Complaint Investigation Report
Parent & Parent v. Penobscot County CDS
02/04/08

AMENDED REPORT

Complaint #:	08.018C
Complaint investigator:	Sheila Mayberry
Date of Appointment:	August 28, 2007

I. Identifying Information

Complainants:	Parent Address City and Parent Address City
Respondent:	Debra Hannigan, Board Chair Penobscot County Child Development Services 146 State House Station Augusta, Maine 04333-0146
Site Director:	Maribeth Barney
Child:	Student DOB: xx/xx/xxxx

II. Summary of Complaint Investigation

The Department of Education received this complaint on August 27, 2007. The complaint investigator was appointed on August 28, 2007. The complaint investigation proceedings were held in abeyance from September 10, 2007, until October 3, 2007. Thereafter, the complaint investigation proceeded. The complaint investigator received 56 pages of documents from the parents and none from the Respondent. Interviews were conducted with the Child's Parent; Maribeth Barney, Site Director, Penobscot County Child Development Services (CDS); Christine Lindsey, Penobscot County CDS education specialist; Holly Harrison, Penobscot County CDS service coordinator; Pamela Peck, physical therapist; Erica Engelmann, occupational therapist; Kimberly MacLeod, speech-language pathologist; Cathryne Van Dolman, developmental therapist; Elizabeth (Betsy) Dyer, speech-language pathologist; Debra Hannigan,

CDS Board Chairwoman; and Jaci Holmes, assistant to the Commissioner of the Department of Education.

This report was delayed due to an order to hold the proceedings in abeyance pending the resolution of a due process hearing request filed during the complaint investigation, but later withdrawn. In addition, difficulty in contacting witnesses arose during the investigation.

III. Preliminary Statement

The Child is xx years old and lives primarily with his mother and two older siblings in Bangor, Maine. He also has overnight visitations with his father some days of the week. The Child is enrolled at Little Angels Daycare five days a week. He is eligible for services under the category of developmental delay based upon his diagnosis of Down Syndrome.

IV. Allegations

1. Failure to provide the following services: physical therapy, speech and language services, and occupational therapy consultation services. MDOE Reg., Chapter 180 (for services n provided before August 3, 2007) and Chapter 101;
2. The imposition of a unilateral cap on services. (MDOE Reg., Chapter 180).

V. Summary of Findings

1. The Child was diagnosed with Downs Syndrome in October 2005. He was referred to Penobscot County CDS on November 16, 2005 and was found eligible for services under the category of Developmental Delay. An Individualized Family Service Plan (IFSP), dated December 4, 2006, included the following services: service coordination for 60 minutes, twice a week; developmental therapy for 60 minutes, twice a week; and physical therapy for 60 minutes, three times per month.

2. A speech and language evaluation was conducted on January 1, 2007, by Kimberly MacLeod, MS, CC-SLP. The Child's pediatrician, Dr. Leonardo Leonidas, referred the Child for the evaluation. The evaluator used the Receptive Expressive Emergent Language Test – 3 to assess the Child's receptive and expressive language. The Child's performance was found to be in the "very poor" range. The evaluator stated: "His performance demonstrates significant impairment in both his understanding of language as well as the area of expressive language. Specifically, whereas (the Child) is somewhat playful and seems to enjoy interactions, he is just beginning to respond to words such as 'no' or 'stop that,' does not consistently and regularly stop when someone calls his name, will not look in the direction of an object when that object is object is named consistently, and does not give toys or other things to a caregiver on request. These are just a sampling of skills that would be expected of a child his age. Expressively, though he does appear to playfully babble and sometimes reply vocally with nonspecific sounds when interacting with him, he does not have the speech sound repertoire that we would expect,

nor is he producing any words or word approximations for meaning. Additionally, though he has just started to play games such as 'Pat-a-Cake,' he is not yet playing 'Peek-a-Boo.' He is beginning to do some imitations in the form of raspberries and smacking his lips, though imitation in general is somewhat random." The evaluator reported that, based upon inconclusive results from a preliminary hearing test, the Child's hearing was going to be reevaluated the following month. The evaluator summarized that the Child, "is presenting with a significant impairment in all areas of communication including his development of speech sounds for articulation, his receptive (understanding) language, as well as expressive language. I am encouraged that he is beginning to do some degree of imitation though would like to see more consistency and a greater repertoire of motor imitation." In her recommendations, Ms. MacLeod stated, "I do think it would be appropriate to consider putting speech pathology services on this plan and would think that consultative services would be appropriate at this time."

3. An Occupational Therapy Pediatric Evaluation was performed on February 27, 2007, by Erica Engelmann, occupational therapy R/L. The Child was referred for the evaluation by Dr. Leonidas. The Peabody Developmental Motor Scale – Second Edition, was used to asses his overall fine motor skills. The evaluator reported that the Child's performance ranked within the third percentile range. The Child's overall performance fell more than 1.5 standard deviations below the mean, indicating "significant deficits overall." Self-care skills were also assessed using the Pediatric Evaluations of Disability Inventory. The Child's skills fell more than 1.5 standard deviations below the mean. The Child's sensory processing abilities were also assessed using the Infant and Toddler Sensory Profile.[1] The Child's performance fell more than one standard deviation from the mean in the areas of registration or the ability to recognize and immediately utilize sensory information. His performance in the following areas fell within the typical performance or average range: auditory, visual, tactile, vestibular, and oral sensory processing. The evaluator recommended continued work on his mobility, an expansion into language, and then into fine motor development later on. "Therefore, this therapist would recommend monthly consultation, consulting both with speech therapy and physical therapy, the family and other caregivers as appropriate to expand his play and functional skills." Long-term goals included: 1) demonstrating improved independence in his self-care abilities, specifically self-feeding; and 2) demonstrating improved ability to explore, learn, and play within his environment.

