DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
Office of Dispute Resolution
1050 First Street, N.E., Third Floor
Washington, D.C. 20002

Student,[1] through *Parents*, *Petitioners*,	)	Case No.: 2018-0201
	)	Date Issued: 9/28/18
v.	)	Hearing Officer: Keith L. Seat, Esq.
District of Columbia Public Schools ("DCPS"), Respondent.	)	Hearing Dates: 9/13/18 & 9/14/18
	)	Hearing Room: 112

HEARING OFFICER DETERMINATION

Background

Petitioners, Student's Parents, pursued a due process complaint alleging that Student had been denied a free appropriate public education ("FAPE") in violation of the Individuals with Disabilities Education Improvement Act ("IDEA") because Student had not been provided a residential placement. DCPS responded that it had not received sufficient information to determine the need for a residential placement for educational purposes.

Subject Matter Jurisdiction

Subject matter jurisdiction is conferred pursuant to the IDEA, 20 U.S.C. § 1400, *et seq.*; the implementing regulations for IDEA, 34 C.F.R. Part 300; and Title V, Chapter E-30, of the District of Columbia Municipal Regulations ("D.C.M.R.").

Procedural History

Following the filing of the due process complaint on 7/31/18, the case was assigned to the undersigned on 8/1/18. Respondent filed a response on 8/21/18, which did not challenge jurisdiction. The resolution session meeting ("RSM") took place on 8/8/18 without success. The 30-day resolution period ended on 8/30/18. A final decision in this

[1] Personally identifiable information is provided in Appendix A, including terms initially set forth in italics.

matter must be reached no later than 45 days following the end of the resolution period, which requires a Hearing Officer Determination ("HOD") by 10/14/18.

The due process hearing took place on 9/13/18 and 9/14/18. Petitioners were represented by *Petitioners' counsel*. DCPS was represented by *Respondent's counsel*. At least one Petitioner participated in the entire hearing.

Petitioners' Disclosures, submitted on 9/6/18, contained documents P1 through P53, which were admitted into evidence without objection. Respondent's Disclosures, submitted on 9/6/18, contained documents R1 through R32, which were also admitted into evidence without objection.

Petitioners' counsel presented 4 witnesses in Petitioners' case-in-chief (*see* Appendix A):

1. *Evaluating Psychiatrist* (qualified without objection as an expert in Psychiatry)

2. *Parent*

3. *Attending Psychiatrist* at *Hospital B* (qualified without objection as an expert in Child Psychiatry)

4. *Educational Advocate* (qualified without objection as an expert in Clinical Psychology

Respondent's counsel presented 4 witnesses in Respondent's case (*see* Appendix A):

1. *Principal* of *Prior Public School* (qualified without objection as an expert in Educational Administration)

2. *Home and Hospital Instruction Program ("HHIP") Analyst* (DCPS)

3. *Director of Admissions* at *Nonpublic School*

4. *Compliance Case Manager* (DCPS)

At the beginning of the due process hearing, the parties stipulated to all of the factual findings set forth in the 4/14/18 HOD in Case No. 2018-0019 (corrected 4/30/18), which the parties agreed may be relied on and incorporated by the undersigned into this HOD.[2] The parties did not enter into any other stipulations.

[2] The stipulated Findings of Fact ("FOF") are followed by the paragraph number from the 4/14/18 HOD (corrected 4/30/18) and are incorporated herein using the public terms from Appendix A of this HOD for consistency, along with word edits by the undersigned as deemed appropriate.

The issue to be determined in this Hearing Officer Determination is:

Issue: Whether DCPS denied Student a FAPE by failing to place and fund Student in a residential facility despite (a) a July 2018 psychiatric evaluation, (b) the recommendations of 2 psychiatric hospitals treating Student, and (c) Student's inability to access education in a less restrictive environment. *Respondent has the burden of persuasion on this issue, if Petitioners establish a prima facie case.*

The relief requested[3] by Petitioners is:

1. A finding that DCPS denied Student a FAPE.
2. DCPS shall place and fund Student in a residential placement with transportation for Parents and Student.
3. Any other relief that is just and reasonable.

