that Student should be placed for such services under the LPS. As will be discussed later, Dr. Rowe rejected mental retardation but did find that Student suffered from developmental delay due to FAS. It is unclear whether the Juvenile Court judge ordered a mental health evaluation under the Protocol for Competence Evaluations based on developmental delay.

- (4) Student should be provided with ongoing medication management by a pediatric psychiatrist with experience in treating FASD.
- (5) Student should be provided with social skill- building interventions.
- (6) Student should receive dialectical behavior therapy (DBT) to target mood modulation and emotion control.²³
- (7) Student should participate in family therapy with Mother.

Testimony of Dr. Brown

95. After Dr. Brown was retained as an expert for the instant matter, she re-reviewed the materials she had used for her April report plus a 2008 psychiatric evaluation by Jaga Nath Glassman, M.D.; the 2009 psycho-educational assessment by Ms. Brewer; the IEPs developed by the COE; STAT notes from Student's JDF psychiatrist, psychologists and therapists; and Probation logs. Dr. Grossman had diagnosed Student with Autism and Impulse Control Disorder-NOS under axis one and FAS under axis three.

96. Dr. Brown explained that alcohol prevents the normal development of the brain in a child which mostly affects the development of the frontal lobe. This causes improper brain cell development causing developmental delays, distorted perceptions, and executive function impairment. Executive functioning includes regulating judgment, decision-making, social behavior, self-regulation, and emotion control. Student's history show this to be the case in and out of school which resulted in his aggressiveness to his Mother and then to the incident itself which caused the death of a child. Dr. Brown explained that psychotropic medication can be utilized, and was in Student's case, to decrease his arousal level. But any such medication is only effective on a short-time basis. Thus, Student must be constantly monitored and medications may be changed on a frequent basis.

97. Dr. Brown cited that research indicates that FAS children require a therapeutic milieu stressing behavior modification and reinforcing positive behaviors and not using punishment techniques. She explained that the milieu should be predictable, supervised, and constant. The behavior modification is best done by repetition. The program must include developmental services, skills training, case management, medication management, and socialization. Transitions must be kept to a minimum as FAS children can not cope with

²³ DBT is a skill-building therapeutic approach developed by Marsha Linehan, Ph.D. of the University of Washington. It combines standard cognitive-behavioral treatment techniques for emotional regulation and mindful awareness from Buddhist meditative practice. It is known to help persons to accept and tolerate emotions. (www.wikipedia.org/wiki/Dialectic_behavior_therapy.)

change and transitions only worsen problems. It is also essential all staff react in the same manner to the child's bad behaviors. She classified Student as being a severe case. Dr. Brown opined that any placement less restrictive to an RTC would only make Student's behavior problems worse. Dr. Brown stated that placement in a day treatment program can not work for Student as it is not a 24 hour environment and the transition to home each day would be too disruptive. She did point out that Student was doing "okay" in JDF, which is highly structured although without being a therapeutic environment and without behavior modification techniques. Additionally, Dr. Brown stated that Student had a sensory integration deficit which should be met at first with one to one instruction to reduce stimuli to a minimum. After progress is achieved, then Student can be instructed in a small group and then eventually to be moved to a small classroom.

98. During cross-examination, Dr. Brown did concede that Student had received some educational benefit at CVUSD based upon the WWJ II scores reported in the Metcalf assessment report. She believes that Student can only achieve up to a certain level and then no more. Dr. Brown was of the opinion that because of Student's brain infirmity his executive functioning will plateau and then worsen which will cause his behaviors to further interfere with his learning and social functioning. She also noted that Student had recently been prescribed Haldol which she characterized as a "last straw" in attempting to control his behaviors. She claimed that Student is still young enough to benefit from a behavior modification program. Such programs lose their effective outcomes if started at about 14 years of age when the behaviors are too ingrained to alter.

Jeffrey K. Rowe, M.D.

99. Dr. Rowe is currently clinical director of child and adolescent psychiatry at the University of California, San Diego and Rady Children's Hospital. From 2006 to 2012, he was the supervising psychiatrist for the BHD and Children's Mental Health Services of the HHSA. He had been employed in numerous positions with HHSA since 1991. During his career at HHSA, he served three stints as the supervising psychiatrist for Juvenile Forensic Services in 1995-1996, again in 1999-2000, and then 2001-2005. He had been in private practice in Wisconsin from 1987 through 1989. He also has maintained a private psychiatric practice specializing in treating adolescents and adults since 1991. Dr. Rowe received his M.D. from the Medical College of Wisconsin in 1983. He completed residencies in internal medicine at UCLA-LAC Medical Center, general psychiatry at the University of Wisconsin Hospital & Clinic, and child and adolescent psychiatry at the University of California, San Francisco. He has a California medical license and holds certifications from the American Board of Psychiatry and Neurology with a subspecialty in child and adolescent psychiatry. He has made numerous presentations including the Judicial Conference of California, where he also recorded a five disc DVD on the effects of domestic violence on children. Dr. Rowe has conducted numerous competency evaluations for the Juvenile Court and he was appointed by the court to evaluate Student. Over his career, Dr. Rowe has attended 50 or more IEP meetings. Dr. Rowe was a knowledgeable and effective witness. The ALJ gave great weight to his testimony.

Dr. Rowe's Court Ordered Psychiatric Evaluation

100. Dr. Rowe was retained by the Juvenile Court to conduct a Forensic psychiatric evaluation of Student to determine whether he was competent to stand trial. Pursuant to the Juvenile Court protocol, Dr. Rowe submitted a written report dated June 12, 2012. Dr. Rowe conducted a clinical interview with Student and a telephone interview with Mother. He also reviewed reports generated by three experts retained by Student's attorney- Drs. Minagawa, Greenspan, and Brown;²⁴ CVUSD evaluations; audio interviews conducted by detectives of Student, Mother, and two of his teachers; various medical and psychological reports; and CVUSD records including the February 4, 2011 IEP, report cards for school year 2010-2011, the October 29, 2011 BSP; and psychiatric reports from Student's last two psychiatrists- Drs. de Lima and Jensen.