4. Pamela Peck, the Child's physical therapist, submitted a progress summary and plan of care, dated March 6, 2007. The progress report covered treatment delivered between December 6, 2006 and March 6, 2007. At the time of the report, the Child was 16 months old and attending Little Angels Daycare full time. The three outcomes included in his plan were: 1) the ability to demonstrate postural control; 2) self support in upright

[1] The evaluator explained that "A score of more than others in general means that the child has difficulty in this area more than other peers. A score of less than others would indicate that the child has difficulty with that skill less than other peers. Within those 2 atypical categories of less than others and more than others, there are 2 scores, including probable difference, which is 1 standard deviation or more from the mean, or a score of definite difference, which is more than 2 standard deviations from the mean, both indicate a deficit with definite difference deficits (sic) being of significant concern."

standing at chest-height surface for play; and 3) stand for two minutes to pursue toys and investigate his environment. The summary of the Child's physical therapy objectives within each of the three outcomes were reported as follows:

a) Improvement in dynamic trunk control evidenced by the ability to side-sit for reach of toy 10-12 inches to the left;
b) Achieved participation in transition from supine to sit with diaper change;
c) Achieved pull stand at support surface from a straddle sit position;
d) Some improvement in reaching forward from straddle position to retrieve a toy;
e) Achieved standing for two minutes at a support surface manipulating toys with one hand;
f) Achieved moving self forward with a commando crawl;
g) No change in progressing to crawling in quadruped distances of 4-6 feet.

Ms. Peck stated in her report that, "(The Child) has made great functional gains, though his initiation of the above mentioned activities is quite variable. (The Child) continues at times to stare off into space and does not perform on command successfully. Spontaneous activities, do appear much improved." Ms. Peck outlined five new outcomes on which to work. They included:

a) Pull to stand through half-kneel at support surface from quadruped;
b) Stand at support surface manipulating lightweight toys with 2 hands;
c) Lower himself with control to half kneel;
d) Creep up a set of 5 stairs with reciprocal technique;
e) Start to take steps with support at trunk.

Ms. Peck's stated plan was to provide physical therapy four hours per week in the form of consultation and treatment in the daycare environment as well as clinic-based activities. Emphasis would be on the home and daycare settings each session.

5. A developmental therapy progress report, dated March 12, 2007, was submitted by Cathryne Van Dolman, M.Ed., D.T. The report indicated that the Child's long-term goals were to: 1) improve his gross motor skills to a level commensurate with same-age peers; and 2) maintain receptive and expressive language skills to a level commensurate with same-age peers. The report stated that, "With assistance, (the Child) is occasionally able to sit independently. He is unable (sic) kneel or stand while holding onto an object. (The Child) will babble on occasion. (The Child) shows happiness and frustration through facial expressions and vocalizations. His visual tracking skills appear to be on target."

6. Ms. Van Dolman reported on 14 short-term objectives. The Child made "Adequate" progress in the following receptive language objectives:

    1. Correctly point to two body parts with prompting;
    2. Identify his mother by looking or pointing when asked "Where is _?" once per session;

3. Respond to his name by turning his head or making eye contact two out of three times per session;

With respect to expressive language objectives, the Child made the following progress:

- "Slow" progress in the areas of waving "hi" and "bye" once per session.
- "Good" progress in the following two objectives:
  - o Identifying the sound combinations "mama", "dada" and Baba", at least once per session;
  - o Identifying his mother through oral expression (i.e."Ma" for his mother) once per session.
- "Very good" progress in signing to eat when given two visual or hand over hand prompts once per session.

The Child "Achieved" the following motor skills objectives:

- Clapping his hands twice per session;
- Sit unassisted for one minute once per session;
- Creep two feet to obtain a desired object or destination twice per session;
- Kneel while holding onto an object for three seconds once per session;
- Stand while holding onto an object for five seconds once per session;
- Roll a ball back and forth two times per session.

7. A developmental evaluation was conducted on March 20, 2007. It was performed by Heidi LeBlanc and Christine A. Lindsey, Penobscot County CDS educational specialists. The evaluators used the Battelle Developmental Inventory, Second Edition (BDI-2). The BDI-2 measures adaptive, personal, social, communication, motor, and cognitive abilities. The Child's scores were as follows:

   1. Adaptive: 55 ("well below average range" and below the first percentile*);
   2. Personal Social Domain: 77 ("below average range" and at the 6th percentile*);
   3. Communication: 59 ("well below average range" and below the first percentile*);
   4. Motor Domain: 55 ("well below average range" and below the first percentile*);
   5. Cognitive Domain: 84 ("low average range" and at the 14th percentile*).

