STATE OF CONNECTICUT
DEPARTMENT OF EDUCATION

Student v. Board of Education

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Appearing before: Attorney Deborah R. Kearns, Hearing Officer

FINAL DECISION AND ORDER

ISSUES:

Whether the Board offered the Student an appropriate physical therapy program from November 30, 2007, to the present?

If not, whether the Parent is entitled to reimbursement for physical therapy services from a private provider from November 30, 2007, to the present?

Whether the Student requires physical therapy services from the private provider for ten hours per week to receive an appropriate program?

Whether the Student requires physical therapy services from the private provider for ten hours per week for the extended school year to receive an appropriate program?

PROCEDURAL HISTORY:

The Parent, through counsel, requested a Due Process hearing on December 1, 2008. At a prehearing conference on December 10, 2008, the parties agreed they would proceed to mediation. The first day of hearing was scheduled for January 9, 2009. Mediation was held on January 9, 2009; several issues were resolved. The Parent withdrew the resolved issues restating the issues for hearing, in a letter dated February 2, 2009. The attorneys agreed to an extension of the date to mail the final decision to schedule additional hearing dates and file post-hearing briefs. The hearing convened on January 23, 2009, January 26, 2009, February 23, 2009, March 16, 2009, March 17, 2009, and March 20, 2009. The parties agreed to a briefing schedule, the record closed May 2, 2009.

The date for mailing the final decision is May 29, 2009. The following witnesses testified at the hearing: The Parent; Ms Suzanne Davis of Pediatric Therapy, Assoc.; Mr. Mathew Gardella of Crossroads Physical Therapy; Ms. Susan Hogan of EASTCONN; Ms. Tirza Roda, Board occupational therapist. Ms. Debra Bubela of the University of Connecticut; Mr. Richard Bohannon of Physical Therapy Consultants; Ms. Hartigan, Board Director of Pupil Services.

To the extent that the procedural history, summary, and findings of fact actually represent discussion/conclusions of law, they should be so considered, and visa versa. Bonnie Ann F. v. Callallan Independent School Board, 835 F. Supp. 340 (S.D. Tex.1993).

SUMMARY:

The Student is diagnosed with Cerebral Palsy, Left Cerebral Hemiatrophy, Bilateral Optic Nerve Hypoplasia, Cerebral Calcifications, Diabeties Insipidus, and Hypothalmic Dysfunction. The Student has severe delays in gross motor, fine motor and communication skills. The Student has impairments to the sensory, visual, and vestibular systems. The Student has instability to the Autonomic Nervous System function. The individualized education program (IEP) provides for physical therapy for three hours per week, speech therapy for two hours per week, occupational therapy for two hours per week, and preschool instruction for one hour per week. The Parent claims the Student's IEP is inappropriate. The Parent provides private physical therapy for eight to ten hours per week. The IEP team rejected the Parent's request to include the private physical therapy services in the Student's IEP. The Parent claims the private physical therapy services are appropriate and necessary if the Student is to meet her educational goals and the Student requires the private physical therapy services to meet her complex needs.

FINDINGS OF FACT

1. The Student's diagnosis is Cerebral Palsy, Left Cerebral Hemiatrophy, Bilateral Optic Nerve Hypoplasia, Cerebral Calcifications, Diabeties Insipidus, and Hypothalmic Dysfunction. The Student's gross motor, fine motor and communication skills are severely delayed. Suzanne Davis RPT, of Pediatric Therapy Associates, provided treatment services for the Student, beginning when she was one year old. Ms. Davis referred the child to Crossroads Physical Therapy in December 2005. Ms. Davis continues to treat the Student annually, when the Student attends a camp in Connecticut. (Testimony, Davis, 2/23/09, Testimony, Roda, 3/20/09, B-36)

2. Ms. Davis, of Pediatrics Therapy Associates, describes the Student's needs. The child was hospitalized, as an infant, eight times, for high fevers. Repeated spinal taps injured the spinal tissue. A diagnostic MRI shows problems with the neurological processes. The Student is extremely sensitive. She has long periods of distressed crying. She is unable to maintain her body temperature, and has visual and vestibular/auditory dysfunction. The Student does not have self-calming strategies. When she is stressed she stiffens. Any therapist, who works with the Student, has to have full knowledge of the Student's impairments. She has neurological, musculoskeletal, respiratory, and digestive systems problems. The Student has significant impairment in her spine, apart from cerebral palsy. She is a very complex child to treat. (Testimony, Davis, 2/23/09, B-4, B-8, B-18, B-36)

3. Ms. Davis notified the Board about the Student's needs, in a letter dated August 22, 2008. (P-18). A Birth to Three therapist banged pots and pans to get a motor response. The sudden input caused the Student's autonomic nervous system to go into flight or fight mode. Ms. Davis urged the family to discontinue the services. The services caused the Student's nervous system to over-react. When the Student over-reacts, it causes increased irritability, which causes dehydration, which in turn, impacts the Student's ability to regulate her body temperature. When therapy discontinued, the Student was more stable. The Student must receive therapy from therapists experienced in Neurodevelopmental Treatment. They should be experienced with children with multiple impairments, including, instability in the autonomic nervous system functions. Without this knowledge, treatment can result in further brain damage. The Student requires 8-10 hours of physical therapy per week. (P-18)

4. Ms. Davis, testified by telephone from Florida. A Florida Notary Public, Mr. Francisco Carreras, established his authority to take an oath in the State of Florida. He then took the oath of the witness. The Notary agreed to monitor the use of exhibits provided by the attorney. He confirmed they are unmarked exhibits to be reviewed at the request of one of the attorneys. (Testimony, Davis, 2/23/09, Tr. at 178)

5. Ms. Davis has a Bachelor's degree from the School of Medicine at the University of Maryland and twenty-nine years of work experience. She is a member of the American Academy for Cerebral Palsy and Developmental Medicine, a member of the Neurodevelopmental Treatment Assoc., and an instructor in Neurodevelopmental Treatment. The witness is adjunct faculty at Florida International University and a guest lecturer at Nova Southeastern University in the Doctoral Program. The witness authored two articles and part of a book on Neurodevelopmental Treatment. The witness teaches, nationally and internationally. She teaches an eight week course for school-system physical therapists. It takes four years of training to become an instructor in Neurodevelopmental Treatment. Thirty people in the world are certified to teach the courses. (Testimony, Davis, 2/23/09, Tr. at 180-183)

6. Ms. Davis first evaluated the Student in November 2005. She describes the Student as stiff, very irritable, arching, and turning. The child had no independent movement. Ms. Davis last treated the Student in August 2008. Ms. Davis describes the child as very complex with multiple impairments. The Student has impairments to the musculoskeletal system and the neurological system. The Student has sensory system impairments. The Student is easily distressed causing uncontrollable crying. It is difficult to calm her nervous system. She has shallow breathing with an increased heart rate. She has very, unstable temperature regulation. Due to lumbar punctures, the child has decreased mobility in the spine. The area is very sensitive, unstable, and painful. Standard physical therapy treatment cannot help the Student to move towards function. The Student was referred to Crossroads Physical Therapy (Crossroads) for an evaluation. Ms. Davis referred three children to Crossroads in twenty-five years of practice. Ms. Davis treats clients, 20-40 hours per week. The witness believes the child's spinal injury causes pain. (Testimony, Davis 2/23/09, Tr. at 184 187-88, 203, 210)

7. The therapy focus is to move the Student towards functional activities. You must address the underlying impairments first. To move straight towards functional activities causes significant distress. First, the Student needs help to calm the nervous system, to be less stiff, and less hypersensitive. The witness has worked with many, medically-complex children, with cerebral palsy. The Student's nervous system is far more unstable than other severely, involved children, with whom I've worked. The Student's therapist must understand her sensory system impairments, at each treatment session, if the Student is to benefit from the therapy. The Student has multiple systems involved with her disability. (Testimony, Davis 2/23/09, Tr. at 193)

8. Ms. Davis trains school-based physical therapists. She reviewed, Exhibit B-47, an IEP progress report prepared by the school-based physical therapist. Ms. Davis states, the report is vague, it does not give a good description of the Student's current needs. It does not discuss the Student's impairments. Tolerating Ankle-foot orthosis (AFO) is not a functional goal in pediatric therapy. Exhibit B-47 does not explain the impairments that have to be addressed to improve the Student's function. Treatment strategies are not stated. A progress summary should state the reason the Student did not meet goals and objectives. Whether the impairments are addressed appropriately? When a child has not met two-thirds of their goals, a more elaborate report is appropriate. (Testimony, Davis 2/23/09, Tr. at 196, 216, 229)

9. Ms. Davis is credible in her assessment of the report, Exhibit B-47. She has outstanding credentials. She has experience in training therapist to provide school-based programs. Ms. Davis knows the Student and has provided therapy to the Student. She worked with the Student when she wrote the letter, Exhibit B-18. (P-15, P-18, B-47)