101. Dr. Rowe reviewed the results of previous evaluations starting with evaluations made in early 2004. He then presented a history of Student's "present illness," where he noted that Student "has a long history of difficulties with anxiety, emotional reactivity, anger, irritable mood, aggressive behavior, social interaction, frustration tolerance, restlessness, oppositionalism, impulsive behavior, speech and language problems, focusing on school work, participation in class, problem solving, and self observational skills." Dr. Rowe observed that for the prior three years, Student had been treated as if he had Bipolar Disorder and in the more distant past as if he had Attention Deficit Hyperactivity Disorder (ADHD) and Anxiety Disorder. Dr. Rowe also stated that Student was "recently" diagnosed with FAS by Kenneth Jones, M.D. Consistent with FAS, Dr. Rowe found that Student has "growth deficiency, has several facial abnormalities, definitely has CNS (central nervous system) functional impairments (CT Scan at 2 months did not demonstrate structural abnormalities) in the areas of impulse control, social perception, communication, abstract thinking, math skills, memory, attention, judgment, executive function (attention management, self control, learning from experience, option review before acting), and difficulties responding to common parenting practices because of learning abnormalities." He also listed that at the time of the evaluation, Student was taking Abilify, Lamictal and Tenex.

102. At the first session of the mental status examination, Student started yelling and protesting as he was led into the exam room and continuing thereafter forcing Dr. Rowe to leave. Student was later able to calm down with the assistance of a female probation officer. Dr. Rowe then observed Student in class where he was not disruptive although he only attended to the lesson intermittently. At a second session, Student protested being

²⁴ Dr. Minagawa, a clinical and forensic psychologist, concluded that Student was not competent to stand trial as his emotional development was significantly delayed as a result of FAS. Dr. Greenspan, a psychologist, college professor and expert on developmental disability, concluded that Student met the criteria for mental retardation based on intellectual functioning, adaptive behavior and developmental onset. Dr. Greenspan pointed out that Student had scored full scale IQ 67 on the Reynolds Intellectual Assessment Scale (RIAS) which he had administered.

interviewed and then agreed to answer 20 minutes of questions. The questions were adapted from the Juvenile Adjudicative Competence Interview taking into account Student's language problems and the limited tolerance to being interviewed. Dr. Rowe concluded that Student had "a very basic and immature understanding of legal proceedings," and he can not assist his attorney as Student "cannot reasonable (sic) or rationally discuss the events" or defense preparation. Based on his observations and Student's history, Dr. Rowe concluded that Student "is a danger to others as evidenced by his aggressive, impulsive, and threatening behavior throughout his life and the treatments to date have not diminished this danger."

103. Dr. Rowe diagnosed Student under Axis I with ADHD; Oppositional-Defiant Disorder; Anxiety Disorder, NOS; Intermittent Explosive Disorder; and Communication Disorder-language pragmatics. Under Axis II, Student was diagnosed with Developmental Delay due to a medical condition with an Axis III diagnosis of FAS. Under Axis IV, Dr. Rowe diagnosed primary support system, social support system, educational problems, and legal system interaction. As to the specific referral questions, Dr. Rowe's responses were:

1. Does the minor have a mental health disorder?
 - a. Yes, he has conditions related to FAS which include ADHD, ODD, and Intermittent Explosive Disorder.

2. Does the minor have a developmental disability?
 - a. He does not have classically diagnosable Mental Retardation (MR), but has a developmental delay due to his FAS such that he will require similar supports to those needed by someone with MR.

3. Is the minor developmentally immature?
 - a. He is developmentally immature-despite a significant amount of treatment and support, [Student] is developing at a slower rate than other children his age. His functional abilities are uneven, but most are in the 6-8 years of range (a Vineland Scales of Adaptive Functioning could clarify this more precisely).
* * * * *

7. Is the minor a danger to self, others, or gravely disabled?
 - a. He is a danger to others and will remain so for a significant period because of his Intermittent Explosive Disorder and FAS.

8. Could the minor benefit from restoration of competence classes?
 - a. It is possible that efforts to restore competence could improve his understanding of the court processes. It is possible that intensive residential treatment could improve his ability to manage himself in the courtroom. It is unclear how long this will take; best estimate is at least 6 months or longer.

9. Do you have recommendations for treatment for this minor?
 - a. Yes, this minor requires intensive residential treatment in a secure facility that has experience working with FAS patients. Consistent,

supportive, low stimulus care is necessary to assist [Student] in his learning, executive functioning development (self control, attention, problem solving, planning, etc.). Medication treatments might be helpful, but also can cause side effects so this part of treatment requires an experienced Child Psychiatrist.

b. Treatment does need to be in a structured setting, must be involuntary as he requires a specific setting and specific treatments for the foreseeable future, but does not necessarily need to be “locked.” [Student’s] mother loves him, wishes to ensure he has good and effective treatment, but can be self-referential (according to records, not as a result of an evaluation by me) in her determining what treatments to submit her son to. It would not be helpful for [Student] to start residential treatment only to be removed by his mother against medical advice and for a non-medically supported reason as has been the case in the past (her history of unilaterally altering medication doses or stopping them completely without discussion with the prescribing doctor). This can sound harsh, but it is not meant to, as [Student’s] need for consistent, low stimulus, highly predictable, well supervised environment meets both his clinical needs and the communities’ (sic) need for safety.

Testimony of Dr. Rowe

104. In late December 2012, Dr. Rowe was retained by Student’s attorney to conduct an education evaluation and testify in this matter. Dr. Rowe conducted a document review, including educational records, for five and half hours. He was reimbursed by the Public Defender’s Office for his records review, educationally related evaluation and his testimony. Dr. Rowe explained that his initial court appointed evaluation was for the purpose of establishing whether Student can (a) perceive the rightness and wrongness of his action, and (b) assist in his defense. The purpose of his review was to find the appropriate education placement for Student based on his needs as well as reviewing the appropriateness of the Peddie-Musser ERMHS report. Dr. Rowe admitted that Student had made progress at JDF which is evidence that he does not require psychiatric hospitalization. Dr. Rowe characterized his progress on being in a highly structured environment. He also noted that although JDF was highly structured, it lacked a therapeutic milieu. He also agreed with Ms. Peddie-Musser’s that Student demonstrated having significant emotional and behavior difficulties and he requires a highly structured and supervised RTC. He disagrees with the ERMHS report in that Student requires a RTC placement as Student’s mental health issues are interfering with his education.