Findings of Fact

After considering all the evidence, as well as the arguments of both counsel, the Findings of Fact[4] are as follows:

1. Student is a resident of the District of Columbia; Petitioners are Student's Parents.[5] Student is *Age*, *Gender* and in *Grade* at Nonpublic School, which Student has not begun since being placed there in April 2018, due to an ongoing psychiatric hospitalization.[6] Prior to Student's current months-long hospitalization, Student lived with Parents and an older sibling who also has significant needs; both children were adopted but do not have the same biological parents.[7] Student's biological parents reportedly were convicted of murder and

[3] At the beginning of the due process hearing, Petitioners' counsel expressly withdrew the requested relief of "compensatory education for any denial of FAPE," asking that compensatory education be reserved for a possible future claim.
[4] Footnotes in these Findings of Fact refer to the sworn testimony of the witness indicated, to an exhibit admitted into evidence, or to a stipulated fact incorporated from the prior HOD using uniform terminology to keep confidential the personally identifiable information. To the extent that the Hearing Officer has declined to base a finding of fact on a witness's testimony that goes to the heart of the issue(s) under consideration, or has chosen to base a finding of fact on the testimony of one witness when another witness gave contradictory testimony on the same issue, the Hearing Officer has taken such action based on the Hearing Officer's determinations of the credibility and/or lack of credibility of the witness(es) involved.
[5] Parent; R25.
[6] Parent; Director of Admissions; P17-1.
[7] P1-1, Parent.

suffered from Schizophrenia; further, Student's biological father attempted to kill Student's mother while she was pregnant with Student.[8]

2. Student has a complex psychiatric history of aggression, command hallucinations, poor impulse control, suicidal ideation, and an eating disorder; Student has received a high level of services, but continues to have significant psychiatric symptoms that put Student at high risk of harm to self and others, with aggressive outbursts and continued episodes of self-harm, despite having 1:1 staff constantly monitoring.[9] Since April 2018 Student has declined in functioning, both academically and socially; Student has not been stable and had an increase in aggression and hospitalization.[10]

3. Since 2013 Student has received continual psychiatric treatment (approximately once per month) from a psychiatrist in New York; Student has been diagnosed by the psychiatrist with ADHD, Conduct Disorder, Mood Disorder, Schizophrenia, Learning Disorder and Eating Disorder.[11] Student has been treated with a variety of medications, including anti-psychotics, an anti-depressant and ADHD medications.[12]

4. Student has been determined eligible for special education and related services with the classification of Multiple Disabilities ("MD"), with both Emotional Disturbance ("ED") and Other Health Impairment ("OHI") based on Attention Deficit Hyperactivity Disorder ("ADHD").[13] Student has had an Individualized Education Program ("IEP") for Student's entire academic life.[14]

5. Student's current IEP, dated 8/8/18, provides for 32 hours/week of specialized instruction, 240 minutes/month of Behavioral Support Services, 60 minutes/month of Speech-Language Pathology, 120 minutes/month of Occupational Therapy, and 120 minutes/month of Physical Therapy, all outside general education.[15] Student's previous IEP, dated 12/11/17, provided for 30 hours/week of specialized instruction outside general education, 30 minutes/week of Behavioral Support Services inside general education, 60 minutes/week of Speech-Language Pathology inside general education, 30 minutes/week of Occupational Therapy inside general education, 30 minutes/week of Occupational Therapy

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[8] P1-1.
[9] P4-2 (as of 7/19/18); Evaluating Psychiatrist.
[10] Educational Advocate; Principal (Student previously not a danger to self or others at Prior Public School).
[11] Stipulated Finding of Fact ¶ 30 ("FOF-30"); P7-3; P4-2 (similar diagnosis by Attending Psychiatrist as of 7/19/18); P1-2,3,5 (Hospital A treatment team concerned about undiagnosed Autism Spectrum Disorder).
[12] P1-3.
[13] FOF-1; P18-1; P21-1.
[14] Parent.
[15] P18-16.

outside general education, and 30 minutes/week of Physical Therapy outside general education.[16]

6. Student's behaviors are "out of control" and Student is extremely dangerous to self and others.[17] Student was developmentally delayed and received services from six months of age; by age two, Student required a full-time 1:1 dedicated aide due to attacking "everyone" including babies, choking strangers, and forcibly trying to kiss people, among other things.[18] Student attempted to choke Parent as he slept, in April 2018.[19] Student has a history of self-injury, including violently hitting self in the eyes and face, scratching skin off face, trying to pull out own teeth, and punching fists through glass, as well as hurting animals, which Student reportedly enjoyed.[20] Student has auditory and visual hallucinations; voices have told Student to kill Parent and brother, as well as a teacher and school principal.[21] Student often urinates on the floor at home, despite an available bathroom, and drinks dirty water from the toilet bowl.[22] Student has a "talent" for manipulation and negative attention seeking.[23]