   * In comparison with same age peers

8. The BDI-2 report stated that the Child's score in the Personal/Social and Cognitive domains remained approximately the same as his BDI-2 score from 2006.[2] However, his scores were "significantly lower" than they had been in 2006 in the Adaptive, Communication, and Motor domains. The report stated, "It is typical for children with the diagnosis of Down's Syndrome to fall further behind their age peers on standardized tests as they age. This does not mean that (the Child) has not made progress in these areas, as we know he has, it does mean that his peers are gaining skills in these areas more quickly

[2] The Battelle was administered on May 18, 2006 which showed the following results: Adaptive: 90; Social/Emotional: 85; Communication: 73; Physical: 74; and Cognitive: 77. (Standard scores average 85-115)

than (the Child). (The Child) has many personal strengths including, but not limited to, his cognitive and social skills. Both his attentional capacity and his awareness of his surroundings and understanding of his environment are strengths for him. His interactions with adults and his own self-awareness are also personal strengths. (The Child's) weaknesses are his motor, communication, and self-care skills."

9. An Early Childhood Team (ECT) meeting was convened on May 16, 2007. Those present during the meeting included the Child's mother, Cathryne Van Dolman, Pamela Peck, Elizabeth (Betsy) Dyer, Holly Harrison, Christine Lindsey, and Carla Fancy, the Student's aunt. The minutes of the meeting were stated as follows:

> *(The Child's) current progress and evaluations were shared. Cathy Van Dolman Developmental Therapist reported that (the Child) was making great gains. Cathy suggested an increase in developmental therapy from 2x/ week to 3x/week. This was rejected due to his satisfactory progress on his current goals and due to his increase in his cognitive score as well as his now attending daycare and having more opportunities for pre-academic growth and personal/social opportunities. Pam Peck summarized her current plan of care and reported that (the Child's) strengths included bending his knees to get up and down and she feels (the Child) would benefit at this time if he was introduced to some supports for walking, possibly a walker. Pam also reported on Erica Engelmann's Occupational Therapy Evaluation. Erica's concerns were Fine Motor Skills, Self Care Skills and Sensory Processing. Pam suggested a 2 wk. trial period using the brushing Method. Pam will check with Erica on this matter. Erica recommended Occupational Therapy 1x month consultation with Speech, Physical Therapy, Developmental Therapy and Family. Betsy Dyer Speech/Language Pathologist reported on Kim MacLeod's Speech/Language Evaluation. Kim recommended Speech/Language Consultation Services. Christine Lindsey reported on the Battelle Results. (The Child's) Adaptive, Communication, Personal/Social and Motor skills were in the below normal range. His Cognitive Skills were in the low average range.*

10. The ECT meeting report noted that the Child's IFSP would include the following:

- Service coordination, occupational therapy consultation, and collateral services for 60 minutes once a month;
- Developmental therapy for 60 minutes twice a week;
- Physical therapy and speech-language consultation for 60 minutes twice a month

The IFSP included two “Outcome Statements,” including a case management outcome. Outcome Two was described as a “long term functional goal.” The statement for this Outcome read: “To improve (the Child’s) skills in development to more age appropriate levels.” The “Short Term Objectives” under this outcome generally specified the therapies the Child would receive, including DT, PT, SPL, and OT. No other specific information was included. “Progress” would be reported by service providers using their own measurable goals. These goals were not part of the IFSP document.

11. The Prior Written Notice (PWN), dated May 16, 2007, stated that physical therapy was reduced from three times a month to twice a month. It also stated that speech-language consultation would be provided twice a month and occupational therapy consultation would be provided once a month. It also stated that “At this time in (the Child’s) Developmental Stage, the ECT felt that the Child was showing some readiness skills for beginning Speech-language.” The PWN also stated, “Providing Physical Therapy at the current frequency was considered but rejected due to (the Child’s) mastery of objectives. Providing Speech Therapy at the current frequency was considered but would not be appropriate in assisting in strengthening (the Child’s) skills in expressive communication.”

12. Pamela Peck reported on the Child’s progress in a report dated June 11, 2007. Using the Peabody Developmental Motor Scale (PDMS-2) as a standard measure for gross motor performance, she reported that the Child was placed greater than three standard deviations below the mean with respect to his locomotion. She reported the level of progress in his objectives as follows:

    1. Will pull to stand through half kneel at support surface through quadruped. Status – with minimal assistance;
    2. Will stand at support surface manipulating lightweight toys with 2 hands without support. Status - no change;
    3. Lowers himself with control to half kneel and then to the floor. Status – is lowering himself with control through bilateral flexion to his bottom;
    4. Will creep up a set of 5 steps with reciprocal technique. Status – some improvement;
    5. Will start to take steps with support at trunk. Status – achieved.

    The evaluator recommended continuing services three hours a week, two being direct service, one hour being consultation service to encourage pre-gait activities, postural stability, and balance and equilibrium responses.

13. Cathryne Van Dolman reported on the Child’s developmental therapy progress in a report, dated June 12, 2007. The report noted that the Child made “adequate progress” in the following areas: pointing to two body parts; identifying his mother; responding to his name by turning his head or making eye contact; waving “hi” and “bye”. He made “good” progress in the following: babbling using the following sounds- “mama,” “dada,”, “baba;” and signing when to eat given two visual or hand over hand prompts. He made “excellent” progress signing “more” when given two visual or hand over hand prompts.

He "achieved" all of his motor skill objectives as noted in the prior progress report dated March 12, 2007.