105. Dr. Rowe observed Student on four occasions in the JDF school. Student shut down during each observation. He estimated that Student only responded to the teacher or probation officer half the time he was addressed. He was instructed to go to his room to recover. While in the room, Student threw items or lay face down on his bed.

106. In support of his finding that Student’s mental health needs directly interferes with his education, Dr. Rowe cited Student’s difficulties with poor attention span, failure for him to have the ability to control his arousal levels which leads to numerous shut downs in

class; poor ability to read social cues; processing difficulties including memory problems; and extreme anxiety which leaves Student hyper-vigilant and mostly on edge throughout class.

107. Like Dr. Brown, Dr. Rowe explained that FAS presents a wide set of deficits which most importantly, in Student's case, effects his arousal levels. FAS children require a structured setting with positive reinforcement to modify behavior. This requires a tightly monitored and quietly controlled environment designed to calm the FAS child's arousal needs. This requires 24 hour supports in place to provide a rhythmic structured program which may take up to two to four years to show marked progress. Some of the methods which can be utilized to control the arousal level in an integrated treatment plan are physical fitness, yoga, dancing, massage, and other such techniques. Psychotropic medication is an essential part of the program for FAS children which are required for the purpose of regulating the child's arousal levels to allow participation in therapy.

108. Dr. Rowe opined that Student's problems are beyond the ability of individual psychotherapy to remedy. Dr. Rowe stated that any RTC placement must include professionals who are familiar with FAS children and who use de-escalation techniques coupled with a reward system as opposed to a punishment system as present in JDF. The class must contain only a few peers with space between each, few distractions, with each student physically close to the teacher, periods of very brief teaching coupled with numerous breaks, direct instruction, limited materials and constant cuing. Of importance, the setting must be consistent. Dr. Rowe opined that a day treatment placement, although therapeutic in nature, is not sufficient for Student, and FAS children, because he would exit the controlled environment and return to the problems of living each day. Dr. Rowe, like Dr. Brown, stressed the need for a 24 hour consistent environment.

LEGAL CONCLUSIONS

Burden of Proof

1. In a special education administrative due process proceeding, the party seeking relief has the burden of proving the essential elements of his claim. (*Schaffer v. Weast* (2005) 546 U.S. 49 [126 S.Ct. 528, 163 L.Ed.2d 387].) In this case, Student has the burden of proof.

Jurisdiction

2. A child with a disability has the right to a free appropriate public education (FAPE) under the Individuals with Disabilities Education Act (IDEA or Act) and California law. (20 U.S.C. § 1412(a)(1)(A); Ed. Code, § 56000.) The Individuals with Disabilities Education Improvement Act of 2004 (IDEIA), effective July 1, 2005, amended and reauthorized the IDEA. The California Education Code was amended, effective October 7, 2005, in response to the IDEIA. The primary goal of the IDEA is to "ensure that all children

with disabilities have available to them a free appropriate public education that emphasizes public education and related services.” (20 U.S.C. § 1400(d)(1)(A); see *J.L. v. Mercer Island School District* (9th Cir. 2009) 592 F.3d 938, 947 (*Mercer Island*)).

3. Under special education law, the parent of a disabled child has the right to present an administrative complaint with respect to any matter relating to the identification, evaluation, or educational placement of the child, or the provision of a FAPE. (20 U.S.C. § 1415(b)(6)(A); 34 C.F.R. § 300.507(a)(2006)²⁵; Ed. Code, § 56501, subd. (a)(1)-(4).)

Juvenile Court Schools

4. In California, a county office of education is responsible for the provision of a FAPE to individuals who are confined in juvenile hall schools within that county. (Ed. Code, §§ 48645.1, 48645.2, 56150.) When a residential placement is recommended by an IEP team, the local educational agency, such as a county office of education, is financially responsible for transportation to and from the residential placement and all special education instruction and non-mental-health related services. (Cal. Code Regs., tit. 2, §§ 60010, subd. (k) (including county offices of education within the definition of local educational agency), 60110, subd. (b)(2) (for residential placements, “The LEA shall be responsible for providing or arranging for the special education and non-mental-health related services needed by the pupil.”), & 60200, subd. (d).)

Issue (1) Since January 16, 2012, has the COE deprived Student of a FAPE by failing to offer (a) appropriate mental health services including therapy and counseling; (b) appropriate academic services when the COE offered 240 minutes of academic instruction daily; and (c) appropriate OT services?

Definition of a FAPE

5. A child with a disability has the right to a FAPE under the IDEA and California law. (20 U.S.C. §1412(a)(1)(A); Ed. Code, § 56000.) A FAPE is defined as special education and related services that are provided at public expense and under public supervision and direction that meet the state’s educational standards and that conform to the student’s IEP. (20 U.S.C. §1401(9); Cal. Code Regs., tit. 5, § 3001, subd. (p).) Special education is defined as specially designed instruction and services (DIS), provided at no cost to parents, that meets the unique needs of a child with a disability and permits him or her to benefit from instruction. (20 U.S.C. § 1401(29); Ed. Code, § 56031.) Special education related services include transportation, and developmental, corrective, and supportive services, such as mental health counseling services, that may be required to assist the child with a disability to benefit from special education. (20 U.S.C. § 1401(26); Ed. Code, § 56363.)

²⁵ All references to the Code of Federal Regulations are to the 2006 version.