10. After the initial evaluation, the Student did not improve. Ms. Davis referred the Student to Crossroads Physical Therapy for evaluation. When the Student was referred to Crossroads she was unstable, irritable, susceptible to sensory influences, and unable to regulate her nervous system. After treatment first began at Crossroads, she was not as stiff and cried less; there was immediate, noticeable improvement. (Testimony, Davis, 2/23/09, Tr. at 47-48)

11. Ms. Davis worked with the Student in August 2008. She is much calmer and happier, indicating a more stable nervous system. She is attempting to reach with her arm to make contact with objects; her vision is more stable. She has a better sense of her body in midline. She is not arching and extending. The Student is able to maintain some flexion and keep her head in midline. She can tolerate position changes without distress. The witness observed the Student's treatment sessions with Crossroads therapists. The progress is attributed to treatment at Crossroads. When the witness began treating the Student, she cried during therapy. The Crossroads referral was not simply because the Student was crying. She was in extreme distress caused by the impairments to her sensory and autonomic nervous system. The reason for crying was beyond the scope of my skill, she needed someone experienced in working with her combination of impairments. The witness believes she is an expert in the field on physical therapy. The Student requires more than three hour a week of therapy. The testimony which reports progress is credible. Ms. Davis observed changes in the Student after the first treatment at Crossroads and over a long period of time. (Testimony, Davis, 2/23/09, Tr. at 197-199, 212, 219, 228-229,234, 236)

12. Neurodevelopmental Treatment (NDT) is a handling technique for working with a child with neurological impairments. The techniques regulate the tone or stiffness in the body. It is a hands-on approach of guiding the Student towards normal movement patterns, for better function. Every moment of every session requires constant evaluation of the Student's response to treatment. The goal is to allow the Student be independent. We improve alignment, to change stiffness and help move muscles in an appropriate motor pattern. My work used NDT, but it wasn't enough. The Student's autonomic nervous system and the sensory system deficits have to be addressed to permit guided, functional, movement patterns. The NDT literature does not have studies of children, as complex as, this Student. Ms. Davis does not believe a physical therapy professor, who does not provide hands-on treatment, is qualified to determine what the Student needs for physical therapy. (Testimony, Davis, 2/23/09, Tr. at 200-205, B-32)

13. The Student needs more than therapy that provides deep pressure input, predictable vestibular input, and soothing auditory input. The techniques were not enough to calm the Student. These techniques were not effective for the other physical, occupational, and speech therapists in Ms. Davis' practice. These are the strategies used by Ms. Hogan, the school-based physical therapist, to calm the Student. (Testimony, Davis, 2/23/09, Tr. at 221-223)

14. Ms. Davis reviewed Exhibit P-18, a report she wrote, dated, August 22, 2008. Ms. Davis recommends 8-10 hours per week of physical therapy. Physical therapy for three hours per week is not adequate to make the functional changes the Student needs for the academic setting. She needs more physical therapy to address her complex impairments. The recommendation is made for educational purposes, to make the Student available for learning. In the past, the Student regressed, when therapy was not available, or when the treatment causes crying and a startle response. The child's nervous system requires the support provided by Crossroads to progress. One physical therapy principle for working with children, is first to work through the impairments; then work through the systems; and then work on the overlying function. Crossroads is appropriate for the child. They are unique and highly skilled in working with very complex children. The Student was referred to Crossroads because manual therapy makes changes, in complex children. (Testimony, Davis, 2/23/09 Tr. at 206-208)

15. Crossroads Physical Therapy provides private physical therapy (PT) for the Student 10-15 hours per week. It is a for-profit center, payment is from clients or insurance companies. The Student is treated by Mathew Gardella who works at Crossroads. He testified his work experience includes the Burke Rehabilitation Hospital in White Plains, New York; Montowese Health and Rehabilitation; and Crossroads Physical Therapy, for the past eight years. He teaches Physical Therapy at Mercy College, Quinnipiac University, and a program offered by Crossroads. He is licensed in New York, Massachusetts, and Connecticut. Steve Moran, another Crossroads' physical therapist, has a doctorate. He teaches at Quinnipiac University, Trinity Seminars, and the University of Massachusetts, Medical School. Mr. Moran is a licensed physical therapist in New York, Massachusetts, and Connecticut. The Student was first evaluated in December 2005. Ms. Davis believes the Student benefits by the therapy offered at Crossroads. As a physical therapy expert, Ms. Davis was unable to work

with the child; she believed there was something more going on with the child. (Testimony, Gardella, 2/23/09)

16. Crossroads first evaluated the Student when she was 1.5 years old. She screamed all the time and had very protective posturing. The Student exhibits Asymmetrical Tonic Neck Reflex (ATNR) which is seen in children under the age of three months. The Student exhibits severe neurological injury. When she came, the Student was extending her body, very stiff and rigid, and cried twenty-four hours a day. Children come to my office from California, New York, New Jersey, Massachusetts, New Hampshire, Rhode Island, Maryland, Virginia and Connecticut. In all the years he practiced, Mr. Gardella has not seen such a complex Student. (Testimony, Gardella, 2/23/09, Tr. at 58-59)

17. Mr. Gardella describes a child in a lot of distress. At the first evaluation, we were able to reduce tone; she stopped screaming. The Student went from extended posture to a flex position, during the first session. Her arms moved from extension above her head to a mid-line position. I saw a dramatic change the first day; she was more at ease and more organized. (Testimony, Gardella, 2/23/09, Tr. at 14)

18. The medical history from the Parent and Ms. Davis reports the Student screamed 24 hours a day. I was shocked to learn the early intervention physical therapist tried to stimulate movement by banging pots and pans. This caused a startle response, which pushes the Student further into a protective mode. There is no reason to doubt the Parent's report because the Student exhibited the behaviors. (Testimony, Gardella 2/23/09, Tr. at 193)

19. Mr. Gardella evaluated the Student to determine the techniques to be used. If the body has low tone, certain techniques increase the tone. Manual therapy compliments some of the traditional techniques. The therapist evaluates the body for function and structure. The structure dictates the function. A dislocated shoulder joint will stop the movement to raise the arm above the head. The function can also influence the structure. If you run a marathon, the repetitive movement can cause pain, resulting in limited movement. Manual therapy will evaluate both the structure and function. I monitor the Student's response. I look at her smile, movements, muscle tone, eye coordination, her response to sound, and how her body is moving in space. Manual therapy is taught in universities; the Connecticut Physical Therapy Association gives continuing education credits for the courses. Manual therapy is a graduate level, physical therapy program. Manual therapy techniques include spinal techniques, extremities techniques, and nerve techniques. I use traditional physical therapy techniques. (Testimony, Gardella, 2/23/09, Tr. at 20-22)

20. Mr. Gardella describes the Student's disabilities. She has severe developmental disabilities. Her motor milestones are grossly limited. She requires assistance to roll over. She has significant visual deficits. Eye movement indicates when the Student is not using central focus and is relying on peripheral vision. She has poor balance, poor trunk control, and cannot hold herself up against gravity. Her hearing is hypersensitive. She responds to unexpected sound with a startle response. She has tactile defensiveness that will cause a startle or protective response. The response causes the child to reflex and extend. Structurally, she has contractures, with stiff ankles, a lot of extensor tone in her legs, and

more tone on one side. She has more tone in the extremities than the trunk. Her extremities are trying to hold up the trunk. (Testimony, Gardella, 2/23/09)

21. The spinal cord had damage from lumbar punctures. Ultrasound confirms there is scar tissue. The damage impacts the diaphragm, which impacts breathing. The *dura mater* is the protective tissue surrounding the spinal cord. The tissue is unique; it produces extra-segmental reference of pain. This is similar to the pain produced by a disc injury. The scar hurts when the vertebrae moves, and when the pain sensitive, *dura mater,* is disturbed. The spine is stuck in a flexed position causing the Student to bend forward. Breathing is impaired due to the posture. Extending the spine improves breathing. The shoulders and neck are working to produce respiration. This is breathing controlled by the brainstem. A person, who has just been running, breathes with the shoulders. Brainstem controlled breathing increases the autonomic nervous system, fight or flight response. The Student must be able to extend the spine without pain to use relaxed breathing. When the breathing is relaxed her attention can shift from survival to readiness for learning. Therapy is needed to move the Student away from the primitive survival mode. (Testimony, Gardella, 2/23/09)

22. Injury to the spine inhibits natural reflexes to lift the head, when the child rolls over. The Student's posture limitations, cause build-up of fluids and gas in the sinuses. Therapy techniques that address the problem, complement the Student's mobility. (Testimony, Gardella, 2/23/09)

23. The Student is unique; she can't regulate temperature and hydration. Extremes in these systems cause the Student to be lethargic and fighting for survival. Collaboration with the Parent and Dr. Moran is frequent. No one from the school team has contacted the witness to learn about the Student's physical therapy needs. (Testimony, Gardella, 2/23/09)