7. Parent had an independent neuropsychological evaluation conducted in January and February 2015 because of the behavior issues Student was exhibiting, with an evaluation report dated 3/1/15 in which the psychologist assessed Student's cognitive, academic and social/emotional functioning.[24] Student's overall cognitive functioning fell in the Average range with a full scale IQ of 94; the evaluator administered the Woodcock-Johnson III ("WJ-III") educational assessment and Student's academic functioning was Low to Average, with reading and writing abilities in the Average range, and math skills in the Low range.[25] A psychological and educational evaluation in July 2016 reflected a decline in Student's cognitive scores, with a full scale IQ of 71.[26]

8. In October and November 2017 Parent had Student evaluated by an independent psychologist whose office had conducted Student's 2015 evaluation; the psychological evaluation report was completed on 1/8/18.[27] Student's assessed cognitive and academic functioning declined between the two evaluations conducted in 2015 and 2017; Student's cognitive abilities had declined from Average to Borderline with a full scale IQ of 76.[28] The evaluation report recounted Student's history of self-injurious behaviors and auditory

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[16] P21-1,9.
[17] Parent.
[18] P1-2.
[19] *Id.*
[20] P1-2; P7-1.
[21] P1-2.
[22] P1-2; P7-1.
[23] P1-4.
[24] FOF-3.
[25] *Id.*
[26] FOF-4.
[27] FOF-20.
[28] *Id.*

hallucinations and noted Parent's desire that Student be placed in a residential therapy facility based on doctors' recommendations.[29] The psychologist on 1/8/18 did not recommend a residential placement based upon her inability to confer with Student's treating psychiatrist and Student's teacher(s) and confirm Student's symptoms and behaviors.[30] The 4/14/18 HOD concerning Student ordered that a psychiatric evaluation be undertaken by DCPS or an independent evaluator; an independent educational evaluation ("IEE") was conducted by Evaluating Psychiatrist with a report on 5/29/18, as discussed below.[31]

9. Petitioner requested that DCPS provide Student a residential placement when Student began attending Prior Public School on 11/15/17.[32] DCPS immediately contacted OSSE and on 11/20/17 initiated a formal change of placement request for Student; the request noted that Petitioner had provided DCPS a letter from Student's treating psychiatrist recommending a residential treatment facility with a nonpublic school with an intensive therapeutic setting.[33] On 12/4/17, DCPS and OSSE convened a change of placement meeting; Petitioner reiterated his request for a residential placement.[34] On 12/11/17, DCPS reconvened the meeting with Petitioner and the Prior Public School team; Petitioner again requested a residential placement for Student and provided a letter dated 12/8/17 from Student's psychiatrist that recommended residential placement.[35] DCPS convened a multi-disciplinary team ("MDT") meeting on 1/18/18, attended by Parent, his attorney and educational advocate at which the team reviewed Student's 1/8/18 psychological evaluation.[36] Parent's advocate requested that Student be provided a residential placement based on Student's documented mental health and history of self-harm and aggressive behavior.[37]

10. Petitioner and Student visited approximately five of the schools to which OSSE sent referrals, including Nonpublic School.[38] None of the schools Petitioner visited, except for Nonpublic School, accepted Student, either because the schools could not meet Student's needs or did not have an opening.[39] Student was admitted to Nonpublic School, but never attended due to hospitalization.[40] Nonpublic School had a total of 102 students in grades 1 through 12 with various disability classifications including ED and OHI; other students at Nonpublic School from time to time are hospitalized for social/emotional issues;

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[29] *Id.*
[30] *Id.*
[31] P47-17; P1-9 (DCPS does not conduct psychiatric evaluations).
[32] FOF-13.
[33] FOF-15.
[34] FOF-16.
[35] FOF-17.
[36] FOF-21.
[37] *Id.*
[38] FOF-23.
[39] *Id.*
[40] FOF-29; R18; Director of Admissions; P47-16 (placing and funding Student at Nonpublic School).

hospitalization is not an automatic basis for excluding any student from acceptance and attendance at Nonpublic School.[41]