6. Psychological and occupational therapy services are considered to be included in a DIS. (Ed. Code, § 56363, subd. (a); Cal. Code of Regs., tit. 5, §§ 3051.10 and 3051.6.) Behavior intervention is also considered included in a DIS. (Ed. Code, §§ 56520 et seq.; Cal. Code Regs., tit. 5, § 3052.)

7. There are two parts to the legal analysis of whether a local educational agency (LEA), such as a school district, offered a student a FAPE. The first question is whether the LEA has complied with the procedures set forth in the IDEA. (*Board of Education of the Hendrick Hudson Central School District v. Rowley* (1982) 458 U.S. 176, 206-207 [102 S.Ct. 3034] (*Rowley*)). The second question is whether the IEP developed through those procedures was substantively appropriate. (*Id.* at p. 207)

Procedural Violations

8. Procedural flaws do not automatically require a finding of a denial of FAPE. A procedural violation does not constitute a denial of FAPE unless the procedural inadequacy (a) impeded the child's right to a FAPE; (b) significantly impeded the parent's opportunity to participate in the decision-making process regarding the provision of FAPE; or (c) caused a deprivation of educational benefits. (20 U.S.C. § 1415(f)(3)(E)(i) & (ii); Ed. Code, § 56505, subd. (f)(2)(A)-(C); *W.G. v. Board of Trustees of Target Range School District No. 23* (9th Cir. 1992) 960 F.2d 1479, 1483-1484 (*Target Range*)).

Parent Participation in the IEP Process

9. Special education law places a premium on parental participation in the IEP process. Parents must have the opportunity "to participate in meetings with respect to the identification, evaluation, and educational placement of the child, and the provision of a free appropriate public education to such child." (20 U.S.C. § 1415(b)(1).) In this regard, an educational agency must ensure that one or both of the parents of a child with a disability is present at each IEP team meeting. (34 C.F.R. § 300.322(a)(2006); Ed. Code, §§ 56341.5, subd. (a), 56342.5.) The United States Supreme Court has recognized that parental participation in the development of an IEP is the cornerstone of the IDEA. (*Winkelman v. Parma City School District* (2007) 550 U.S. 516, 524 [127 S.Ct. 1994, 167 L.Ed.2d 904].) Parental participation in the IEP process is also considered "(A)mong the most important procedural safeguards." (*Amanda J. v. Clark County School* (9th Cir. 2001) 267 F.3d 877, 882.)

10. Under these guidelines, an educational agency must permit a child's parents "meaningful participation" in the IEP process. (*Ms. S. v. Vashon Island School District* (9th Cir. 2003) 337 F.3d 1115, 1131-1132.) In order to fulfill the goal of parental participation in the IEP process, the school district is required to conduct, not just an IEP meeting, but also a meaningful IEP meeting. (*Target Range, supra*, 960 F.2d at p. 1485; *Fuhrman, supra*, 993 F.2d at p. 1036.) A parent has meaningfully participated in the development of an IEP when she is informed of her child's problems, attends the IEP meeting, expresses her disagreement regarding the IEP team's conclusions, and requests revisions in the IEP. (*N.L. v. Knox*

County Schools (6th Cir. 2003) 315 F.3d 688, 693; *Fuhrmann, supra*, 993 F.2d at p. 1036.) Parents have an adequate opportunity to participate in the IEP process when they are “present” at the IEP meeting. (34 C.F.R. § 300.322(a); Ed. Code, § 56341.5, subd. (a).) An adequate opportunity to participate can include a visit by the parent to the proposed placement. (*Fresno, supra*, 626 F.3d at p. 461.) An adequate opportunity to participate can occur when parents engage in a discussion of the goals contained in the IEP. (*J.G. v. Briarcliff Manor Union Free School District*. (S.D.N.Y 2010) 682 F.Supp.2d 387, 394.)

Determination of Appropriateness of an IEP

11. An IEP is a written document that is an educational package that must target all of a student’s unique educational needs, whether academic or non-academic. (*Lenn v. Portland School Committee* (1st Cir. 1993) 998 F.2d 1083, 1089.) The term “unique educational needs” is broadly construed and includes the student’s academic, social, emotional, communicative, physical, and vocational needs. (*Seattle School District. No. 1 v. B.S.* (9th Cir. 1996) 82 F.3d 1493, 1500[citing J.R. Rep. No. 410, 1983 U.S.C.C.A.N. 2088, 2106].) The IEP must be reasonably calculated to enable the student to receive education benefit (*J.W. v. Fresno Unified School District* (E.D. Cal. 2009) 611 F. Supp. 2d 1097, 1107.) which is tailored to the unique needs of that particular child, who, by reason, of disability, needs special education and related services. (*Ibid.*)

12. Federal and State special education laws require generally that the IEP developed for a child with special needs contain the present levels of the child’s educational performance and measurable annual goals, including benchmarks or short-term objectives, related to the child’s needs. (20 U.S.C. § 1414 (d)(1)(A)(ii); Ed. Code, § 56345, subd. (a).) For each area in which a special education student has an identified need, the IEP team must develop measurable annual goals that are based upon the child’s present levels of academic achievement and functional performance, and which the child has a reasonable chance of attaining within a year. (Ed. Code, § 56344.) The IEP must also contain a statement of how the child’s goals will be measured. (20 U.S.C. § 1414(d)(1)(A)(viii); Ed. Code, § 56345, subd. (a)(3).) The purpose of goals and measurable objectives is to permit the IEP team to determine whether the pupil is making progress in an area of need. (Ed. Code, § 56345.)

13. In resolving the question of whether a school district has offered a FAPE, the focus is on the adequacy of the school district’s proposed program. (See *Gregory K. v. Longview School District* (9th Cir. 1987) 811 F.2d 1307, 1314 (*Gregory K.*.) A school district is not required to place a student in a program preferred by a parent, even if that program will result in greater educational benefit to the student. (*Ibid.*) Nor must an IEP conform to a parent’s wishes in order to be sufficient or appropriate. (*Shaw v. District of Columbia* (D.D.C. 2002) 238 F.Supp.2d 127, 139.)