24. The three main sources for sensory input are vision, proprioception (from joint compression) and vestibular/auditory. Visual limitations impact the child's mobility. It is difficult for her to relax until her vision provides information that she is safe in her environment. The Student's particular combination of impairments makes her unable to obtain visual, proprioceptive, and vestibular input, to determine where she is in space. She feels like someone churning in a wave or an avalanche. Since she is able to use her central hearing, she can be cued to anticipate movement. It helps her tolerate position transitions used in physical therapy without reverting to a startle reaction. Therapy helps integrate these sensory systems. (Testimony, Gardella, 2/23/09 Tr. at 39)

25. The head up position requires multiple systems. The musculoskeletal system provides the framework, but the central nervous system must integrate and orchestrate the movement. The visual system provides information about position in space. The vestibular system provides information about balance and gravity. Movement requires muscle and bones, nerves, blood flow and respiration. As a physical therapy undergraduate, anatomy and physiology and some techniques to treat are taught. How the systems integrate, is not taught. (Testimony, Gardella, 2/23/09)

26. The Student has complex system deficits. She has difficulty extending her spine; she sits flexed forward. Extending the spine to sit in an upright position causes discomfort due to scar tissue. We can work to extend the spine because she is still young and pliable. She requires 20-30 minutes of preparation. If I skip the preparation, she will scream. The Student requires preparation to avoid reacting to sudden changes in position due to nervous system impairments. Without consideration of the multiple systems, I would move the child through a therapeutic sequence to get them to sit, crawl, and walk. If I can't get the child to sit, it makes no sense to start to walk her. We must build on the foundations. I must be aware of how long it is taking for the Student to process where she is in space. If she is moved before she is ready, it will feel like she is spinning. Moving her too fast causes her to resort to primitive patterns. Mr. Gardella understands the need for daily assessment. (Testimony, Gardella, 2/23/09 Tr. at 43-46)

27. The prone position requires preparation because of her back. The Student must first be assessed at each visit to determine what she can do. Some days, she is not ready for aggressive movement. I must rely on more passive techniques. With proper preparation, she is tolerating prone position. She is starting to pick up her head despite her central vision deficits. Vision stimulates the child's desire to move towards something that is seen. (Testimony, Gardella, 2/23/09 Tr. at 48)

28. The Student is able to be placed in a hands and knee position, quadraped. Recently, she attempted tall kneeling. With some rocking, she started to move her legs making some attempts to crawl. She is showing signs of development. (Testimony, Gardella, 2/23/09, Tr. at 49)

29. The Student can be placed in standing position. Positional techniques reduce tone. Movement to kneeling shows whether the Student's spine can tolerate weight bearing. It can take a half-hour depending on the day and her tone level. Preparation is taking less time because her systems are getting integrated. She may be able to remain in the position for 10-30 minutes. One-hour may not be enough time for a therapy session. (Testimony, Gardella, 2/23/09, Tr. at 57-58)

30. When the Student is fearful, she requires passive mobilization and positional techniques. Position techniques help the systems integrate. When she is ready to move, I can transition her to a more organized [higher level] positions. I often see the child as fearful. I then need to adapt to her needs to bring her out of the primitive reflex position. It is now easier to move her out of a primitive response, than when she began therapy. When the Student is upset, the Parent sometimes reports she has had a tough time in [school] therapy. Mr. Gardella does not believe it is appropriate to begin every session with bouncing the Student up and down. If she is in a more primitive state, bouncing is not going to be appropriate. It may elicit a fear response. The daily treatment plan is developed by first assessing the child. The goals remain the same; hold up her head, reduce tone in her limbs, and develop good trunk control. How to achieve the goal is up to the expertise of the clinician. (Testimony, Gardella, 2/23/09 Tr. at 50-2)

31. The Student exhibits spinal injury by her limitations. In a sitting position, she is flexed forward; sections of the spine do not arch. When her back extends, the spine is stuck in a flex

position. The limited mobility is due to scar tissue. This is confirmed by medical history and ultrasound. It surprises me, that Ms. Hogan states there is nothing wrong with the Student's spine. Background information and medical history is important before providing physical therapy. (Testimony, Gardella, 2/23/09 Tr. at 57-59)

32. Mr. Gardella spends 40-50 hours per week treating clients. He does not believe, Mr. Bohannon, who does not do clinical work, can assess the Student without seeing her. The expertise of the clinician is working in the trenches with patients. Mr. Gardella never worked with a more complex child, than the Student. I can't look at a piece of literature and determine the child's needs, without putting hands on the child, it is not appropriate. It is the clinician's job to assess and evaluate the child. (Testimony, Gardella, 2/23/09 Tr. at 59-60)

33. Neurodevelopmental techniques were developed for working with children with have special needs and neuro-musculoskeletal injuries. The handling techniques help the body develop postural control by facilitating the body with hand placements. You assist the movement patterns. The hand may slightly turn the head or move the trunk, to induce the child to roll. The technique is used with the child, but it is not the primary technique. Manual therapy consists of a host of techniques. (Testimony, Gardella, 2/23/09)

34. Techniques using repetition and exposure will not be effective for the Student because of her visual and vestibular deficits. Repetition is ineffective, if I don't address the root of the problem. Repetition can help reinforce movement, after it has already been learned. If the Student is in protective mode, learning does not register in the primitive areas of the brain. I use stretching and range-of-motion, all traditional physical therapy. The Student's largest deficit is her sensory system. It is critical to understand integrating these systems from a physical therapy standpoint. Integrating the sensory input from the environment is critical to movement. Without it, all the therapy will not result in progress. School systems pay for Crossroads services, including the therapy techniques used for the Student. The techniques are the tools to accomplish therapy. (Testimony, Gardella, 2/23/09 Tr. at 64-71)

35. Techniques which use colored toys on the Student's seat are not effective to encourage movement, the Student processes the information using her peripheral vision. The Parent's voice can be processed with her central hearing, which can encourage movement. (Testimony, Gardella, 2/23/09, Tr. at 68)

36. The position of the head on the neck is critical for vision. If the head is tilted one way and turned another, it causes difficulty with vision. The therapist must use a cranial technique or a cervical technique to get the head in line with the body. Some research can say this doesn't work, other research says it does. If I don't use a cranial or cervical technique, and do nothing, the child still has a tilted head. I must determine the intervention based on the child's needs. (Testimony, Gardella, 2/23/09, Tr. at 72)

37. The Student has made progress, when she arrived she was constantly in a protective response. She showed primitive brain stem reflexes, rigid extension, and screaming. Now I see her sitting in midline, upright at times, lifting her head in an attempt to organize movement. She tries to turn her head when someone walks into the room. She is starting to

move her legs. Progress is attributed to the therapy she receives at Crossroads. No other therapy is integrating these systems. Ms. Hogan needs to understand the child's sensory system because she is doing movement. The occupational therapist cannot make up for sensory needs in separate sessions. If a primitive extension happens when the Student is moved improperly; she will cry and extend. If the child is crying one or two times per session, if more than momentary, it is not good. It can cause her to regress, into more primitive responses. The Student does not cry and startle during my therapy sessions. She does not have speech, so crying is her way of saying ouch. (Testimony, Gardella, 2/23/09, Tr. at 73-80)

38. Evidence based practice is the latest trend in physical therapy. There are three components considered when making a determination for treatment. The literature about different treatments, the opinions of experts who provide therapy, and the patient's preference for a given therapy. The literature simply reports findings, it does not state that a treatment is right or wrong. (Testimony, Gardella, 2/23/09)

39. It is important for any therapist working with this Student, to be trained in systems-based manual therapy. The Student has injury to multiple systems. A two-day seminar is not enough training in manual therapy. (Testimony, Gardella, 2/23/09)

40. I don't recommend ankle-foot orthosis (AFO) at this time. The Student is attempting to integrate proprioceptive input. The ankle joint registers information about the standing surface. The knee and hip joint compress and provide feedback to the brain, about the position in space. Placing something rigid, like the AFO, between the floor surface and the foot, limits proprioceptive feedback. The AFO's prevent pushing up on toes, which prevents plantar flexion. The feedback is necessary for nervous system development. Fixing the foot at the ninety degree angle, can cause complications in the hip joint and lower back. The Student has to show consistency in standing without the brace; and tolerate different surfaces, before using AFOs to take steps. The type of AFO needs to be evaluated. (Testimony, Gardella, 2/23/09, Tr. at 82-84)

41. There is a finding a therapist working with the Student has to have sound training, information and judgment to determine the Student's needs on a given day. Use of AFO's or the walker can cause injury to the back or hip. A physical therapy sequence cannot take priority over the needs the Student presents in a physical therapy session.