11. Student was first hospitalized for psychiatric reasons from 9/17/17 through 9/29/17; Student's family relocated to the District of Columbia within weeks of Student being released from the hospital.[42] Since beginning at Prior Public School, Student has been psychiatrically hospitalized for self-injurious behaviors and auditory hallucinations telling Student to harm others.[43] Student has been hospitalized on multiple occasions: from 1/23/18 to 2/8/18, from 2/19/18 to 2/20/18, from 2/23/18 to 3/12/18, and from 4/8/18 during the April 2018 due process hearing.[44] On 5/21/18, Student began the Hospital B partial hospitalization program, but on the first day had auditory hallucinations telling Student to kill people; six staffers were required to restrain Student, one of whom was injured by a kick in the groin.[45] Student was transferred to the inpatient psychiatric unit at Hospital B on 5/22/18 where Student was admitted due to severe behavioral dysregulation, aggression, self-injurious behaviors, and reporting command hallucinations to harm self and others.[46] Student has remained hospitalized at Hospital B since 5/22/18 through the current due process hearing and is considered a "stuck kid" by Hospital B.[47]

12. When Student was discharged from the hospital early in 2017/18, Student's outpatient psychiatrist in New York recommended a residential treatment program be considered to address longstanding behavioral problems.[48] Student's psychiatrist recommended Student be placed in residential treatment because of Student's auditory hallucinations and hospitalization and because in his opinion Student's condition had not improved despite Student's placement in a nonpublic special education school in the past.[49] Student's psychiatrist provided two letters, one dated 12/8/17, and one dated 3/27/18, recommending Student be in a residential treatment facility with a nonpublic school with an intensive therapeutic setting so that Student had constant supervision for behavioral support.[50]

13. On 2/10/18, a DCPS psychologist conducted a review of Student's 1/8/18 psychological evaluation and noted that the 1/8/18 evaluator stated she could not clearly recommend residential placement "from a professional and ethical standpoint."[51] The DCPS psychologist recommended, based on her review of the evaluation, other documentation regarding Student, and a conversation with Student's Prior Public School

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[41] FOF-29.
[42] FOF-10; P1-3.
[43] FOF-26.
[44] FOF-26; P1-3.
[45] P1-3,4.
[46] P1-4; P36-5; P4-2.
[47] Parent; Attending Psychiatrist.
[48] FOF-11.
[49] FOF-30.
[50] FOF-30; P6-1; P7-1.
[51] FOF-25.

teacher, that Student be placed in a nonpublic special education separate school and not a residential placement.[52]

14. When student was released from Hospital A in April 2018, as upon Student's earlier discharges, Hospital A did not recommend that Student be placed in residential treatment.[53] However, Student's attending psychiatrist at Hospital A on 4/11/18 recommended a residential treatment facility because Student's safety could not be assured in an outpatient setting, with a goal of ultimately reintroducing Student into community and family environments.[54]

15. Evaluating Psychiatrist recommended in his 5/29/18 psychiatric IEE that Student immediately be placed in an appropriate residential setting where Student could receive 24/7 monitoring, psychiatric care and educational assistance to have the best chance of effectively addressing the "tragic trajectory" of Student's current life.[55] Evaluating Psychiatrist was very concerned about what happens when Student leaves the hospital, due to homicidal and suicidal ideation and ongoing risk of harming self in the absence of monitoring.[56] Evaluating Psychiatrist stated in his evaluation and credibly testified at the hearing that a residential therapeutic program is where Student's psychiatric, academic and social needs can best be addressed.[57] A residential treatment center is needed in part because Student feels safest in a stable setting like a hospital.[58] While evaluating Student, Evaluating Psychiatrist talked to Student's treating staff to get a sense of the next step for Student, and everyone Evaluating Psychiatrist spoke with thought Student needed a residential setting.[59]

16. Attending Psychiatrist, who currently attends to Student, stated in a "certificate of need" on 7/19/18 that Student's treatment needs cannot be met in a less restrictive setting than a residential treatment center, which would provide intensive ongoing therapy, medication management and appropriate educational placement to work on developing coping skills to be safe and successful in the community.[60] Student was not safe to discharge home and needed to be directly placed in a residential treatment center.[61] On cross-examination, Attending Psychiatrist credibly testified that residential treatment was not just a benefit to Student, but was "absolutely required."[62] Residential is the best option for Student's educational needs and therapeutic needs because Student can be very violent.[63]

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[52] *Id.*
[53] FOF-26.
[54] P5-1.
[55] P1-5.
[56] Evaluating Psychiatrist.
[57] P1-6.
[58] P1-5; Evaluating Psychiatrist.
[59] Evaluating Psychiatrist.
[60] P4-2; Attending Psychiatrist.
[61] P4-2 (7/19/18).
[62] Attending Psychiatrist.
[63] Educational Advocate.