14. In a letter to Penobscot County CDS, dated July 9, 2007, the Child's mother stated that she disagreed with some of the statements made in the ECT minutes of May 16, 2007 and wanted them corrected. The Parent stated:

> *In the notes, it is stated that an increase in developmental therapy from 2 to 3 times per week was denied because (the Child) was making satisfactory progress on his current goals. This is not the reason the increase was denied. The reason I was given during the meeting was that 2 times per week was all CDS would allow, in spite of the recommendations. Although (the Child) has made noticeable progress in DT, he still falls behind as demonstrated in his Battelle Evaluation as well as his DT reports. The notes also stated that providing physical therapy at the current frequency was considered but rejected due to (the Child's) mastery of objectives. Again, this is not accurate. PT was decreased because that was the only way, according to you and Christine Lindsey, that 2 speech-language consultations per month would be allowed. This was agreed upon by me, Pam Peck and Kathy (sic) Van Dolman only due to the fact that (the Child) is more significantly behind in his speech and language development than his other development and not due to his mastery of PT goals. The developmental evaluations will show that he certainly hasn't mastered these goals, especially since he is now 21 months old and still not walking. Pam Peck's progress report for the period of 3/6-6/11/07 also demonstrates that the Child is greater than 3 standard deviations below the mean with regard to his locomotion. This can hardly be considered mastery of his PT goals. I believe it was made quite clear by me and the attending therapists that we disagreed with the IFSP and that more DT, at least the current level of PT, and Speech/Language Therapy and Occupational Therapies are all needed, but we were told that that could not be approved due to state regulations. I am requesting that the meeting notes be updated to accurately reflect the conversation that transpired. If you decide not to make correction (sic), please at the very least include this letter in (the Child's) records.*

15. Penobscot County CDS did not respond to the Parent's request to amend the minutes.

16. In an interview with the complaint investigator, the Child's mother reported that in the IFSP meeting in May 2007, Pam Peck, the physical therapy provider stated that she would be willing to give up one physical therapy session a month so that the Child could have two speech-language consultations a month. However, the mother stated that she was still concerned about the Child's inability to walk. He was xx years old on xx/xx/xx,

and still not walking. She also reported that the Penobscot County CDS staff told the team that only two sessions a week of developmental therapy would be approved for any child, regardless of the recommendation to increase the level of service.

17. The Child's mother also stated that, although occupational therapy was agreed upon at the May 2007 ECT meeting, his first session occurred on October 22, 2007. She stated that it took CDS several months to provide it. The Child was put on a waiting list at Maine Rehabilitation because they did not have any openings.

18. The Child's mother stated that she had been frustrated with the lack of communication between herself and Penobscot County CDS staff. She explained that Laura Specyl, the speech-language therapist, had done an evaluation in the home in late July 2007, but that she did not hear anything from the therapist until late October 2007. She did not know that speech-language consultation services had been occurring at the daycare until she found out in mid October 2007 that Ms. Specyl had been going there to provide the consultation services. Neither Ms. Specyl nor the daycare staff had reported that services were being provided. She stated that since she had not heard anything from Penobscot County CDS, she went outside the program to get speech-language services. Since the beginning of October 2007, the Child was receiving direct services once a week. She engaged Dyer and Associates to provide the services because Elizabeth (Betsy) Dyer had extensive experience with Down Syndrome children and was flexible enough to accommodate the mother's work schedule. The mother mentioned that she had asked Penobscot County CDS to choose Dyer and Associates as the speech-language therapy provider, but that her request was not taken into consideration.

19. In an interview with the complaint investigator, Cathryne Van Dolman, the Child's developmental therapist, stated that she started working with the Child when he was an infant. Initially, services were provided for one hour per week. Then it increased from once to twice a week. She stated that, although the Child made some progress in 2006, he was not progressing the way that he should have. He still did not talk and was not walking. She stated that, during the May 2007 ECT meeting, she told the team that the Child was making some gains, but that he was still slow, and that was why she recommended consultation three times per week. The response from the Penobscot County CDS staff, Christine Lindsey and Holly Harrison, was that developmental therapy was limited to twice a week for a child his age. She recalled that the Child's aunt, who was present at the meeting asked the Penobscot County CDS staff if the limit on the number of hours was dependent on his age, to which the Penobscot County CDS staff replied in the affirmative.

20. Ms. Van Dolman also recalled that the Penobscot County CDS staff stated that the Child would only be eligible for one hour per month of speech-language consultation. The team believed that the Child needed more than one hour per month. She stated that there was an offer made to exchange one hour of physical therapy for an extra hour of speech-language consultation, an offer that was accepted by the Penobscot County CDS staff.

21. In an interview with the complaint investigator, Erica Engelmann, occupational therapist, stated that she performed an occupational therapy evaluation of the Child pursuant to a referral from his pediatrician. Her evaluation pointed to global delays, as was expected of a child with Down Syndrome. In terms of the severity of his fine motor delay, the overall motor quotient of 73 was statistically significant and more than 1.5 standard deviations below the mean. His visual motor development was far below average. His self care skills quotient was 1.5 standard deviations below the mean. Ms. Engelmann stated that her agency, Maine Rehabilitation Outpatient Center, had received a referral for service sometime in July 2007. The referral was mistakenly written for a one-time only consultation. However, she was told that the occupational therapy services were going to be for one session per month. She reported that her office contacted Penobscot County CDS and requested a new referral form, but never received another one. She stated that the Child's mother decided to start the services, which began on October 22, 2007, regardless of the referral issue. She stated that the referral was for direct service, but that there had been some discussion about going to the home and the daycare so that everyone understood what strategies were being used.