42. A walker is not appropriate for the Student at this time. The Student is just coming out of the primitive reflex. In her brain, she is starting to develop a sense of where she is in space. She needs to be able to bend, turn, and touch her toes; she can't do in a walker. The walker will be appropriate after she has learned where she is in space. The Student's movement pattern suggests she is still learning about her orientation in space. (Testimony, Gardella, 2/23/09 Tr. at 84-86)

43. Bouncing the Student up and down, to prepare her for the walker, might not be appropriate, on two levels. The Student may not need to be bounced. She may not be ready to be placed in the walker. If her back is not prepared to come out of the flex position, it could cause a

painful stretch. If she does not want to be placed in the walker, anger is the only way she can express dissatisfaction. Pain and anger trigger primitive emotions. Supportive equipment, braces, walkers, and body jackets are not appropriate at this time. The Student is still figuring out where she is in space. The Student's focus in therapy is to hold the head upright, decrease shoulder elevation, and transition from side-sitting to supine. The goal is for the Student to remain calm and relaxed during movement and transition activities. (Testimony, Gardella, 2/23/09, Tr. at 91-94)

44. The Student receives physical therapy 10 hours per week at Crossroads. Mr. Gardella provides two to four hours of therapy. The Student is very complex. She requires a hands-on approach to monitor her for safety, development, and progress. There is a risk of regression if therapy is discontinued. The Student can slip back to the primitive patterns she had, when she first came to Crossroads. She was stuck, screaming twenty-four hours a day, and unable to sit. It is not possible to separate the Student's medical needs from her educational needs. If you ignore the spine and breathing, you will severely limit her ability to sit upright and know where she is in space. Her breathing had been overlooked before she came to us. (Testimony, Gardella, 2/23/09, Tr. at 95-118; B-37)

45. Mr. Richard Bohannon cannot determine whether therapy techniques are appropriate without seeing the Student. It is not possible for Mr. Bohannon to know what the Student needs on a given day, if he hasn't assessed the child. Mr. Bohannon has never met the Student. (Testimony, Gardella, 2/23/09, Tr. at 98-99; B-32)

46. The Student's endurance level may make it necessary to change the pace or move to more passive therapies. Therapy does not terminate because of endurance. Ms. Hogan's log does not show the child is having difficulty with endurance. Mr. Gardella testified the Student's respiration and endurance improves from therapy. It makes her more available for learning. (Testimony, Gardella, 2/23/09, B-17)

47. Crossroads Physical Therapy provided services to the Student before she entered the Board's school system. Consultation with the treating therapists would provide important information about the Student's physical therapy needs. The Student attended the Crossroads therapy program for fifteen hours per week compared to Birth to Three, for two hours per week. The team adopted an inappropriate program for physical therapy service. (B-16, B-17, B-47, B-48, Testimony, Gardella, 2/23/09 Tr. at 115, 149)

48. The Crossroads, physical therapy evaluation is part of the record maintained at Crossroads. The therapist uses some cranio-sacral techniques, a gentle position technique, to reduce tension at the base of the skull if the Student is showing extensive muscle spasm and showing poor biomechanics of movement. Myofacial release, allows the tissues surrounding the muscle to lengthen. Muscle tissue does not stretch. It is the facia, the connective tissue that allows the muscles to elongate. When developing a treatment program for the Student, Crossroads consulted with the Student's pediatrician and her eye doctor. The Parent keeps Crossroads updated on medical issues. (Testimony, Gardella, 2/23/09 Tr. at 123-131)

49. Mr. Gardella agrees with the Connecticut Guidelines for Physical Therapy in Educational Settings, which states the focus of educational physical therapy should be to acquire functional abilities, to access education, and adapt to the education environment. Crossroads works to improve the Student's functional activities, moving towards being able to sit and work in a classroom. Currently, the Student's educational setting is the home. A walker is beginning to be more appropriate, as the Student is able to accept weight bearing. When the equipment is not appropriate, therapy is used to prepare her to tolerate standing. Any therapist, who provides physical therapy to this child, must consider her sensory needs. The Student's sensory needs are an essential part of providing physical therapy to the child. Treatment involves movement. First the child must understand where she is in space. It is not sufficient for the occupational therapist, in a separate session, to provide for the Student's sensory needs. If the sensory needs aren't met, physical therapy is not going to happen. If the child reacts with a response to a squeaking chair during therapy, I need to be able to reintegrate the sensory system. (Testimony, Gardella, 2/23/09 Tr. at 155, 162)

50. The witness testified he volunteers at Camp Care. Physical therapists from all over the State of Connecticut volunteer at the camp. The current pamphlet for Camp Care is Exhibit P-33. The witness testified he is not familiar with a prior version of the brochure. Religion has nothing to do with my physical therapy practice. I see my goal as motivating the human spirit to work and try to succeed. (Testimony, Gardella, 2/23/09, P-33)

51. Mr. Gardella believes it is possible the Student will be able to walk. She may need support. She has begun to take volitional steps and is standing. She is showing me the potential. (Testimony, Gardella, 2/23/09, Tr. at 146-147)

52. Mr. Gardella treats the visual system with therapy to organize head, neck, and eye movement. If the head turns right, the eyes should go right. Stimulus, such as, sound or lights can motive the Student to look in a direction. Applying gentle pressure to the head helps the Student turn to see. The therapy helps coordinate eye movement with head movement. (Testimony, Gardella, 2/23/09, Tr. at 161)

53. The Parents and the school team agreed to have the Student evaluated at Therapy Works. The evaluation is dated August 14, 2008. The diagnosis is Cerebral Palsy, Left Cerebral Hemiatrophy, Bilateral Optic Nerve Hypoplasia, Cerebral Calcifications, Diabeties Insipidus and Hypothalmic Dysfunction. The Student has severe delays in gross motor, fine motor and communication skills. The child is described as having severe cerebral palsy, visual motor deficits, and temperature, regulation problems. The Student requires maximum assistance for sitting, standing, and transition to different positions. The Student has visual stabilization difficulties. She becomes inconsolable when moved during therapy. The Student has a complex neurological status. The evaluation is to gain a better of understanding of the Student's challenges. (Exhibit B-36)

54. The Student has a significant startle response and autonomic nervous system response. When startled, she becomes legitimately, extremely upset. The Student cannot reconcile visual information with the movement she experiences in therapy. Her nervous system interprets the movement as threatening. The perception of threat is increased due to her impaired vision.

The Student shows progress in calming herself, if the individual working with her provides verbal reassurance, before and during movement. (B-36 p.17)

55. The Student exhibits severely, delayed motor skills. Calcifications on the hypothalamus, cause body temperatures that are low and unstable. The Student enjoys sound and requires maximal assistance to move. She requires specific types of positioning and handling if she is to develop voluntary, motor control. The Student has difficulty stabilizing her eyes to use center vision. Verbal explanations, calm touch, and slow transitions, help the Student tolerate movement in therapy. The Student enjoys heavy input to her body, facilitated by NDT handling techniques. The Student is stressed by sudden movement or when she feels unsupported. (B-36 at 3)

56. The visual-vestibular and motor systems impact learning and behavior. Inefficient tactile processing, either an over or under response, affects daily function. Effective tactile processing is a precursor of mature visual perception. Deep pressure, tactile experiences, and visual attention help the Student develop effective, visual-perceptual skills. The tactile system has two parts, light touch and deep pressure. Light touch receptors are part of the protective system. Sensation travels to primitive parts of the brain, which processes the flight or fight reaction. Light touch always triggers an arousal response. It is best to avoid light touch with the Student, especially, when introducing new visual stimuli. Ms. Dixon states the Student has deep pressure touch challenges, as well. Deep pressure touch and proprioception travels down the same neural pathways and is processed in the cortex for learning. The Student is unable to access deep pressure touch through crawling, rolling, and rough-housing. It is critical for the Student to have frequent, appropriate therapy to develop visual perception, body awareness, and basic physiological balance. Deep pressure releases nor-epinephrine and dopamine, which are critical for cortical function, learning, and a feeling of wellbeing. The Student is sensitive to light touch and at the same time under responsive to deep pressure touch. (B-36 at 3-4)

57. Proprioception is the perception of joint position. Receptors, located at the end of muscles in the joint capsule, provide feedback to the brain. The input provides awareness of body position without visual feedback. Impaired visual perception and impaired feedback from the spine to the neck is an obstacle for head control. Head control is vision driven. Sensory motor treatment and Neurodevelopmental Treatment provide therapy to address eye instability and motor challenges. (B-36 at 4)

58. Low postural tone and lack of proprioceptive awareness gives a sensation of “spaciness” or being disconnected from the body. This can lead to sensory defensiveness. Other systems go into overdrive to help the person interpret the environment. The Student demonstrates significant sensory defensiveness in both the auditory and tactile domains. Proprioceptive and resistive therapies improve body position awareness. Serotonin and norepinephrine are released in the nervous system and promote a feeling of attention and calmness. The chemicals counteract the stress chemistry associated with sensory defensiveness. The Student requires this therapy to make her available for learning. (B-36 at 4-5)

59. Visual-vestibular and auditory systems provide the individual with an understanding of gravity, linear movement, acceleration and deceleration, and position in relation to the environment. These are basic safety and survival mechanisms. Minor disturbances cause a significant sensation of threat to the individual. Children will compensate for vestibular disturbance by squirming in a chair or touching everything as they move around. These avenues are not available to the Student due to her motor inabilities. The Student's combined deficits lead to significant compromise in her feeling of safety in space. The vestibular system works most closely with the visual system to integrate neck, eye and postural adjustments in response to movement. This system is most closely aligned with regulation of attention and arousal. (B-36 at 5)