14. In *Rowley*, the United States Supreme Court addressed the level of instruction and services that must be provided to a student with disabilities to satisfy the requirements of the IDEA. Under *Rowley*, and federal and state statutes, the standard for determining whether a district’s provision of services substantively and procedurally provided a FAPE

involves four factors: (1) the services must be designed to meet the student's unique needs; (2) the services must be reasonably designed to provide some educational benefit; (3) the services must conform to the IEP as written; and (4) the program offered must be designed to provide the student with the foregoing in the least restrictive environment. While this requires a school district to provide a disabled child with meaningful access to education, it does not mean that the school district is required to guarantee successful results. (20 U.S.C. § 1412(a)(5)(A); Ed. Code, § 56301, *Rowley*, *supra*, at p. 200.) The IDEA does not require that school districts provide special education the best education available or to provide instruction designed to maximize a student's abilities. (*Rowley*, 458 U.S. at p. 198.) It does require school districts to provide a "basic floor of opportunity" that consists of access to specialized educational benefit to the student. (*Id.*, at p. 201; *Mercer Island*, 592 F.2d at 947.)

15 An IEP is evaluated in light of information available at the time it was developed; it is not judged in hindsight. (*Adams v. State of Oregon* (9th Cir. 1999) 195 F.3d 1141, 1149.) "An IEP is a snapshot, not a retrospective." (*Id.* at p. 1149, citing *Fuhrmann v. East Hanover Board of Education* (3d Cir. 1993) 993 F.2d 1031, 1041 (*Fuhrmann*).) Under this "snapshot rule," it must be evaluated in terms of what was objectively reasonable when the IEP was developed. (*Ibid.*)

16. There is no one test for measuring the adequacy of educational benefits conferred under an IEP. (*Rowley*, *supra*, 458 U.S. at pp. 202, 203 fn. 25.) A student may derive educational benefit under *Rowley* if some of his goals and objectives are not fully met, or if he makes no progress toward some of them, as long as he makes progress toward others. A student's failure to perform at grade level is not necessarily indicative of a denial of a FAPE, as long as the student is making progress commensurate with his abilities. (*Walczak v. Florida Union Free School District* (2d Cir. 1998) 142 F.3d 119; *E.S. v. Independent School District, No. 196* (8th Cir. 1998) 135 F.3d 566, 569; *In re Conklin* (4th Cir. 1991) 946 F.2d 306, 313; *M.H. v. Monroe-Woodbury Central School District* (S.D.N.Y. March 20, 2006, No. 04-CV-3029-CLB) 2006 WL 728483, p. 4; *Houston Independent School District v Caius R.* (S.D.Tex. March 23, 1998, No. H-97-1641) 30 IDELR 578; *El Paso Independent School District v. Robert W.* (W.D.Tex. 1995) 898 F.Supp. 442, 449-450.) The issue is whether the IEP was appropriately designed and implemented and is reasonably calculated to convey a student with a meaningful benefit. (*Rowley*, *supra*, 458 U.S. at p. 192; *Adams*, *supra*, 195 F.3d at p. 149; *J.W. v. Fresno Unified School District* (9th Cir. 2010) 626 F.3d 431, 439 (*Fresno*).)

17. For a school district's IEP to offer a student a substantive FAPE, the proposed program must be specially designed to address the student's unique needs, must be reasonably calculated to provide the student with educational benefit, and must comport with student's IEP. (20 U.S.C. § 1401(9).) Educational benefit is not limited to academic needs but includes social and emotional needs that affect academic progress, school behavior, and socialization. (*County of San Diego v. California Special Education Hearing Office* (9th Cir. 1996) 93 F.3d 1458, 1467 (*San Diego*).) In measuring educational benefit, the question is whether the child had made progress toward the annual goals set forth in the IEP. (*Ibid.*)

Remedies

18. When an LEA fails to provide a FAPE to a student with a disability, the student is entitled to relief that is “appropriate” in light of the purposes of the IDEA. (*School Committee of Burlington v. Department of Education* (1996) 471 U.S. 359, 369-371 (*Burlington*); 20 U.S.C. § 1415(i)(2)(C)(3).) Based on the principle set forth in *Burlington*, federal courts have held that compensatory education is a form of equitable relief that may be granted for the denial of appropriate special education services to help overcome lost educational opportunity. (*Student W. v. Puyallup School District* (9th Cir. 1994) 31F.3d 1489, 1496.) The purpose of compensatory education is to “ensure that the student is appropriately educated within the meaning of IDEA.” (*Ibid.*)

Issue 1 (a) COE Has Provided Student Appropriate Mental Health Services.

19. Student contends that the February 15, 2012 IEP failed to provide Student a FAPE as the mental health services were not appropriate to meet his mental health needs. Student avers that the one 30 minute weekly counseling session offered in the IEP was not sufficient to address Student’s massive mental health needs and was based on “what he would attend” rather than his needs. Additionally, Student contends that Student’s refusal to attend the weekly counseling sessions with the school psychologist should have been addressed by the IEP team.²⁶ The COE contends that the mental health services were appropriate to meet his educational needs in light of his being at JDF coupled with the extensive mental health services provided by JDF.

20. The COE provides the educational services at JDF while the STAT team is charged with providing mental health services for detainees. Thus in developing an educational program for Student, the IEP team must take into consideration those services which Student was already receiving because of his placement at JDF. As part of the JDF program, Student’s mental health needs were being extensively met by services from the STAT team which included a psychiatrist, psychologist and therapist. Student’s psychiatrist met at least weekly with him for purposes of medication management. He also received at least weekly sessions with an assigned psychologist plus daily counseling sessions with a therapist. Additionally, STAT team members were present and would intervene during times when Student appeared in need of counseling or calming. Dr. Metcalf, in his triennial assessment, recommended that DIS counseling be available on an “as needed basis” in light of the services Student was already receiving from the STAT team; but the IEP team opted to provide DIS counseling on a more consistent basis. (Factual Findings 1, 25 through 28, and 82.)

²⁶ In support of his argument, Student cites Education Code § 56346. This section involves parental consent and is not applicable here.

