EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

G.T. by his Parents Michelle and Jamie T., K.M. by his Parents Danielle and Steven M., *on behalf of themselves and all similarly situated individuals*, and THE ARC OF WEST VIRGINIA,

Plaintiffs,

v.

THE BOARD OF EDUCATION OF THE COUNTY OF KANAWHA,

Defendant.

Civil Action No. 2:20-cv-00057

Judge Irene C. Berger

DECLARATION OF SARA BOYD, PH.D.

I, Sara Boyd, do hereby declare as follows:

1. I have been retained to act as an expert witness for the Plaintiffs in the above-captioned action.

2. Attached hereto as Exhibit A is a true and accurate copy of my April 16, 2021, Report in support of Plaintiffs' Motion for Class Certification, and the exhibits attached thereto (collectively, my "report").

3. My report describes the primary records and other information I considered in forming my opinions.

4. My CV is attached as Appendix 1 to my report, and sets forth my qualifications and all publications I have authored in the past 10 years

5. A list of cases in which I testified as an expert at trial or by deposition in the last four years is attached to my report as Appendix 2.

6. I am compensated for work on my report at a rate of $250 per hour.

7. I respectfully adopt and incorporate into this Declaration my report, which describes the testimony I am offering in support of Plaintiffs' Motion for Class Certification.

8. I understand and intend that my report is to be presented to the Court with the same weight and consequences as if I had stated the report orally, under oath, in a court of law

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 25th day of April, 2021.

Sara Boyd, Ph.D.

EXHIBIT A

Report of Sara Boyd, Ph.D.
April 16, 2021
G.T. v. Board of Education of Kanawha County

I. OVERVIEW

I am a licensed clinical psychologist in private practice and affiliated with the Institute of Law, Psychiatry, and Public Policy at the University of Virginia. Over the past 15 years, I have evaluated the educational programs of hundreds of children with disabilities, including those with significant behavior support needs in West Virginia, Virginia, Kentucky, New York, and the District of Columbia. I am licensed in West Virginia, Virginia, and the District of Columbia.

I have been retained to review the educational programs and services provided to the two individual students, G.T. and K.M., who are Plaintiffs in the class action complaint, *G.T. v. Board of Education of the County of Kanawha* (January 24, 2020).

My review of these two students' educational programs and services reveals consistent similarities, including deficiencies in support provided by Kanawha County Schools ("KCS"). Based on my review and my professional expertise, I have reached the following conclusions:

- Both G.T. and K.M. are children with disabilities who require behavior supports and have experienced disciplinary removals from the classroom.
- For both of these students, KCS failed to provide effective behavior supports, including performing a Functional Behavioral Assessment ("FBA") that meets commonly-accepted standards and then developing, implementing, and revising a Behavior Intervention Plan ("BIP") based on the FBA. They did not use accepted and effective behavioral psychology principles to develop the BIPs. I believe that if KCS had performed timely and effective FBAs, developed BIPs based on those FBAs, and implemented those BIPs with fidelity, the students may have been able to avoid out of school disciplinary removals and segregated placements.
- Both children were denied an appropriate education and educational opportunities enjoyed by their peers without disabilities because they were suspended or segregated. They missed opportunities for academic skill building and social engagement with their same age peers. Due to the lack of effective supports, they are both at risk of further removals from school, and the related harms of disengagement and alienation from school and peers.

- In my experience, the methods that KCS needs to employ to serve these children are not unusual or cost-prohibitive. The methods I describe here and in my report are supported by research and have proven to be effective. However, KCS did not develop or implement a comprehensive array of effective supports that, in my experience, make it much less likely that schools remove students with disabilities like G.T. and K.M. from the classroom.

II. PROFESSIONAL EXPERIENCE

I am a licensed clinical psychologist in private practice and affiliated with the Institute of Law, Psychiatry, and Public Policy at the University of Virginia. I have evaluated the psychoeducational needs of hundreds of children with disabilities over the past 17 years, in West Virginia, Virginia, Kentucky, New York, and the District of Columbia. I am licensed in West Virginia, Virginia, Kentucky, and the District of Columbia. I am board certified in the forensic specialty with the American Board of Professional Psychology.

My work at the University of Virginia and in private practice involves providing evaluation and consultation in adult and juvenile criminal and civil matters. Through testing, observation, and interviews, I evaluate youth with disabilities under the custody of juvenile justice agencies, so that I can make appropriate recommendations about placement and services. I have done this work in West Virginia, Virginia, New York, and in the District of Columbia. I evaluate youth with developmental or intellectual disabilities, who have been diagnosed with a serious emotional disturbance, or who have co-occurring conditions. These evaluations look at a child's performance in school, and recommend instructional interventions, services, and placement for children with disabilities with Individualized Education Program ("IEP") plans. I am often called on to testify about my evaluations and recommendations in juvenile court.