60. The visual system is responsible for feedback from the eyes. It is interpreted on two levels, the peripheral visual field and the central visual field. The peripheral field provides information of position in space. Peripheral vision works closely with the inner ear and postural muscles for equilibrium. Movement in the periphery elicits an arousal response. It registers in the sub-conscious parts of the brain, not the cortex or learning portion of the brain. The Student's postural response indicates a heavy reliance on vision for processing movement. Movement in the periphery detracts from the Student's use of the central visual field for learning. Movement in the periphery causes a balance response, even in adults. The effect is used by designers of roller coaster or "fun houses". The Student experiences a sensation of being pushed when an individual quickly approaches her. The Student needs to be prepared, verbally, when someone intends to enter her space. (B-36 at 6)

61. The central visual field is the primary connection to the cortex and higher level brain function. The cortex analyzes the object for learning and understanding. When combined with touch, a child can develop visual perception. Central and peripheral visual systems must function simultaneously with the vestibular, auditory and postural systems. This will allow movement through space and around obstacles. All systems must provide matching information to the individual while moving, or there will be a significant stress response. The Student has significant difficulty coordinating the two systems. She has difficulty with vestibular processing and she relies heavily on her peripheral visual system. When arousal levels are high, unexpected movements in the periphery will register in the primitive parts of the brain. When stress levels are high, there is peripheral vision predominance, which hinders the Student's ability to learn. Physical therapy can reduce stress levels. (B-36 at 7)

62. The Student requires vestibular input to access the central visual field. A feeling of safety in space decreases reliance on peripheral vision. Vestibular input improves central stabilization. The Student's tone requires specific handling techniques or the Student will not feel safe. The spine must be in the correct position to register vestibular input. (B-36)

63. The auditory and vestibular systems process input to the primitive areas of the brain designed for safety and survival. Disturbances to processing this information results in safety and basic needs being met before learning can take place. Auditory defensiveness is triggered by unexpected sounds, loud sound, or specific pitches of sound. During the evaluation, the Student startled several times and became very upset in response to sound, such as, the click of a flashlight or the pitch of an unfamiliar vibration. Activities to improve vestibular

registration and visual spatial awareness decrease the Student's reliance on ambient auditory sound. (Exhibit B-36 p. 7)

64. Therapists must know when the Student is feeling stressed and vulnerable. It is important that everyone understand her nervous system, visual function, and be confident when handling the Student. The Student responds to intense vestibular sensation, which provides input to help her understand movement. Stimulation to the spine and inner ear is critical for maintaining the proper level of arousal and biochemical balance. Therapy is important because the Student is unable to move on her own. (B-36 at 9)

65. The visual control part of the vestibular system is not reliable for the Student. Proprioception and vestibular sensation provide information about the "self in relation to self" and "self in relation to gravity". The Student must rely on peripheral senses, which causes the other senses to become hyper-acute. The Student depends heavily on external organization, predictable routines, and cues from the environment. (B-36 at 9)

66. The child has high tone in the limbs and low tone in the trunk. Focus must be on activities that assist organized movement to positions, such as, supported sitting, and quadraped. Transition positions require manual facilitation, or handling techniques for tone control. The Student must develop underlying skills prior to use of equipment. The quadraped position helps develop a sensation of weight bearing, weight shifting, and trunk control. All are required for the functional use of the crawler. If the child is to access functional, voluntary movement, everyone who handles her must have instruction in handling techniques. (B-36 at 15-17)

67. The Student's tone creates positioning and handling challenges for a therapist. The evaluator was able to use handling techniques to transition the child from a supine to a quadraped position. With stabilization from the therapists, the child was able to bear some weight and respond to manual weight shifts. The quadraped position is important, for the Student to develop skills like bilateral integration, visual stabilization, proprioceptive awareness of limbs, stabilization of major joints, and trunk strengthening. In this position (only when she is weight bearing), the Student can minimize limb tone. The position is best attained when it follows a sequence for preparation. Without proper positioning and handling, the child is locked in by tone and unable to benefit from her education. Without proper seating and handling, the Student will be unable to demonstrate purposeful responses. Improper handling will create a feeling of vulnerability and fear. The child will not be able to demonstrate her educational abilities. (B-36 at 16-17)

68. The Parent assists Ms. Hogan when she transitions the Student to quadraped position. The Student has unique disabilities. Transitioning the Student is a challenge for the most, highly, qualified physical therapists, such as, Ms. Hogan and Ms. Davis. The Crossroads' therapists are uniquely qualified to provide the therapy the Student requires. Ms. Hogan testified she is successful in transitioning the Student to a quadraped position only twenty-five percent of the time. The Crossroads therapist is able assess when the Student is ready for the transition to quadraped. Mr. Gardella is able to transition the Student to quadraped without difficulty. Positioning in therapy is important to the Student's development and physical therapy goals.

Ms. Dixon explains, in Exhibit B-36, quadraped position is important to develop skills such as visual stabilization, proprioceptive awareness of limbs, and bilateral integration. The position minimizes the high tone in the Student's limbs, which frees them to learn movement. The Student often cries more than once and startles frequently in therapy sessions with Ms. Hogan. Crying and fear trigger primitive reflexes. The Student regresses when she moves to primitive extension. Ms. Hogan recently attended a course in neurodevelopmental therapy and myofacial release. These therapy techniques benefit the Student, but Ms. Hogan is unable to meet the Student's needs at this time. Ms. Davis, who treated the Student, recognized the Student's unique combination of disabilities require the services provided at Crossroads. (Testimony, Parent; Testimony, Ms. Hogan)

69. Therapy will support the Student to meet 2008-2009, IEP goals and objectives. The Student is to fully participate with peers in learning activities that involve visual attention and purposeful responses. The Student will use a walker and crawler, functionally, purposefully, with control, and with an understanding of the movement. (B-36, B-37, B-48)

70. The addendum to August 2008, Therapy Works Evaluation clarifies certain points in the full evaluation. The evaluator states the Student requires manual facilitation of the legs, because she is locked in her tone. The crawler and walker should be used, minimally. The focus should be to develop the underlying motor skills. The Student's therapy must address gross motor and sensory needs if the Student is to access her education. Referencing the number of hours of therapy, the evaluator states, the Student has the most "neural plasticity" at this age. She recommends three hours of [school PT] and assumes the Crossroads services will continue, as it is pivotal to the Student's overall success. Meeting the Student's physical therapy needs is primary if she is to access her learning potential. (B-36, B-37)

71. Proper movement and handling helps the Student have the proper level of arousal and comfort. Therapy helps develop visual, auditory, and tactile skills. Training should begin with a two-hour in-service in sensory processing and handling techniques, followed by on-going training. The specific type of training recommended by the evaluator is NDT and sensory processing. The therapists, Parents, aides, and teachers should be trained in the NDT philosophy. They need hands-on training to properly position the Student to overcome tone issues. High tone in the Student's legs, impacts head control and visual stability. Everyone who works with the Student must feel comfortable in helping the Student with tone control and posture stability. (B-37)

72. Ms. Dixon clearly states in the addendum to her report, Exhibit B-37, "I was under the assumption: 1.That her outside physical therapy would continue." The therapist words are not ambiguous. There is a finding, the Crossroads services are required, to meet the Student's therapeutic needs, which are identified in Ms. Dixon's evaluation testimony. Three hours of physical therapy per week is not sufficient. The school-based staff requires training to work with the Student. Highly qualified, experienced physical therapists are not sure how to work the Student. She presents a very complex picture. Ms. Hogan, who appears to be a competent physical therapist, requires training and skill development to work with this particular child. Crossroads is ready to meet the Student's needs, with the therapeutic interventions, outlined in Ms. Dixon's evaluation. (B-36, B-37)

73. Ms. Hartigan, the Director of Pupil Services, wrote a letter dated, November 8, 2007, which concludes, the Crossroads services are inappropriate. The conclusion was made without the benefit of evaluation, without contacting Crossroads therapists, and prior to observing the Student at Crossroads. The conclusion is based on conversations with others, who never met the Student, or the therapist; and based on information on a web site. Ms. Hogan never made a written evaluation of the Student. An independent evaluation was performed and reviewed by the PPT team one year after the child began receiving services through the school district. The Board observed a therapy sessions at Crossroads in April of 2008. The letter states the decision will be made at an upcoming PPT. (B-11)

74. The testimony is clear, the services at Crossroads Physical Therapy are provided by appropriately educated, licensed therapists, who use basic and advanced, physical therapy techniques. The techniques are necessary for the Student to make progress. The physical therapy services are designed to improve the Student's function, so she can access her education program. The therapy has improved the Student's ability to support her trunk, hold up her head, and move her limbs. The therapy calms the Student and prepares her to use her central visual and auditory function for learning.