21. It is reasonable for the COE to take into account services provided at JDF in assessing what educational services should be provided. Since the STAT services were extensive and designed to address Student's mental health needs which directly affected his ability to learn in school and get benefit from his education, the IEP can take into account those services in drafting an educational program. Student made considerable progress in meeting his annual goals in comprehension, calculations, and coping skills as well as making significant progress in his mechanics (writing) goal as demonstrated in comparing Student's goal baselines at his February 15, 2012 IEP and the February 8, 2013 IEP. Student would shut down between 70 and 80 percent of class time at the time of his entry at JDF compared to presently being disruptive only 15 to 20 percent of the time per Ms. Eddy. The February 8, 2013 IEP noted that Student completes less than 50 percent of his assignments "without consistent prompting" as opposed to requiring "regular prompting" at his arrival at JDF. As noted by Ms. Hulley, Student now regularly volunteers to go to the blackboard and read to the class. Mr. Young and Mr. Christopher both noted Student's improved behavior and class participation as compared to his arrival. Outside of academics, Student's behavior had improved as demonstrated by fewer outbursts and less severe outbursts when they occurred as observed by Dr. Trammel, his teachers and Ms. Eddy. Although, Student failed to access the DIS counseling, he has failed to demonstrate that not being provided DIS counseling had any impact on Student's academic functioning or his learning coping skills. (See, *Parents v. Riverside County Department of Mental Health* (2009 OAH Case No. 2008100383.)) Thus, Student has failed to meet his burden to demonstrate that the COE failed to provide appropriate mental health services. (Factual Findings 1, 8, 10 through 46, 58, 65 through 75, 80 through 84.)

Issue 1 (b) COE Provided Student Appropriate Academic Services.

22. Student contends that the COE failed to provide him appropriate academic services as he was unable to access a full school day plus he failed to meet his writing goal. Student cites to Student being allowed to exit class after one o'clock due to fatigue caused by psychotropic medications. The COE counters that Student met three of his four annual goals, made significant progress on his fourth goal, greatly improved academic skills, and Student's classroom behavior had significantly improved over time.

23. As stated above (Legal Conclusion 22), Student met three of his four annual goals and made significant progress on the fourth. Student had exceeded his comprehension goal and was reading grade level books; met his calculations goal; and exceeded his coping skills goal by using appropriate coping skills 85 percent of the time. In his mechanical (writing) goal, he was able to construct a multi-paragraph composition using topic sentence, three supporting ideas with transitional expressions and a concluding paragraph summarizing important ideas with 75 percent accuracy in four out of five times as opposed to writing a paragraph using a graphic organizer with 50 percent accuracy which was the baseline for this goal at the February 15, 2012 IEP. Student being permitted to exit class early, as an accommodation to the effects of his medications, because of fatigue or anxiety, did not impact his academic progress or education benefit. Student has failed to meet his burden of

proof as to the appropriateness of the IEP academic services. (Factual Findings 1, 8, 10 through 46, 58, 65, 75, and 80 through 84.)

Issue 1 (c) COE Provided Student Appropriate OT Services.

24. As stated in legal Conclusions 7 and 8, a FAPE analysis must first look to whether the LEA committed any procedural violations of the IDEA and whether such procedural flaws impeded the child's right to a FAPE, significantly impeded the parent's opportunity to participate in the IEP decision-making process, or caused a deprivation of educational benefits to the child.

25. Ms. Ramos conducted an OT assessment which found that Student had OT deficits in the areas motor development maturity, failure to develop hand curvatures to complete fine motor tasks, writing where he was on the second grade level, regulation skills, engaging in paper and pencil tasks, coordination, and following directions. (Factual Findings 39 through 45.) An IEP is required to contain the present levels of the child's educational performance and measurable annual goals including benchmarks and/or short term objectives. (Legal Conclusion 12.) The setting of goals is essential to determining the level and type of services which must be provided to meet Student's unique needs as well permitting the student's parents to be able to meaningful participate in the IEP decision making process. Without goals, it is impossible for a parent to determine whether their child has made progress on his/her goals or obtained education benefit from the IEP. Here, the IEP neglected to determine Student's PLP, nor set annual goals, which is a procedural violation. By failing to have proper baselines and measurable annual goals, a parent has no way to be apprised as to whether the student is making progress or receiving educational benefit and thus can not appropriately participate in the IEP decision-making process. (Factual Findings 1, 36, 39 through 45, and 47.)

26. As stated in Legal Conclusion 18, when a LEA fails to provide a student with a FAPE, the student is entitled to relief that is "appropriate." Here, Student has offered no evidence as to Student's lost education opportunity or what compensatory education would be appropriate. Accordingly, the COE shall conduct a new OT assessment and the IEP team shall convene a meeting to develop OT related PLP, goals, and services.

Issue (2) Since August 21, 2012, did the COE deny Student a free appropriate public education (FAPE) by failing to offer Student an appropriate placement when it failed to offer him placement at a residential treatment center (RTC), which was the least restrictive environment (LRE)?

27. Legal Conclusions 1 through 19 are incorporated herein as if fully repeated herein.

28. As stated in Legal Conclusion 6, there are two parts to the legal analysis of whether a LEA offered Student a FAPE. The first inquiry is whether the LEA complied with the procedures set forth in the IDEA as well as state law. Student contends that the COE has

committed a procedural violation by not considering Student's placement after being notified that the Juvenile Court would release him from detention. In support of its position, Student cites two previous OAH rulings. The COE disputes the authority cited as controlling. Thus, first, it is necessary to determine whether or not the COE's IEP team had an obligation to hold an IEP meeting to discuss placement upon release from the JDF. Secondly, it is necessary whether COE and the IEP team properly considered where Student should be placed upon release from Juvenile Hall.

COE Had an Obligation to Determine Placement upon Student's Release from Juvenile Hall.