Student could not access education while in the hospital, as the focus was on trying to stabilize Student there; once stabilized Student could receive instruction in the hospital, but at that point Student could be released to a residential setting which would be better for education.[64]

17. Attending Psychiatrist testified that Student improved in August 2018, so the 1:1 supervision was reduced to staff checking on Student every 15 minutes; however in the week prior to the hearing Student attacked staff at Hospital B and tried to bite them.[65] While it is not safe for Student to go home, Student has made all the progress possible at Hospital B and needs to be transferred to residential as soon as possible.[66]

18. A residential setting is the only environment in which Student can be adequately monitored and receive psychiatric care as well as education.[67] Student has no prospect of accessing education outside a residential setting at this stage, as Student needs constant supervision 24 hours/day.[68] In the absence of a residential setting with the stability of 24 hour/day structure and access to resources, Student will continue to decline, with an increased risk of harm to self and others, and will be unable to access the educational resources Student needs.[69] The premise of a residential setting is that Student would be stabilized and would have more educational options, as this is a critical developmental time for Student to be receiving education.[70] If Student were discharged without transferring to a residential setting, then readmission through an emergency room would be likely and the process of trying to stabilize Student would begin all over again, which would be very disruptive and hurt Student's education.[71]

19. DCPS sought to speak with Student's psychiatrists and stated at the RSM meeting that it was waiting on an updated medical release form before considering whether to provide residential treatment for Student.[72]

20. In late April 2018, Parent contacted and was working with Student's insurer to try to obtain a residential setting for Student.[73] Student's insurer is currently paying for Student's hospitalization at Hospital B and in September 2018 provided an application to be completed by Parent and Hospital B to determine whether the insurer would pay for Student's residential treatment.[74] Evaluating Psychiatrist testified that he was unsure about

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[64] *Id.*
[65] Attending Psychiatrist.
[66] *Id.*
[67] Evaluating Psychiatrist.
[68] Evaluating Psychiatrist; Attending Psychiatrist.
[69] Evaluating Psychiatrist.
[70] *Id.*
[71] Attending Psychiatrist.
[72] R32-2.
[73] P35-2; Parent.
[74] Parent.

the process for obtaining residential treatment for medical reasons, testifying that he had never gone through that process for any patient.[75]

21. In late April 2018, Parent sought help in placing Student at a residential treatment facility from DC's Department of Behavioral Health, but personnel there encouraged Parent to continue to "pursue school/residential placement through DCPS/OSSE" as Student seemed to need an environment that could address cognitive limitations and education needs as well as behavioral/emotional concerns.[76]

22. Student has not received HHIP or other educational services while in the hospital; Parent took HHIP paperwork to Hospital A in April 2018 and then took the paperwork to Hospital B when Student went there.[77] Parent was told that Hospital B doesn't work with DCPS due to the hospital's location; Parent asked Hospital B whether it would permit interim tutoring by DCPS and didn't hear back.[78]

23. If Student was not stable, that would limit the ability to provide HHIP services.[79] Student had not been stable enough to receive educational services until the last 3-4 weeks prior to the hearing.[80] HHIP definitely does not replace the need for a residential program.[81] HHIP would have difficulty providing all the hours on Student's full-time IEP, but the IEPs for children in hospitals are often amended since they are sick and cannot handle as many hours.[82] Attending Psychiatrist testified that it would not be appropriate or sufficient to consider HHIP in place of a residential setting; Student is no longer appropriate in a hospital and needs a residential setting for stability.[83]

24. HHIP Analyst testified that if Student can attend Nonpublic School, Student should do so, with education separated from residential for medical necessity.[84] Nonpublic School never taught Student, provided services or had any interaction with Student, so is not now able to say whether Nonpublic School is Student's least restrictive environment.[85] Since Student's behaviors escalated since Nonpublic School's last interaction with Student and the doctor now says it's not safe for Student to be discharged into the community, Nonpublic School cannot provide services to Student.[86] Nonpublic School has never educated a student who was in a residential placement; residential settings have schools and when

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[75] Evaluating Psychiatrist.
[76] P35-2; Parent.
[77] Parent.
[78] *Id.*
[79] HHIP Analyst.
[80] Attending Psychiatrist.
[81] HHIP Analyst.
[82] *Id.*
[83] Attending Psychiatrist.
[84] HHIP Analyst.
[85] Director of Admissions.
[86] *Id.*

students are released from residential they can return to Nonpublic School.[87] Compliance Case Manager testified that he was familiar with a residential setting in which students could go "off campus" to a nonpublic school, although it was some time ago in Kentucky.[88]

Conclusions of Law

Based on the Findings of Fact above, the arguments of counsel, as well as this Hearing Officer's own legal research, the Conclusions of Law are as follows:

The overall purpose of the IDEA is to ensure that "all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living." 20 U.S.C. § 1400(d)(1)(A). *See Boose v. Dist. of Columbia*, 786 F.3d 1054, 1056 (D.C. Cir. 2015) (the IDEA "aims to ensure that every child has a meaningful opportunity to benefit from public education").