75. Ms. Hartigan reports there are religious items at Crossroads. Ms. Hartigan's determination that an item is religious can be very subjective. There is no finding the physical therapy services establish any religion or support any religious organization. Mr. Gardella, credibly, testifies that the items Ms. Hartigan believes are religious are gifts from therapy clients. The testimony is clear; religion is not discussed or invoked during therapy. Reference to "spirit" is the human spirit. There are references to spirit in the physical therapy literature. Payments to Crossroads are not for the establishment of religion; they are for physical therapy services. (Testimony, Ms. Hartigan; Mr. Gardella, B-32 at 23)

76. Ms. Hogan is a registered physical therapist, who provides physical therapy services to the Student. The Board contracts with EASTCONN, to provide these services. Ms. Hartigan, the Director of Pupil Services, states the contract is not exclusive. Ms. Hogan states, physical therapy is very important to the Student. She needs to develop basic motor skills, if she is to sit with classmates, hold up her head, and focus on classroom material. The motor skills help her benefit from speech and occupational therapy. (Testimony Hogan, 1/26/09, Tr. at 4-6, Testimony, Hartigan)

77. At a physical therapy session, we greet and review a calendar. It helps the Student understand the schedule for the session. We have a "hello" song. I explain the materials that will be used. We end with a goodbye symbol. I have a checklist that follows the IEP. There is a concrete plan; it may be necessary to regroup and provide activities that are more comforting. (Testimony Hogan, 1/26/09, Tr. at 6-8)

78. The 2007, IEP contains one physical therapy goal. Ms. Hogan describes some techniques she uses in therapy sessions. To get the Student to hold up her head she bounces on the ball. Position techniques, on different pieces of equipment, help the Student with proper alignment for head control. Tapping a muscle provides input to the muscles needed for work. Toys

provide interest. If she's tight, I might relax her; if she is tired, I stimulate her. To calm the Student; I use slow movement and a calm voice. I use sensory integration techniques, bouncing on the ball to make her more alert, deep pressure for a calming effect, or slow-rocking movements. She sits in my lap with support, or on the floor in front to me. The Parent is always present during sessions. If the Student gets upset, we try a new activity. The Student cries during session. She cries for different reasons. She may have intestinal pain, I will pat her back to relieve a gas pain or maybe bounce her on the ball. (Testimony Hogan, 1/26/09, Tr. at 6-11)

79. Ms. Hogan took undergraduate education classes involving systems, anatomy and physiology, before 1980. Courses involving the nervous system are on my resume. (Testimony Hogan, 1/26/09, Tr. at 12-16, B-62)

80. To activate the visual system, I use a toy or vestibular stimuli to encourage the Student to turn her head. Visual skills are handled by the occupational therapist. I don't consider visual skills to be part of my therapeutic technique. I use visual skills to facilitate motor skills. (Testimony Hogan, 1/26/09, Tr. at 16-22)

81. The Student has difficulty using the eyes together for tracking; eye coordination is very difficult for her. Visual difficulties impact movement, vision and movement are kind of interconnected. "I'm trying to think of how to say this, you will often learn through movement and your vision information about the environment together will contribute to cognitive development". (Testimony Hogan, 1/26/09, Tr. at 22-24)

82. The Student does not enjoy lying on her stomach, in a prone position, but she has made progress. She has difficulty in a prone position. Her tolerance for the position varies day to day. Sometimes she will stay in prone for twenty minutes. Her vestibular system is implicated when she is in prone. If she doesn't want to be there, she may protest. I try to do a little bit of weight shifting if she gets tense to get her to relax. If she is screaming and rigid, it takes a few minutes to calm her. Some days I think it is more than the position making her uncomfortable, a gastrointestinal-type thing. When she is screaming there is definitely something going on. It takes no more than five minutes to get her to stop screaming. If we try the position again she may cry again. (Testimony Hogan, 1/26/09, Tr. at 25-29)

83. The Parent reports that crying and startle reactions occur during physical therapy sessions with Ms. Hogan. When the Student is agitated she regresses into a more primitive state. Ms. Hogan is uncertain about the source of Student's stress. Prone position extends the spine and impacts scar tissue.

84. To calm the Student's sensory system, I use deep pressure and explain the next activity to the Student. These are the strategies that the Florida therapist, Ms. Davis, found to be ineffective in getting the Student to make progress. Ms. Davis referred the Student to Crossroads. (Testimony Hogan, 1/26/09, Tr. at 36-37)

85. Neurodevelopmental therapy (NDT) is a handling technique that facilitates movement and acquisition of motor goals in a functional way. Ms. Hogan's exposure, and use of NDT

techniques, is limited. There is no specific request that NDT techniques be used exclusively. Ms. Roda provides instruction and direction in handling the Student for the School team in weekly meetings. Ms. Hogan needs to be able to effectively handle the Student at each therapy session. (Testimony, Hogan, 1/26/09, Testimony, Roda, 3/20/09)

86. Ms. Hogan did not review the Physical Therapy Evaluation for the PPT team. The Student's occupational therapist presented the sensory motor, vestibular evaluation for the team even though Debra Dixon is a physical therapist. The witness states the sensory portion was reviewed by the occupational therapist because she is the member of the team who addresses the Student's sensory needs. The Connecticut State Guidelines for Physical Therapist in Schools requires a physical therapist to address the sensory system in children. Ms. Hogan believes sensory systems are an area of expertise for the occupational therapist. An occupational therapist and physical therapist have a different license, they are not the same. Ms. Hogan states she has understanding and background in the sensory system but the occupational therapist has an expertise in the sensory system, she is the person on the team who addresses the sensory system. Ms. Dixon's evaluation asserts everyone on the team must understand the Student's sensory needs. (Testimony Hogan, 1/26/09, Tr. at 48, 54, Testimony, Davis 2/23/09, B-36)

87. My functional goal for the Student is to improve gross-motor skills, in terms of head control, better sitting posture and getting her to use her legs. We encourage all the goals of a typical preschooler. "The goal is for her to be able to listen to a teacher, sit in circle, and be ready to learn". Range of motion may be medical, but activities such as sitting and standing are school-based goals. For a student with severe disabilities, there is overlap between medical [and educational], but the focus is to get the Student to participate in her educational program. It is not possible to separate the sensory and motor pieces for a child like the Student. (Testimony Hogan, 1/23/09)

88. Physical therapy provided in the Board program and at Crossroads is necessary to improve gross-motor skills, head control, sitting posture, and leg use. These skills are required for a preschooler to participate in school and to learn. Range of motion is required for movement. The therapy activities carryover into school-based goals, such as sitting, standing, reaching and hitting a switch. Therapeutic activities to make the Student comfortable, focused, and secure are essential to make the Student available for learning activities. The goal, to have the Student participate in a school-based program, is also the Parent's goal.

89. The Parent has asked Ms. Hogan to be aware of the Student's reactions. She has intervened during sessions, said the child is afraid, "please stop", and held a mirror reflecting the Student's expression so the therapist can see. Ms. Hogan testified the Student and fear just don't go together. Clearly, a careful review of the Student's record, a full history and meeting with the Crossroads therapists would have informed Ms. Hogan about the Student's spinal injury and pain response to sensory input. (B-9, Testimony Hogan, 1/26/09, Tr. at 43, Testimony Parent, 1/23/09, Testimony, Gardella, 2/23/09, Testimony, Davis)

90. Ms. Hogan testified she keeps a data sheet, recorded at the time she provides therapy. The data is not part of the Board's exhibits. The Parent credibly testified, crying and startle reflex

interrupts Ms. Hogan's therapy sessions, two-three times per session. Sometimes therapy is terminated. (Testimony Hogan, 1/23/09, Testimony, Parent, 1/23/09)

91. Ms. Hogan's skill and professionalism is supported by Ms. Roda, the occupational therapist, and Ms. Bubela, a physical therapy consultant, for the Board. Their testimony is credible. Ms. Hogan may be outstanding in her ability to meet the needs of the other children she serves for the Board. The Student presents a complex puzzle to most professionals, who try to meet her needs; even for Ms. Davis, who is a nationally, recognized therapist. The Student is fortunate she is able to access the physical therapy skills and training provided at Crossroads. Based on Ms. Hogan's testimony, she does not understand the complexity of the Student's disability. Debra Dixon's evaluation and Mr. Gardella's testimony describe the Student's needs. The IEP recommendation, for three hours of physical therapy per week, does not seem appropriate, to meet the Student's educational needs. (Testimony, Hogan, 1/26/09 at 32-35, Testimony, Roda, 3/20/09, Testimony Bubela. 3/20/09)