22. In an interview with the complaint investigator, Elizabeth (Betsy) Dyer, owner of Elizabeth G. Dyer & Associates, LLC, stated that the Child's mother requested that she attend the May 2007 ECT meeting. She stated that she was a speech pathologist and has a child with Down's Syndrome. She believed that the Child's mother requested the she provide direct speech-language services to the Child because of her specific knowledge in that area. She reported that during the May 2007 ECT meeting, she was asked to review the speech-language evaluation performed by Kimberly MacLeod, since Ms. MacLeod was not present at the meeting. She stated that she reviewed the report. She then asked whether direct speech-language services could be provided, rather than just consultation services. The Penobscot County CDS staff informed the team that direct services were not going to be provided because, based upon the regulations and the law, they were only allowed to provide "parent coaching." Ms. Dyer stated to the complaint investigator that it was her opinion that the Child needed direct speech-language services because he was severely delayed in that area.

23. Ms. Dyer also recalled that all the providers at the meeting in May 2007 expressed their concerns about the Child's lack of language progress. She stated that the CDS staff told the team members that the Child was only allowed one hour of speech-language consultation per month. Ms. Dyer reported that, based upon the limitation given, Pam Peck offered to give up one of her hours of physical therapy if the Child could have one more hour of speech-language consultation.

24. Ms. Dyer stated that, as owner of Dyer and Associates, one of her employees is developmental therapist, Kathy Van Dolman. Ms. Dyer stated that it was her opinion that the Child's other providers, such as speech-language therapist Laura Specyl, should have been in contact with Ms. Van Dolman regarding the Child's progress with his speech-language therapy, because Ms. Van Dolman had been the Primary Service Provider for the Child's services. However, to the best of Ms. Dyer's knowledge there had not been any contact from Ms. Specyl.

25. In an interview with the complaint investigator, Kimberly MacLeod, speech-language pathologist, reported that she recommended speech-language services for the Child based upon his need. She stated that she understood that consultation services were the preferred service provider service delivery model for children under three years of age.

26. In an interview with the complaint investigator, Laura Specyl, Penobscot County CDS speech-language therapist, stated that her first consultation was with the Child's mother on July 31, 2007. Thereafter, she has provided consultation services twice a month at the Child's daycare center. She stated that there had been inconsistent staffing at the daycare center, which has resulted in inconsistent, minimal progress. She stated that each time she is at the daycare center, she needs to explain the same things to different personnel. She described that during one session, she saw that the Child immediately put his arms up when a staff member approached, but the staff person did not respond by signing to him. She believed that the staff members have not been truly aware that they should be using those opportunities to try to reinforce and encourage the Child's participation. However, she believed that the staff was following through to a certain extent with her suggestions related to teaching the Child to communicate his wants and needs, particularly regarding food.

27. Ms. Specyl stated that she was glad to have met with the Child's mother in mid-October 2007 to get clarification of what he was doing at home. She told the mother that the Child needed to communicate his needs, especially in the area of food.

28. In an interview with the complaint investigator, Christine Lindsey, a former Penobscot County CDS education specialist, stated that she was assigned to the 0-3 age group team performing evaluations for Penobscot County CDS. She was assigned to administer the Battelle Developmental Inventory, Second Edition (BDI-2) evaluation to the Child. She also facilitated the ECT meeting in May 2007, a meeting she characterized as "awful." She explained that Elizabeth (Betsy) Dyer asked many questions regarding the provision of direct speech-language services, taking the meeting off track. Ms. Lindsey stated that she explained to the team that Penobscot County CDS was "mandated" to use the "parent-coaching" service delivery model rather than direct services, and that parent coaching is used to train caregivers to work with the child. Nevertheless, she believes the Child's mother became confused about how services were being delivered, and therefore advised the Parent to discuss the matter with the site director, Maribeth Barney.

29. Ms. Lindsey reported that, prior to May 2007, the Child was receiving physical therapy, developmental therapy, and collateral and service coordination. At the meeting in May 2007, monthly occupational therapy was recommended. Speech-language consultation services were recommended, although the evaluator, Kimberly MacLeod, did not suggest the frequency or intensity of that service. It was her opinion that since there was no evidence that the Child needed more developmental therapy, since his cognitive score on the BDI-2 had increased from the year before, no additional developmental therapy was added to the Child's IFSP. At some point during the meeting, the team discussed the amount of speech-language consultation that the Child needed. One of the participants in

the meeting asked whether physical therapy hours could be decreased in order to get an additional hour of speech-language consultation. Ms. Lindsey stated that she had no problem reducing physical therapy because the Child, who was in a daycare setting, did not need physical therapy three hours a week. She stated that if Pam Peck believed that the Child needed all three hours, she should not have agreed to the change. Ms. Lindsey stated that there was a discussion regarding the average number of hours of service. She stated that, although it was her understanding that the number of hours are dependent on the need of each child, the hours were "parent-based." She explained, "If they (parents) only want once a month when CDS thought twice a month, then it could only be once a month."

30. In an interview with the complaint investigator, Penobscot County CDS Site Director, Maribeth Barney, stated that she was surprised to learn that there had been an exchange of services at the IFSP team meeting in May 2007. She did not believe that there was a regulatory limitation on the number of hours of service to be provided. She stated that it was her belief that physical therapy services were reduced based upon the progress that the Child had been making.