"The IEP is 'the centerpiece of the statute's education delivery system for disabled children.'" *Endrew F. ex rel. Joseph F. v. Douglas County Sch. Dist. RE-1*, 137 S. Ct. 988, 994, 197 L. Ed. 2d 335 (2017), *quoting Honig v. Doe*, 484 U.S. 305, 311, 108 S. Ct. 592, 98 L.Ed.2d 686 (1988). "The IEP is the means by which special education and related services are 'tailored to the unique needs' of a particular child." *Endrew F.*, 137 S. Ct. at 994, *quoting Bd. of Educ. of Hendrick Hudson Cent. Sch. Dist. v. Rowley*, 458 U.S. 176, 181, 102 S. Ct. 3034, 73 L. Ed. 2d 690 (1982).

Once a child who may need special education services is identified and found eligible, Respondent must devise an IEP, mapping out specific educational goals and requirements in light of the child's disabilities and matching the child with a school capable of fulfilling those needs. *See* 20 U.S.C. §§ 1412(a)(4), 1414(d), 1401(a)(14); *Endrew F.*, 137 S. Ct. at 994; *Sch. Comm. of Town of Burlington, Mass. v. Dep't of Educ. of Mass.,* 471 U.S. 359, 369, 105 S. Ct. 1996, 2002, 85 L. Ed. 2d 385 (1985); *Jenkins v. Squillacote*, 935 F.2d 303, 304 (D.C. Cir. 1991); *Dist. of Columbia v. Doe*, 611 F.3d 888, 892 n.5 (D.C. Cir. 2010).

The IEP must be "reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances." *Endrew F.*, 137 S. Ct. at 1001. The Act's FAPE requirement is satisfied "by providing personalized instruction with sufficient support services to permit the child to benefit educationally from that instruction." *Smith v. Dist. of Columbia*, 846 F. Supp. 2d 197, 202 (D.D.C. 2012), *citing Rowley*, 458 U.S. at 203. The IDEA imposes no additional requirement that the services so provided be sufficient to maximize each child's potential. *Rowley*, 458 U.S. at 198. In its decision, the Supreme Court made very clear that the standard is well above *de minimis*, however, stating that "[w]hen all is said and done, a student offered an educational program providing 'merely

[87] *Id.*
[88] Compliance Case Manager.

more than *de minimis*' progress from year to year can hardly be said to have been offered an education at all." *Endrew F.*, 137 S. Ct. at 1001.

In addition, Respondent must ensure that to the maximum extent appropriate, children with disabilities are educated with children who are nondisabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. 34 C.F.R. 300.114; *Endrew F.*, 137 S. Ct. at 1000 (children with disabilities should receive education in the regular classroom to the extent possible); *Montuori ex rel. A.M. v. Dist. of Columbia*, 2018 WL 4623572, at *3 (D.D.C. 9/26/18).

A Hearing Officer's determination of whether a child received a FAPE must be based on substantive grounds. In matters alleging a procedural violation, a Hearing Officer may find that a child did not receive a FAPE only if the procedural inadequacies (i) impeded the child's right to a FAPE; (ii) significantly impeded the parent's opportunity to participate in the decision-making process regarding the provision of a FAPE to the parent's child; or (iii) caused a deprivation of educational benefit. 34 C.F.R. 300.513(a). In other words, an IDEA claim is viable only if those procedural violations affected the child's *substantive* rights. *Brown v. Dist. of Columbia*, 179 F. Supp. 3d 15, 25-26 (D.D.C. 2016), *quoting N.S. ex rel. Stein v. Dist. of Columbia*, 709 F. Supp. 2d 57, 67 (D.D.C. 2010).

Petitioner carries the burden of production and persuasion, except on issues of the appropriateness of an IEP or placement on which Respondent has the burden of persuasion, if Petitioner establishes a prima facie case. D.C. Code Ann. § 38-2571.03(6); *Z.B. v. Dist. of Columbia*, 888 F.3d 515, 523 (D.C. Cir. 2018) (party seeking relief bears the burden of proof); *Schaffer ex rel. Schaffer v. Weast*, 546 U.S. 49, 62, 126 S. Ct. 528, 537, 163 L. Ed. 2d 387 (2005). "Based solely upon evidence presented at the hearing, an impartial hearing officer shall determine whether . . . sufficient evidence [was presented] to meet the burden of proof that the action and/or inaction or proposed placement is inadequate or adequate to provide the student with a FAPE." 5-E D.C.M.R. § 3030.3.