92. When asked if the walker can cause spine pain Ms. Hogan states it is hard to pinpoint. She believes more exposure will allow the Student to adapt to the equipment and tolerate an upright position. When asked about the Student's spine she is not aware of the Student's injuries stating in her opinion the spine is fine. She states the Student should continue to work with the walker. The therapist is unable to draw upon the Student's medical history and does not know why the Student cries when placed in the walker. Ms. Hogan testified it is important for the Student to have exposure and repetition to increase tolerance of the walker. To prepare the child to use the walker, Ms. Hogan states she tries to make it a fun activity, adjust the height, make adjustments for support, and increase tolerance for the foot orthotics. The therapist sees the problem as a lack of tolerance for the walker not a lack of spinal preparation to be placed in the walker. Mr. Gardella testified he must prepare the spine for the Student to sit in an upright position sometimes for more than thirty minutes. (Testimony Hogan, 1/26/09, Tr. at 95, 104-105, Testimony, Gardella)

93. The Student participated in the Birth to Three Program. The progress reports show she made progress from August 2006 to August 2007. The program provided two hours of physical therapy per week. The Student privately attended physical therapy at Crossroads for fifteen hours per week. Progress was likely due to the therapy at Crossroads. (B-3, B-4, B-7, B-8, B-9, B-10, B-11, B-12, B-13, B-14, B-15, B-16, P-7)

94. The October 20, 2007, IEP has 12 goals; one is a physical therapy goal. The IEP recommends 2 hours of physical therapy per week. At the time the IEP was adopted, the Student was receiving 2 hours of physical therapy per week from the Birth to Three program and 10-15 hours per week from Crossroads. The Crossroads report (Exhibit B-9) was available to Ms. Hogan when she made a determination about the appropriate program and hours for therapy for the 2007-2008 school year. Ms. Davis, who trains school-based physical therapists, believes the Student did not meet two-thirds of the goals and objectives. (Testimony Hogan, 1/26/09, Tr. at 55, Testimony, Davis, B-9, B-16, B-47)

95. The Student's IEPs (Exhibit B-16, B-48) provide for physical therapy goals and objectives. The Student is to fully participate with peers in learning activities that involve visual

attention and purposeful responses. The Student will use a walker and crawler, functionally and purposefully. The IEPs developed for the Student fail to provide specialized instruction and related services, which are individually designed, to provide an educational benefit to the Student. The Student did not master many of her physical therapy goals. The school team did not fully understand the services the Student required to make progress.

96. Mr. Bohannon criticizes the therapy offered at Crossroads. He focuses on a range of therapies offered at the center, but not necessarily the primary therapy used with the Student. Mr. Bohannon after review of a web-site concludes some of the therapies provided at Crossroads, lack support in the peer-reviewed literature. There was no attempt to contact Crossroads to determine the precise therapies and techniques used to provide services to the Student. Mr. Bohannon never saw the Student. It is clear there is no evidenced-based literature of therapies that work for the Student because her combined disabilities make her utterly unique. The Student cannot be denied the therapy she requires because a group has not conducted research to prove its effectiveness. (B-32, Testimony, Bohannon, 3/17/09, Testimony, Gardella, 2/23/09, Tr. Pp. 98-99)

97. A letter from Crossroads, dated October 1, 2007, outlines the Student's unique needs. The needs are severe, visual processing delays; severe sensory processing, receptive and integration delays. Reaction to loud sounds causes primitive reflexive postural patterns. The Student has complex tone issues with low tone in the core and high tone in the extremities. Tone limits fine and gross motor activities. The Student has mid-brain and brain stem, reflexive activity which is not controlled by the cortical area of the brain. The Student has hypothalamic imbalances, which impacts auto-regulation especially her regulation of the body temperature, the sympathetic, the parasympathetic and the limbic systems. She has severe cognitive impairment. She has severe, spinal dysfunction due to scar tissue in the meninges and spinal cord. The condition causes pain that limits spine movement and impacts sitting. The Student has upper and lower respiratory challenges which impact endurance and energy levels. The Student was referred to Crossroads after many qualified therapists were unable to help the Student. Crossroads is able to provide the expertise needed to handle the Student's chronic and severe neurological and systemic needs, to facilitate a recovery process. The Student has made progress in sensory modulation, motor/postural control, head and trunk stability, and auto regulation. The Student is at the beginning stages of progress, she requires structural and neurodevelopmental, manual physical therapy. The therapy is required, five times per week for three hours per day, to address the various systems. Crossroads invites anyone to ask questions about the Student's treatment. Neither Ms. Hogan nor other district personnel, called Crossroads to plan an IEP for the 2007-2008 school year. It is not likely any of the school-team understood the broad range of the Student's systemic deficits and the therapeutic interventions she required until the team reviewed Debra Dixon's Therapy Works evaluation a year after the Student began services in the Board's school. (B-9, B-36)

CONCLUSIONS OF LAW:

1. The Student is identified as a child with disabilities pursuant to the Individuals with Disabilities Education Act (IDEA) 20 U.S.C. § 1400 et seq. and Section 10-76(a) et seq. of

the Connecticut General Statutes. The parties do not dispute the Student is eligible to receive special education and related services.

2. In Connecticut, the public agency has the burden of proving the appropriateness of the child's program or placement. This burden shall be met by a preponderance of the evidence. Section 10-76h-14(a) of the Conn. Agencies Reg. A party seeking reimbursement for a private program must prove the appropriateness of the program by a preponderance of the evidence. Section 10-76h-14(a) of the Conn. Agencies Reg.

3. Whether a program provides FAPE is determined by the two-prong test articulated in The Bd. of Education of the Hendrick Hudson Cent. Sch. Dist. v. Rowley, 458 U.S. 176, 206-207 (1982). First, the procedural requirement of IDEA must be met. Second, the IEP must be reasonably calculated to enable the child to receive an educational benefit. The Parent claims there are procedural violations. Relief for procedural violations is only warranted when the procedural violation results in a denial of FAPE. J. D. v. Pawlett Sch. Dist., 224 F.3d 60, 69 (2d Cir. 2000). The Board did not conduct a full individual evaluation of the Student prior to the initial provision of services as required by IDEA. 34 C.F. R. § 300.301(a). An assessment includes motor skills. 34 C.F. R. § 300.304(c)(4).[1] The team did not evaluate the Student to make a determination of her physical therapy needs. The evaluation must be sufficiently comprehensive to identify all the Student's special education and related services needs, whether or not commonly linked to the disability. The PPT team made no attempt to fully understand the therapy services provided at Crossroads and the impact the services have on the Student's fundamental access to learning. The Parent's request to include Crossroads physical therapy services in the Student's IEP was not fully considered. The team could not have fully understood the Student's needs for such services until the Therapy Works evaluation was completed and reviewed by the PPT in November 2008, nearly a year after the Student first received special education services from the Board's program. An initial evaluation is fundamental to developing the IEP. The procedural violation resulted in a denial of FAPE.

4. The Parent claims the Board predetermined that the Crossroads physical therapy program is not an appropriate program. The Director of Pupil Services sent a letter (Exhibit B-11) prior to the 11/20/2007, PPT meeting. The director claims the services are not supported by scientific data and are not educationally focused. The letter states the decision is to be made at the PPT meeting. The Parent attended the PPT meeting. The Parent strongly advocated for the Student and provided input for the team to consider. There was a meaningful opportunity to participate in the PPT process. A Parent who disagrees with a PPT team decision can

[1] 34 C.F.R. § 300.304(c)(4) provides the child shall be assessed in all areas related to suspected disability. These provisions give discretion to determine what assessments are relevant and relate to the suspected disability, subsection (c) requires the evaluation be sufficiently comprehensive to identify all the child's special education and related services needs, whether or not commonly linked to the disability category 34 C.F.R. § 300.306 (c)(1) states when interpreting evaluation data for the purpose of determining if the child is a child with a disability under section 300.8, and the educational needs of the child, each LEA must draw upon information from a variety of sources, including…., parent input, teacher recommendations, as well as, information about the child's physical condition, …; and ensure the information from all these sources is carefully considered.

request a Due Process hearing. This is not a procedural violation that results in a denial of FAPE.

5. Under the second prong of Rowley, the IEP must include special education and related services tailored to meet the unique needs of the child and must be reasonably calculated to enable the child to receive educational benefit. A program is not required to maximize the potential of the child, but opens the door of educational opportunity to provide for more than "trivial advancement". Special education services are "reasonably calculated" when they are likely to produce progress and not regression. Walczak v. Fla. Union Free Sch. Dist.,142 F.3d 119, 130 (2d Cir. 1998)(quoting *Rowley*,458 U.S. at 189, 192; and Mrs. B v. Milford Bd. of Educ.,103 F.3d 1114, 1121 (2d Cir. 1997)). The threshold to access educational benefit for this Student is a physical therapy program. It is required if she is to hold up her head, use her eyes to learn, reach for a switch or participate in a classroom. Physical therapy is the core of the Student's educational program. Without an evaluation and full consideration of the program provided at Crossroads, the PPT team is not able to develop a program of specially designed instruction and related services to meet the Student's needs. The Student has chronic and severe neurological and system needs, visual processing and integration delays, complex issues with tone, auto-regulation problems, spine dysfunction, and respiratory challenges. The information in Exhibit B-9, the testimony of Mr. Gardella, and Ms. Davis (Findings of Fact No. 2-52, 97) was available when the 2007-2008, IEP was developed. The Therapy Works evaluation (Findings of Fact No. 53-72) was reviewed by the IEP team when they developed the 2008-2009 IEP.