29. *Parent v. Los Angeles County Office of Education* (2010 OAH Case No. 2010040889) (*LACOE-I*) involved a student, classified as ED in the Los Padrinos Juvenile Hall, who had been recommended for RTC placement by the Orange County Health Care Agency (OCHCA). LACOE took the position that it did not have a duty to fund, provide or arrange for educational placement at an RTC as it would no longer be responsible for providing student a FAPE upon his release from juvenile hall. Student took the position that LACOE, as the responsible LEA, did have such a duty. The ALJ noted that he was unaware, nor had LACOE produced, any authority "to support LACOE's position that it has no present duty to implement placement in a RTC when recommended by OCHCA, or that LACOE's duty to provide a FAPE is limited or qualified based on the possibility that another agency may have financial responsibility for Student's education upon release from Juvenile Hall." (*LACOE-I*, p. 6.) The ALJ described LACOE's duties thusly (*Ibid*, p. 7.):

Specifically, where the juvenile court has indicated a willingness to release Student to a RTC, LACOE has a responsibility to coordinate efforts between agencies toward this end, including signing any necessary contracts, providing any necessary funding, and transporting Student. After LACOE has met its duty to Student, it may use whatever legal process it deems appropriate to attempt to shift responsibility for the provision of FAPE to another public agency.

30. OAH was faced with similar issues in *Parent v. Los Angeles County Office of Education* (2011 OAH Case No. 2010040050/2011030120) (*LACOE-II*). The ALJ also noted: "Specifically, there is nothing in the IDEA that permits an LEA, like LACOE, to delay implementation of the provision of FAPE for any reason other than lack of parental provision." (*LACOE-II*, at p. 13.) The ALJ ruled that this obligation stemmed from the time that "the Juvenile Court had indicated a willingness to release Student to a RTC as part of the disposition of the wardship." (*Ibid*.)

31. Likewise in *Parent v. Los Angeles County Office of Education* (2012 OAH Case No. 2012090350) (*LACOE-III*), OAH noted that "at all relevant times LACOE was statutorily responsible for providing Student with a FAPE because Student was under the jurisdiction of the juvenile court and housed at Los Padrinos." (*LACOE-III*, P. 35.)

32. COE's contention, that neither of these cases is applicable to the instant matter, relies solely on the fact that in both cases there was a predetermination that Student required RTC placement to obtain a FAPE. COE fails to cite any authority, like LACOE did in the three cases, that it does not have a duty to implement a FAPE placement upon notification of pending release from Juvenile Hall. Thus, COE had an obligation upon notification of a pending release order from Juvenile Court to determine Student's placement upon that release.

COE Did Not Properly Consider Placement after Juvenile Hall.

33. A LEA is required to have a continuum of program options available for a child. (Ed. Code, §56360.) The continuum of program options includes , but is not limited to regular education; resource specialist programs; designated instruction and services; special classes; nonpublic, nonsectarian schools; state special schools; specially designed instruction in settings other than classrooms; itinerant instruction; and instruction using telecommunications in the home or hospitals or institutions. (Ed. Code, § 56361.)

34. COE was informed at the August 3, 2012 IEP meeting by Ms. Meadows that the Juvenile Court scheduled a hearing for August 21, 2012, to determine whether Student was competent to stand trial. On August 20, 2012, Ms. Gaston informed COE counsel that Student would most probably be found not competent which would mean that Student would no longer be placed at JDF. By email on August 21, 2012, COE was informed that the court had determined Student not competent to stand trial. At the August 23, 2012 IEP meeting, the IEP team was informed that Probation would not be placing Student at an RTC which was determined by the Juvenile Court to be the appropriate placement. On October 30, 2012 IEP meeting, the team reviewed Dr. Kelin's report, but the IEP team did not discuss possible placement options when Student would be released from JDF. The COE and CVUSD team members refused to consider RTC placement as Student was making progress on his annual goals at JDF and that their view that the RTC recommendation of Dr. Kelin was based on safety issues not related to education. Thus, the IEP team failed to consider placement options, including RTC and day treatment, when Student would be released from JDF. Thus, COE committed a procedural violation of the IDEA by not discussing potential placement options for Student upon release from JDF. (Factual Findings 60 through79.)

The IEP Team Erred by not Finding that Student Should be Placed at a RTC upon Release from JDF.

35. The test for determining whether an RTC placement provides FAPE is whether the placement is necessary to provide special education and related services to meet the student's educational needs. (*Ashland School District v. Parents of RJ* (D. Or. 2008) 585 F. Supp.2d 1208, 1231, *affirmed*, (9th Cir. 2009) 588 F.3d 1004.) The analysis for determining whether a RTC placement is appropriate hinges on whether the placement is necessary for educational purposes or in response to medical, social, or emotional problems that is quite apart from the learning process. (*Clovis Unified School District v. California Office of Administrative Hearings* (9th Cir. 1990) 903 F.3d 635, 643.) The *Clovis* court

identified three possible tests for determining when a school district is responsible for the cost of a residential placement: (1) when the placement is “supportive” of the child’s education; (2) when medical, social or emotional problems that require residential placement are intertwined with educational problems; and (3) when the placement primarily aids the student to benefit from special education. (903 F.3d at 643; see also *San Diego, supra.*, 93 F.3d at 1468.) The Ninth Circuit found a RTC placement “supportive” where it provides structure and support for the student to achieve his/her IEP and mental health goals. (*San Diego, supra.*, 93 F.3d at 1468.)

36. As discussed in Legal Conclusion 14, an IEP is evaluated in light of the information available to the IEP team at the time it was developed as opposed to being done in hindsight. Here, the IEP team never received the reports by Dr. Brown and Dr. Rowe (as well as the other two experts retained by the Public defender’s Office). (Factual Findings 62 and 74.) The information before the team was the Peddie-Musser ERMHS assessment and the Kelin IEE report. (Factual Findings 59 through 63, and 74 through 76.) Both reports concluded that Student required RTC placement. (Factual Findings 48 through 57, and 66 through 73.) Additionally, Dr. Metcalf had concluded in his Triennial assessment that Student’s ability to learn is adversely affected by his depression and inappropriate types of feeling and behavior. (Factual Finding 35.)