Issue: *Whether DCPS denied Student a FAPE by failing to place and fund Student in a residential facility despite (a) a July 2018 psychiatric evaluation, (b) the recommendations of 2 psychiatric hospitals treating Student, and (c) Student's inability to access education in a less restrictive environment. (Respondent has the burden of persuasion on this issue, if Petitioners establish a prima facie case.)*

Petitioners did establish a prima facie case on the sole issue in the case based on Student's psychiatric hospitalizations and the testimony of attending and evaluating psychiatrists, shifting the burden to Respondent, which did not meet its burden of persuasion on the issue of whether residential placement was required for Student to receive educational benefits.

Quite simply, the applicable legal standard under the IDEA is that Respondent "must place the student in a setting that is capable of fulfilling the student's IEP." *Johnson v. Dist. of Columbia*, 962 F. Supp. 2d 263, 267 (D.D.C. 2013). *See also O.O. ex rel. Pabo v. Dist. of*

Columbia, 573 F. Supp. 2d 41, 53 (D.D.C. 2008) (placement must be in a school that can fulfill the student's IEP requirements). Here, Student's IEP requires over 30 hours/week of specialized instruction and related services. The issue is whether Student requires a residential placement in order to benefit educationally from the services and hours set forth in Student's IEP.

While on the most restrictive end of the IDEA's continuum of placements at 34 C.F.R. 300.115, a residential placement may be appropriate if necessary for educational purposes, but not if the residential placement is a response to medical, social or emotional problems that are segregable from the learning process. *See McKenzie v. Smith*, 771 F.2d 1527, 1534 (D.C. Cir. 1985); 34 C.F.R. 300.104 (a residential program must be at no cost to parents, if "necessary" to provide special education and related services to disabled child). *See also Dist. of Columbia v. Walker*, 109 F. Supp. 3d 58, 66 (D.D.C. 2015) (residential placement may be appropriate if necessary to obtain "any kind of educational benefit" and not used for medical, social, or emotional reasons with only "incidental educational benefit," *quoting Munir v. Pottsville Area Sch. Dist.*, 723 F.3d 423, 431 (3d Cir. 2013)).

Significantly, as noted above, the IDEA expressly mandates that disabled students be educated in their least restrictive environment to the maximum extent appropriate. 20 U.S.C. § 1412(a)(5). So a Local Education Agency must consider less restrictive alternatives before placing a student in a residential facility. *See Leggett v. Dist. of Columbia*, 793 F.3d 59, 72 (D.C. Cir. 2015) (residential placement necessary only where school officials failed to offer a day school reasonably calculated to provide educational benefits); *Teague Indep. Sch. Dist. v. Todd L.*, 999 F.2d 127, 132 (5th Cir. 1993) (residential placement is not appropriate when less restrictive placements can adequately meet a student's needs).

Here, Respondent did not contest Student's need for a residential setting, but asserted that it was only required due to medical necessity and not for educational purposes. Respondent argued that arrangements and funding for a residential facility should occur through Student's insurance or some other source other than DCPS. However, whether or not another source should provide residential treatment for Student is outside the purview of this Hearing Officer. The only issue before the undersigned is whether a residential placement is necessary for Student to benefit educationally from Student's IEP. Based on the compelling evidence in this case, this Hearing Officer concludes that the answer to that question is quite clearly Yes. Student does need a residential placement to be able to access Student's education and receive appropriate educational benefit based on Student's circumstances.

As an initial matter, it is abundantly clear that Student's hospitalizations have kept Student from benefiting educationally during most of the last four months of continuous hospitalization and many weeks off and on before that. While DCPS can provide educational services in hospitals through HHIP, DCPS's HHIP Analyst explained that Student not being stable would limit the ability to receive HHIP services. Specifically, Student's Attending Psychiatrist at Hospital B clearly testified that Student was not stable enough to receive any educational benefits at Hospital B over a period of months, until the last few weeks prior to the hearing when Student stabilized. But when Student was stable

enough for HHIP, Student was finally stable enough to shift to a residential facility where Student could receive a more appropriate and complete education, including interactions with peers.