31. Ms. Barney also stated that she was not sure what happened with a referral regarding occupational therapy services, but that she would look into whether a proper referral was ever submitted to the provider. As of the date of this report, no further information regarding the provision of occupational therapy has been submitted to the complaint investigator. Ms. Barney was also concerned that the Penobscot County CDS speech-language therapist, although providing consultation services at the daycare center, had not been in contact with the mother since July 31, 2007.

32. In an interview with the complaint investigator, Holly Harrison, Penobscot County CDS Service Coordinator, stated that she had been assigned to oversee the Child's programming. She said that she was new to the profession and asked Christine Lindsey to facilitate the May 2007 ECT meeting. She stated that although there were disagreements with respect to what evaluators were recommending, everyone was "pleased" with the progress the Child had made. She recalled that Pam Peck gave up one hour of physical therapy in order to have the Child receive an additional hour of speech-language consultation. She indicated that she was not sure whether it was allowable to give a child more service hours than specified in the regulations.

33. The complaint investigator met with, Debra Hannigan, CDS Board Chairwoman, and Jaci Holmes, assistant to Maine Education Commissioner Susan Gendron, to obtain information on service delivery models and their understanding of the presumption about the level and frequency of services which can be provided.

VI. Conclusions

Allegation No. 1: Failure to provide the following services: physical therapy, speech and language services, and occupational therapy consultation. MDOE Reg. Chapter 180 (for services provided before August 3, 2007) and Chapter 101.

Physical Therapy – **NO VIOLATION**

There is no evidence that the Child did not receive the level of physical therapy consultation services at the level stated in the IFSP from May 2007 and agreed upon at the ECT meeting held on May 16, 2007. The IFSP provided for two consultations per month. This is what the Child has been receiving.

The issue that has been raised is whether the level of physical therapy services was reduced at the meeting held on May 16, 2007, based upon an incorrect interpretation of MDOE, Chapter 180. For the discussion of this issue, see Allegation No. 2.

Speech-Language Consultation – **VIOLATION FOUND**

At the ECT meeting held on May 16, 2007, the ECT agreed to provide two hours per month of speech-language consultation services. These services began on July 31, 2007, with an initial evaluation that was done in the home. Between July 31, 2007 and the date of the submission of this complaint investigation request on August 27, 2007, there were five consultation sessions at the Child's daycare provider location. It is apparent that there were no services provided in June, and only one session in July 2007. Therefore, a total of three sessions were not provided.

It is also apparent that there was 1) a lack of communication between the Penobscot County CDS staff and the parents regarding whether there were services being provided; and 2) a failure to specifically note any speech and language outcomes in the IFSP. The Child's mother was unaware that services were being provided at the daycare or what progress, if any, was being made. In addition, no one from Penobscot County CDS was working with the parents to reinforce the work that was being done at the daycare center. It is apparent that Penobscot County CDS and its providers require a more formal method of communication in order to achieve specified desired outcomes for the Child. These outcomes need to be established by the IFSP process.

Occupational Therapy – **VIOLATION FOUND**

At the ECT meeting held on May 16, 2007, the ECT agreed to provide one hour of occupational therapy per month.[3] It was not until October 22, 2007 that occupational therapy provider Erica Engelmann began providing services. Between May 17, 2007 and October 22, 2007, no occupational therapy was provided. Penobscot County CDS has no explanation for the failure of the provision of this service.

Allegation No. 2: Imposition of a unilateral cap on services. MDOE Chapter 180 § X(3)(C)
VIOLATION FOUND

[3] Although there was disagreement regarding the number of therapy sessions the Child needed, there was no substantive evidence that there was a need for an increase. The Child's progress had been good, as noted in Ms. Van Dolman's progress reports. He achieved many of his objectives and was progressing on others.

A. The Limitation of Service Hours

MDOE Reg., Chapter 180 § X(3)(C) prescribed a presumption for the frequency and intensity of services to be provided to infants and toddlers ages 0 to 3 years old. Specifically it stated:

> For purposes of compliance with this chapter, the appropriate frequency and intensity of home-based developmental therapy/special instruction for any child B-2 eligible for developmental therapy/special instruction is *presumed* to be no more than two (2) hours per week for children three (3) or more years prior to kindergarten.
>
> In making recommendations for developmental therapy/special instruction, the ECT must consider the amount of time recommended for other services for the child, and the goals and objectives relative to those other services, in order to avoid duplication.
>
> The presumption of the appropriate frequency, intensity or duration of developmental therapy/special instruction *may be rebutted*, in the case of any individual child, by an IFSP team decision based on the following:
>
> a. An evaluation by a qualified provider who is not the child's provider of developmental therapy/special instruction, that includes a recommendation of a greater frequency, intensity or duration of developmental therapy/special instruction; and
> b. Documentation, in the child's IFSP, of the modifications and supports that have been tried or considered in the developmental therapy/special instruction program of the frequency, intensity or duration considered typical for the age of the child and rejected as inappropriate, and why.

MDOE, Chapter 180 was replaced by the Maine Unified Special Education Regulations, MUSER, on August 3, 2007. However, Chapter 180 was still in effect when the events occurred which are at issue in this complaint investigation. In addition, the new regulations outlined in the MUSER do not limit the frequency and intensity of services that can be provided by a CDS site. The presumption in Chapter 180 § X(3)(C), as cited above, can be rebutted by evidence that a child needs a higher level of service.