6. The PPT team did not fully consider information provided by the Parent and Crossroads, when they decided the therapy techniques and number of therapy hours to include in the Student's IEP. A program is not likely to meet the Student's needs or be appropriate if the needs are not first identified through evaluation or analysis of relevant information about the Student. At the time the Student entered the Board's school, the Student was receiving seventeen hours per week of physical therapy services; two hour per week from the Birth to Three Program and 10-15 per week from Crossroads Physical Therapy (Crossroads). Information from the Birth to Three Program is not sufficient; they treated the Student for significantly less time than the Crossroads program. Failure to understand the Student's condition exposed the Student to unnecessary risk of regression, and risk of injury. Crossroads understood the Student's needs a year prior to the identification in the evaluation, Exhibit B-36. No one called Crossroads or invited them to elaborate on the Student's needs when planning the Student's program.

7. The Student's IEPs (Exhibit B-16, B-48) contain physical therapy goals and objectives. The Student is to fully participate with peers in learning activities which involve visual attention and purposeful responses. The Student will use a walker and crawler, functionally and purposefully. The IEPs developed for the Student fail to provide specialized instruction and related services which are designed to provide an educational benefit to the Student. The Student did not master two-thirds of her goals. The school team did not understand the services the Student required to make progress. She cannot sit in a class or use a crawler if she can't extend her back without pain. She cannot be in an environment which triggers her sensory deficits. Therapy can effectuate change that allows the Student to access the central

visual field and central auditory channels for learning. The Student's therapy needs are articulated in Ms. Dixon's Therapy Works Evaluation and Mr. Gardella's testimony.

8. The Student requires therapy to hold up her head and maintain a standing position. She requires manual physical therapy to integrate her body movement with her sensory systems. The Student experiences pain if her spine is extended without proper preparation. Extension occurs when she is placed in the walker. Information from Crossroads was necessary to avoid harming the Student and to develop an IEP. Ms. Hogan, the school-based physical therapist did not understand the impact of the Student's spinal injury on the use of equipment. In fact, Ms. Hogan did not acknowledge the Student had a spinal injury. Mr. Gardella testified a physical therapist should be able to assess that scar tissue was limiting movement in the spine. Mr. Gardella, the Crossroads physical therapist, was able to articulate the Student's injury required the spine be prepared to extend for sitting in equipment. He describes a process that may take a half-hour before the Student is ready for weight bearing in a standing position. The Student requires physical therapy if the education goal is for the Student to sit in a walker in a school class. Crossroads information was essential but not fully considered, to formulating an appropriate program which could provide an educational benefit for the Student.

9. Failure to understand the Student's needs exposes the Student to unnecessary risk of regression. Given the Student's complex disabilities, the therapies described by Ms. Dixon and Mr. Gardella are necessary for the Student to access an educational program. The IEP fails to consider the Student's medical history, evaluations, and therapists' recommendations in planning the IEP for the Student. Crossroads understands the Student's limitations and complex needs, factors that should have been considered when planning the Student's program. The IEPs B-16 and B-48, which did not include the Crossroads physical therapy program, do not provide the Student with an appropriate program. The Board has not proven by a preponderance of the evidence that it provides an appropriate program for the Student.

10. When it is determined the Board's program is inappropriate the Parent is entitled to reimbursement, if the private placement is appropriate. Florence County Sch. Dist. Four v. Carter 510 U.S. 7, 12-13 (1993); School Comm. of Burlington v. Dept. of Educ. of Mass., 471 U.S. 359, 369-370 (1985). The determination of the appropriateness of the private placement is a factual one that considers the totality of the circumstances. Frank G. v. Bd. of Educ., 459 F.3d 356, 364 (2d Cir. 2006).

11. The program provided by Crossroads is appropriate to provide the Student with an educational benefit. The Student's progress is attributed to the physical therapy services provided by Crossroads. The testimony of Ms. Davis confirms the Student's progress. Crossroads is successful in providing a program which allows the Student to move beyond a fearful and reactive state. The Student has stopped crying and begun learning. When the Student began physical therapy with Crossroads, she had no independent movement (P-18). The Student is now able to hold up her head in response to handling techniques and appropriate sensory input. She is able to tolerate the quadraped position which facilitates limb movement. Mr. Gardella and Ms. Davis, both, testify the Student has progressed in the private, physical therapy program. If services provided by the Board's contractual provider

were the Student's only physical therapy services, there is no doubt the Student would have regressed. The Student has not mastered two-thirds of the IEP physical therapy goals, which, in fact, are not appropriate for the Student. Parents rely on school Boards to provide expertise in determining the type and amount of services a student requires to benefit from their educational program. Expertise should include the wisdom to know when you do not have the proper training and background to provide particular services. In this case, expertise had to be privately obtained. The private physical therapy program is 10 hours per week of physical therapy services. The physical therapy program is appropriate and designed to provide the Student with an educational benefit. The Parent has proven by a preponderance of the evidence the Crossroads services provide an appropriate physical therapy program for the Student.

12. The Student is likely to regress without the services provided by Crossroads. The record provides sufficient information to make a determination the Student experiences regression following short breaks in therapy. Had the Parent not continued the services with Crossroads it is likely the Student would have severely regressed. The Student's progress from November 30, 2007 to the present, is attributed, primarily, to the physical therapy services provided by Crossroads. The Parent, Mr. Gardella, and Ms. Davis testified that regression occurs when the child is not receiving the services provide at Crossroads. The Student requires an extended school year program, which shall consist of a minimum of ten hours per week of physical therapy at Crossroads during summer vacation and school breaks that are longer than one week in duration.

13. The 2004 amendments to IDEA require the Board employ research-based and peer-reviewed services in IEP development "to the extent practicable", 20 U.S.C. § 1414(d)(1)(A)(i)(IV). The therapists all testified they have never seen an individual with the Student's unique, complex disabilities. Therapy strategies must be carefully selected. A movement technique may exacerbate the Student's vestibular system. Extending the trunk may cause pain and trigger an autonomic nervous system reaction, causing the Student to cry, tighten, and regress into extension. There are no scientifically-based peer-reviewed services, which would meet the Student's needs. The therapy provided at Crossroads is found to be effective in producing progress for the Student. The Student benefits from the treatment which is having a positive impact on preparing the Student to function in the school setting. Before physical movement can occur, Mr. Gardella states, you must first address the Student's sensory and nervous systems, vision difficulties, and her tone. The physical therapy provided at Crossroads is necessary to improve gross-motor skills, head control, sitting posture, and getting the Student her to use her legs. These skills are required for a preschooler to participate in school, to look at learning materials, listen to a teacher, sit in circle, and be ready to learn. Movement is required for school-based goals, such as sitting, standing, reaching and hitting a switch. Whether or not they are peer-reviewed or research-based, the therapy at Crossroads prepares the Student to meet her IEP goals and objectives as well as the overall goals of preparing the Student to participate in school. In this case it is not practicable to rely on research-based and peer-reviewed techniques.

14. The Family Educational Rights Privacy Act (FERPA) provides that a school district can share records of students with school officials who have a legitimate educational interest. 20

U.S.C. § 1232g; 34 CFR Part 99. 31 If "a school official is performing an official task for the school that requires access to information in education records, that school official has a legitimate education interest". Letter R Greater Clark County Sch. Dist., 106 LRP 53018 (7/20/06). The Director testified Mr. Bohannon was hired as a physical therapy consultant. The Parent was surprised to learn for the first time at hearing the witness reviewed the Student's record. The Parent objected to the consultant's testimony claiming the testimony is irrelevant because there was no knowledge the consultant reviewed the Student's record. The Parent then claimed the FERPA violation. The objection was over-ruled to permit the hearing to progress. The parties were instructed to put any legal claims in their post-hearing briefs. Parent's counsel made no attempt to amend the issues for hearing to include the FERPA issue. The issue cannot be added without the mutual agreement of the parties or the hearing officer may grant permission to amend the hearing request, provided permission is granted no later than five days before the hearing. 20 U.S.C. § 1415(c)(2)(D)(i). There is no mutual agreement to add the issue for consideration in the hearing and the hearing officer did not give permission to amend the hearing request. The FERPA violation is not an issue for this hearing.

FINAL DECISION AND ORDER:

1. The individualized education programs, B-16 and B-48, do not provide an appropriate physical therapy program for the Student.
2. Crossroads Physical Therapy provides an appropriate physical therapy program for the Student.
3. The Parents shall be reimbursed the fees paid to Crossroads for physical therapy services, from November 30, 2007, to the present.
4. The Student's IEP shall be modified to include the physical therapy services from Crossroads for 10 hours per week in order to provide an appropriate program for the Student.
5. The Student requires an extended school year program, which shall consist of a minimum of ten hours per week of physical therapy at Crossroads during summer vacations and school breaks which are longer than one week in duration.