Prior to the April 2018 hearing, there had been a split among professionals analyzing and working with Student about the need for residential placement. Student's longstanding psychiatrist in New York urged residential treatment, but an evaluator was unable to obtain answers to her questions so did not recommend residential, nor did the DCPS reviewer of the evaluation. Further, Hospital A had repeatedly cleared Student to return to school and the community upon release from the hospital, rather than recommending a residential setting.

However, beginning on 4/11/18 – the day after the April hearing ended – every psychiatrist (or other doctor in this record) involved with Student recommended a residential setting. On 4/11/18, Student's attending psychiatrist at Hospital A recommended a residential treatment facility for Student. In the 5/29/18 psychiatric IEE that Evaluating Psychiatrist conducted, he recommended that Student immediately be placed in a residential setting where Student could receive 24/7 monitoring, psychiatric care and educational assistance. Evaluating Psychiatrist stated in his evaluation and was highly credible in his testimony that Student's psychiatric, academic and social needs could best be addressed in a residential therapeutic program.

In addition, Attending Psychiatrist, who currently attends to Student, asserted on 7/19/18 that there was no less restrictive setting for Student than a residential treatment center, which could provide therapy, medication management and an appropriate education. Residential was considered by Attending Psychiatrist to be the best option for Student's educational needs and therapeutic needs because Student can be very violent. On cross-examination at the hearing, Attending Psychiatrist credibly testified that residential was "absolutely required" for Student and not just a benefit.

As for whether residential is needed for Student's education or simply for emotional and medical needs, Student's psychiatrists were very clear. Both Attending Psychiatrist and Evaluating Psychiatrist shared the view that Student has no prospect of accessing or benefiting from education outside a residential setting at this stage, for Student needs constant supervision 24 hours/day. Worse, in the absence of a residential setting, Student would continue to decline as Student has during 2018 and as shown in 2015, 2016 and 2017 evaluations, so Student would be unable to access the educational resources Student needs. The evidence was clear and persuasive to the undersigned that if Student is not released to a residential facility, Student would likely run into problems resulting in readmission through an emergency room and the cycle of trying to stabilize Student would begin all over again, which would be very disruptive and harm Student's education.

On the other side of the case, Respondent did not argue against a residential setting and did not present any doctors or medical personnel as witnesses in the due process hearing, despite bearing the burden of persuasion once Petitioners established a prima facie case. Instead, Respondent explained that it sought to speak with Student's psychiatrists before deciding on residential treatment for Student. When it was unable to reach Student's

doctors, Respondent argued at the due process hearing that a residential setting should be provided for Student based on medical necessity (by an entity other than Respondent) and that Student could attend Nonpublic School, which had previously accepted Student. Yet Director of Admissions testified that Nonpublic School has never educated a child who was in a residential placement, since residential facilities contain schools. When children are released from residential facilities they can return and attend Nonpublic School at that point. As for Student, Director of Admissions credibly explained that with escalated behaviors since Nonpublic School's last interaction with Student and Student's doctor saying it is not safe for Student to be discharged into the community, Nonpublic School could not provide services to Student. Nor was any other special education day school suggested by Respondent for Student, making this case similar to *Leggett*, 793 F.3d at 72, where residential placement was necessary when school officials failed to offer a day school that could provide educational benefits.

In sum, this Hearing Officer concludes that Respondent's failure to provide a residential placement for Student caused a direct deprivation of educational benefit and is thus a denial of FAPE. Student does need a residential placement in order to obtain educational benefits that are appropriate for Student's circumstances. This case resolves only whether a residential placement is necessary and not what location would be suitable, which is left to OSSE and the parties to determine as quickly as possible through existing procedures. The Order below requires that Student be placed and funded in an appropriate residential setting, along with transportation.

ORDER

Petitioners have prevailed, as set forth above. Accordingly, **it is hereby ordered that**:

(1) Within 30 days, Student shall be placed and funded in an appropriate residential setting, with transportation for Parents and Student.

(2) Any and all other claims and requests for relief are **dismissed with prejudice, except that this Order is without prejudice** as to Parents' right, if any, to seek compensatory education for the denial of FAPE found herein.

IT IS SO ORDERED.

Dated in Caption

/s/ *Keith Seat*
Keith L. Seat, Esq.
Hearing Officer

NOTICE OF RIGHT TO APPEAL

This is the final administrative decision in this matter. Any party aggrieved by this Hearing Officer Determination may bring a civil action in any state court of competent

jurisdiction or in a District Court of the United States without regard to the amount in controversy within ninety (90) days from the date of the Hearing Officer Determination in accordance with 20 U.S.C. § 1415(i).

Copies to:

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