In this case, the weight of the documents submitted and witnesses' statements suggest that at the ECT meeting on May 16, 2007, the Penobscot County CDS staff informed the team members that the number of hours for services was limited based upon the Maine regulations. Since the team believed that speech-language consultation services were strongly recommended in Kimberly MacLeod's report, there was an agreement to reduce physical therapy services in order to add one additional hour of speech-language consultation services per month. The witnesses were clear that the exchange of services was not based upon a discussion of whether or not physical therapy services should be reduced. All the providers present at the May 16, 2007, as well as the parent, were clear

that the minutes from the meeting inaccurately reflected the reasons why the physical therapy services were reduced. Pamela Peck was clear that the offer to exchange services was made and accepted before there was any discussion regarding the level of physical therapy services that the Child needed. There was no indication that Ms. Peck was not credible in her statement. She stated that she was the person who made the offer because she believed so strongly that the Child had a greater need for the speech-language services at that time. She does not dispute that the Child made some progress in his physical therapy objectives. However, she did not believe that elimination of one hour of service was an appropriate action to take.

Based upon the above, it is apparent that the decision-making process at the May 16, 2007 ECT meeting was flawed because of the limitation of service hours placed on the IFSP Team by the Penobscot County CDS staff and the trading of one therapy for another. The IFSP Team must review whether the level of speech-language therapy is appropriate. It is apparent that many, if not all, ECT Team members were impressed by the lack of progress in the Child's communications skills. Therefore, the limitation placed upon the number of hours allowed for services was in error. If the evidence indicated that the Child was in need of greater services, then the team must have been able to approve an appropriate level.

It was apparent from this complaint investigation that there has been an interpretation of Chapter 101 by various Penobscot County CDS staff that service delivery models are limited only to those outlined in one single section of Chapter 101, which includes the Consultation and Primary Service Provision models. Although these models may be preferred, there is no requirement or mandate that these are the only service delivery tools. For example, there is no restriction on the use of direct service provision if the IFSP Team[4] believes that is what a child needs. In addition, the investigation also found that the use of the "parent-coaching" method of service delivery was a confusing concept to parents.

B. Impact on Physical Therapy Services

An issue raised in this investigation is whether there was a negative impact on the level of physical therapy services provided based upon the exchange of services that took place. Whether or not physical therapy services would have been reduced based upon the Child's need is not clear. Progress reports from both Cathryne Van Dolman, developmental therapist, and Pamela Peck, were not consistent in reporting the level of progress being made with respect to the Child's motor skills. The BDI-2 evaluation noted that the Child scored in the "well below average" range, compared with his same-age peers, in the areas of Adaptive, Communication and Motor skills. All of these scores were worse than those of the prior year, which could lead the ECT to believe that physical therapy hours should remain the same.

Evidence that physical therapy should have remained the same is included in Ms. Peck's June 11, 2007 progress report. The report indicated that the Child's level of

[4] The "ECT" reference was changed in Chapter 101 to refer the team as the "IFSP" team.

development of his locomotion skills continued to be greater than three standard deviations below the mean.

Based upon the above, it is inconclusive whether or not the Child was deprived of an appropriate level of physical therapy consultation because of the exchange of services that took place. However, since the IFSP team must convene to review whether the level of speech-language services are appropriate, it should also review the Child's physical therapy needs based upon the BDI-2 scores, Ms. Peck's June 11, 2007 progress report, and any additional information available.

VII. Corrective Action Plan

1. Penobscot County CDS must provide three speech-language consultations to compensate for the three that were not provided between July 31, 2007 and August 27, 2007.

2. Penobscot County CDS must provide four hours of occupational therapy services to compensate for the four sessions that were not provided between May 17, 2007 and October 22, 2007.

3. Penobscot County CDS must provide an initialed service log with dates, number of hours, and the names of the providers of speech-language consultations and occupational therapy services to the Due Process Office, the parents, the parents' advocate, and the complaint investigator.

4. Based upon the finding that the Penobscot County CDS IFSP Team process was severely flawed in this case, an IFSP meeting must be convened within two weeks of receiving this report, and the following regulations must be followed to ensure that the child's program is appropriate for him:

   a. Attendance at IFSP meetings:
   Chapter 101 §VI.1.B.(1) states:

   B. Initial and Annual IFSP Team Meetings for Children B-2 [34 CFR 303.343(a and b)].

      (1) Each initial meeting and each annual meeting to evaluate the IFSP must include the following participants:

         (a) The parent or parents of the child;

         (b) Other family members, as requested by the parent, if feasible to do so;

(c) An advocate or person outside of the family, if the parent requests that the person participate;

(d) The *case manager* who has been working with the family since the initial referral of the child for evaluation, or who has been designated by the public agency to be responsible for implementation of the IFSP and has written authorization to obligate the IEU's human and fiscal resources.;

(e) A person or persons directly involved in conducting the evaluations and assessments; and

(f) As appropriate, persons who will be providing services to the child or family.

(2) If a person directly involved in conducting the evaluations and assessments is unable to attend a meeting, arrangements must be made for the person's involvement through other means, including:

(a) Participating in a telephone conference call;

(b) Having a knowledgeable authorized representative attend the meeting; or

(c) Making pertinent records available at the meeting.