37. Student contends that Student’s unique needs require a RTC placement as demonstrated in both Ms. Peddie-Musser’s and Dr Kelin’s evaluations as well as the testimony of Dr. Brown and Dr. Rowe. Student avers that the IEP team should have placed Student in an RTC in that his mental health needs directly impact his education, as demonstrated in the Peddie-Musser and Kelin reports. COE counters that Student does not require a RTC as he has made significant progress on his annual goals and his problem behaviors have become more manageable in the school setting.

38. Student has met his burden of demonstrating that COE should have offered placement in a RTC. The information possessed by the IEP team by the October 30, 2012 IEP meeting clearly demonstrated that Student required placement at an RTC when released from JDF for the following reasons:

(a) Student’s history of escalating behaviors and frustration during spring 2011 and fall 2012 demonstrated that he required a more restrictive environment than an SDC. Student’s modest success in the highly structured JDF, the BSP in place, and Sara Anthony staff providing individualized prompting to stay on task resulted in Student to make progress on his annual goals evidences Student’s need for a highly structured milieu to benefit from special education. Student’s teachers, who were part of his IEP team, also believed that Student required a highly structured environment to benefit from his education. (Factual Findings 1, 5 through 22, 25, 28 through 38, 46, 50, and 101.)

(b) Ms. Peddie-Musser observed that Student exhibited very significant emotional and behavioral difficulties in the school setting at JDF as he struggled with

attention, impulse control, poor frustration tolerance, and continued to have anger outbursts. She concluded:

Based upon information obtained through the course of this assessment, *[Student] does have mental health issues that impact his ability to benefit from his education.* This is evidenced by his struggling with mood and behavior regulation issues at school. Over the last six months in school, on a regular basis, he has had frequent mood irritability, sadness, aggressive outbursts (primarily verbal) and impulse issues. (Emphasis added.)

Ms. Peddie-Musser's recommendation that Student was not eligible for ERMHS was based not on whether Student required ERMHS services as part of a FAPE but rather on community safety concerns due the fact that ERMHS, as a special education service, was not mandatory. She opined that it would be "in the best interest of [Student] if the juvenile justice system were to take the lead in providing appropriate treatment/placement to address his needs *in light of safety concerns, as this would provide the best level of supervision and protection of the child and community.*" (Exhibit S-7, Peddie-Musser Assessment report, p. 182.) (Emphasis added.) Thus, Ms. Peddie-Musser found in actuality that RTC placement would be supportive of Student's education; that his social and emotional problems are intertwined with his educational problems; and the placement would assist Student to benefit from his special education. The IEP team should have reviewed closely the basis of Ms. Peddie-Musser's conclusion rather than accepting it at face value. (Factual Findings 48 through 57.)

(c) Dr. Kelin agreed with Ms. Peddie-Musser that Student required placement in a RTC. Dr. Kelin opined that Student "is in need of residential mental health services in order to get a free and appropriate education." Dr. Kelin recommended an RTC with a "very strict, supervised environment, therapy" as well continued psychotropic medication management. Although there is an issue as to severity of Student's emotional and behavioral problems at the time of assessment,²⁷ Dr. Kelin also based his findings on Student's history and his observations during the assessment as Student needed to be coaxed into cooperating by Ms. Eddy even though the purpose of the assessment was explained. Student became easily frustrated, angry and refused to cooperate as his frustration level increased. Dr. Kelin concluded that he "does not believe that [Student] could be educated in a regular school setting, even a more restrictive setting, such as a classroom for emotionally disturbed students" as Student "too easily [becomes] frustrated and becomes explosive, which presents as a danger to both schoolmates and family members." (Factual Findings 66 through 73.)

39. In order for COE to make an appropriate offer of FAPE in determining RTC placement, the IEP team must specifically take into account Student's needs as an FAS child. Both Dr. Brown and Dr. Rowe agreed as to the nature of FAS and the need for an FAS child like Student to be placed in a low stimulus, highly structured therapeutic environment. Both

²⁷ See Factual Finding 69.

were in agreement that Student's FAS interferes with Student's ability to be educated. They cited his attention issues, failure to control his arousal levels causing him to shut down and refusal to complete academic tasks, poor ability to read social cues contributing to his severe anxiety levels, and memory problems. Any program for Student must deal with behavior modification and arousal control utilizing positive reinforcement. Student must be in a tightly monitored and controlled environment 24 hours a day, seven days a week. The program must include developmental services, skills training, medication management, and socialization. Both believed that any placement less restrictive than residential would be unsuccessful and that the program be implemented by therapists familiar with FAS. (Factual Findings 86 through 108.) Here, the IEP team failed to take into account the unique needs of Student as a child with FAS.

ORDER

1. Within 60 days of this decision, COE will conduct an occupational therapy assessment and convene an IEP meeting to determine Student's present levels of performance, goals, and services in the area of occupational therapy.

2. COE is ordered to immediately begin a search for an appropriate residential placement for Student which specializes in behavior modification and is experienced in treating children with fetal alcohol syndrome disorders.

3. Unless countermanded by order of the Juvenile Court, COE shall complete its search for an appropriate residential placement and convene an IEP meeting, which includes the participation of Dr. Rowe and/or Dr. Brown, to review the appropriateness of the residential placement and to implement the placement no later than 45 days from this decision.

4. All other requests for relief are denied.

PREVAILING PARTY

Pursuant to California Education Code section 56507, subdivision (d), the hearing decision must indicate the extent to which each party has prevailed on each issue heard and decided. Here, Student prevailed on issues (1)(c) and (2), and the District prevailed on issues (1)(a) and (b)..

RIGHT TO APPEAL THIS DECISION

This is a final administrative decision, and all parties are bound by this Decision. Pursuant to Education Code section 56505, subdivision (k), any party may appeal this Decision to a court of competent jurisdiction within 90 days of receipt.

Dated: April 16, 2013

_____/s/_____
Robert Helfand
Administrative Law Judge
Office of Administrative Hearings