[NOTE from the complaint investigator: There appears to have been a conflict of interest between one of the providers of services to the Child and an advocate invited by the parent, and steps must be taken to avoid such conflicts. In this case, the supervisor of the Child's primary therapy provider was also present at the ECT meeting as an advocate for the Parent. This may have affected how the provider could respond in the IFSP Team meeting setting to suggestions made by the advocate, given the employment status of the provider. These issues should be resolved prior to the Team meeting.]

b. <u>Determination of Outcomes</u>

Chapter 101 §IX.1.D.(3) states the following with respect to what an IFSP should include for outcome:

> A statement of the measurable results or outcomes expected to be achieved for the infant or toddler and the family, including pre-literacy and language skills, as

developmentally appropriate for the child, and the criteria, procedures and timelines used to determine the degree to which progress toward achieving the results or outcomes is being made and whether modifications or revisions of the results or outcomes or services are necessary. (emphasis added).

The Child's IFSP, dated May 16, 2007, fails to include any statement of measurable outcomes for the Child and the family. The plan merely refers to the therapies and strategies used by the service providers. Therefore, the IFSP team must convene to amend the IFSP to include specific outcomes, based upon what is developmentally appropriate for the child, including the criteria, procedures and timelines used to determine the degree of the Child's progress.

In addition, the determination of outcomes must be developmentally appropriate, given the severity of the Child's disability and his early intervention needs. Goals to achieve skills to the same level as his same-age peers may not be realistic.

c. Natural Environment

Chapter 101 § X.1.B. requires that, to the maximum extent appropriate, early intervention services are to be provided in natural environments, including the home and community settings in which children without disabilities participate. This requirement is in place in order to enhance the capacity of the family in facilitating their child's development through natural learning opportunities that occur in community settings where children live, learn and play. The IFSP must reflect that the natural environment is where the services are provided unless it can be justified that an outcome or outcomes cannot be achieved satisfactorily by doing so.

In this case, it has been noted that physical therapy services are provided only at the provider's office. It is apparent that CDS has not worked toward finding physical therapy services that can be provided in the Angels Day Care facility, where the Child attends on a daily basis. It is unclear how, if at all, physical therapy has been integrated into the Child's natural learning opportunities at home or a day care. Therefore, Penobscot County CDS must ensure that these services can be integrated into the Child's daily living, that is natural, environments.

d. Service Delivery Model

The complaint investigation finding established that the IFSP Team participants did not understand how services were to be provided. What was determined in the investigation was that Penobscot County CDS has, almost

universally, determined that all early intervention services were to be provided using the Primary Service Provision (PSP) model, as described in Chapter 101 X.1.A.(2). Under this model, the provision of services is embedded in everyday routines and activities by one principal services provider. This provider will represent one of a variety of professional disciplines, as determined necessary by the IFSP team, to facilitate the child's progress towards specific IFSP outcomes. Under this model, therefore, no direct services are provided.

In this case, it is unclear whether Penobscot County CDS was actually using or enforcing how the PSP model was being established. Direct services were being provided: physical therapy twice a month, occupational therapy once a month; developmental therapy, twice a week. It was also unclear whether a primary service provider had been chosen and how that provider was communicating with other providers and parents. The PSP model is not exclusively mandated by Chapter 101. Although there are benefits to this model, the IFSP Team must determine how services should be delivered based upon the individual needs of the Child and the family.

If the PSP model is to be used in this case, it must be clearly established who the primary service provider is and how the provider must communicate with other providers, as well as with the family and day care personnel. Since there was no evidence that such communication system existed with the Child's team of providers, the IFSP Team must design a plan for orderly communication between all participants. For example, the IFSP did not indicate how family members were to be included in facilitating skill development for their Child, or when the primary service provider would communicate with family members about the Child's services.

If the PSP model is to be used, the IFSP must clearly establish the communication between providers, family, and day care personnel which must be in place to help the Child acquire the skills in all developmental areas.

e. <u>Authorized Representative at the IFSP Team meeting</u>

Given the unusual procedural history of this case, the IFSP Team meeting that will be convened to implement this corrective action plan shall be chaired by a person familiar with Child Development Services who has not had prior involvement with this case, and who is appointed by Commissioner Gendron. That authorized representative will be responsible for ensuring that an IFSP is either developed by consensus, or, if consensus cannot be reached, that Penobscot County CDS offers an appropriate IFSP to the parents.

5. Penobscot County CDS must provide a copy of the Advance Written Notice of the IFSP Team Meeting, the Written Notice issued after the IFSP team meeting,

as well as any notes that may be taken at the meeting by CDS staff, to the Due Process Office, the parents, the parents' advocate, and the complaint investigator.

Recommendation

The Penobscot County CDS should consider amending the minutes of the May 16, 2007 ECT meeting based upon the Parent's letter, dated July 9, 2007, requesting to amend the minutes. Chapter 101 § XIV.8.B. requires that school administrative units, which also include all intermediate educational units (see Chapter 101 § I,"Policy and Purpose"), must decide whether to amend the information in accordance with the request within "a reasonable period of time of receipt of the request." If the SAU decides to refuse to amend the information in accordance with the request, it must inform the parent of the refusal and advise the parent of the right to a hearing under 34 CFR 300.619. (34 CFR 300.618).