I have evaluated hundreds of children and youth over the course of my career, including many children with intellectual or cognitive disabilities. I have also performed evaluations and consulted with IEP team members for dozens of children in West Virginia, Virginia, New York, and the District of Columbia. I work with teams of teachers and parents to interpret test results and recommend services, interventions and placements for students with disabilities.

Before beginning my work with the University of Virginia in 2016, I worked with a private psychological consulting firm in Woodbridge, Virginia, from 2014 to 2016. At this office, I provided evaluations and recommendations in juvenile criminal and civil matters. I also provided psychotherapy services to children with involvement in criminal and civil matters.

I received my Ph.D. in clinical psychology from the University of Kentucky in 2013. I also have received two master's degrees, in counseling psychology and clinical psychology, from the University of Kentucky. I also earned a certificate in developmental disabilities from the University of Kentucky University Center on Disability, the state's University Center for Excellence in Developmental Disabilities ("UCEDD"). I was a postdoctoral psychology fellow at the Institute of Law, Psychiatry, and Public Policy from 2013 to 2014, and a predoctoral psychology fellow at Westchester Jewish Community Services from 2012 to 2014. In both fellowships, I focused much of my work on evaluating and developing programs for serving individuals with developmental and intellectual disabilities, including autistic children.

My focus in academic research has been on children and adults with developmental disabilities, including autism. I have co-authored a number of papers and presented regularly at national and regional conferences on treatment, evaluations, and accommodations for children and youth with developmental or intellectual disabilities. As a graduate student, I received awards for this work from the American Psychological Association and the Association of University Centers on Disability.

I am compensated for my work on this report at the rate of $250 per hour, which is the same rate the University of Virginia bills clients for my services as an evaluator in similar types of evaluations.

My curriculum vitae is attached to this report as Appendix 1. A list of cases in which I testified as an expert at trial or by deposition in the last four years is attached to this report as Appendix 2.

III. WORK PERFORMED

I was asked to review the educational programs for the two individual students, G.T. and K.M., identified in the class action complaint *G.T. v. Board of Education of the County of Kanawha*, which was filed in the United States District Court for the Southern District of West Virginia on

January 24, 2020. While I have had more opportunities to observe K.M. due to my involvement as an expert in his due process proceeding, my review of both students' educational programs has been standard and sufficient for reaching the conclusions in this report.

My review of the two students' educational programs is described in detail below.

A. Educational Records

For both students, I reviewed school records, including evaluations, FBAs, BIPs, and IEPs. I also reviewed educational and clinical assessments. Specifically:

i. G.T.

- Autism Diagnostic Observation Schedule (ADOS-2) Report for G.T., dated October 28, 2014.
- Speech Language Evaluation report dated April 28, 2015, for preschool exit.
- Evaluation reports by Sara Fragale, Ed.S., School Psychologist for Kanawha County School, dated April 28, 2015 and October 1, 2018.
- Educational Evaluation Report dated October 18, 2018, by David Ellison, M.A., Ed.
- Autism Team Reports dated April 29, 2015, October 17, 2015, and April 19, 2016.
- Letter from Dr. Gilbert Goliath, M.D., dated May 12, 2015.
- Occupational Therapy Eligibility Report dated April 29, 2015.
- Eligibility Committee Report dated May 18, 2015.
- Notice of school district's proposal dated May 18, 2015.
- Task analysis documentation, dated June 1, 2016. Includes task analyses and defined objectives for various domains.
- Individualized Education Program for September 25, 2015.
- In Lieu of IEP Team Attendance Report dated September 25, 2015.
- Notice of Evaluation/Re-evaluation Request dated February 22, 2016.
- Administrative documents such as notices for upcoming IEP meetings.
- Reevaluation Determination Plan dated February 22, 2016.
- ADOS-2 Administration Report dated March 2, 2016.
- ADOS-2 Administration Report dated September 25, 2018.

- Cognitive Ability Assessment report dated April 13, 2016.
- Speech-Language evaluation for preschool exit dated April 8, 2016.
- Eligibility Committee Report dated April 19, 2016.
- Individualized Education Program dated May 19, 2016.
- IEP Meeting date documentation dated August 15, 2016.
- IEP for meeting date August 16, 2017.
- IEP for meeting date September 5, 2018.
- IEP for meeting date December 10, 2018.
- Manifestation Determination for meeting date December 17, 2018.
- Class Dojo behavior feedback report for August 20, 2018 to December 14, 2018.
- FBA meeting date February 7, 2019.
- IEP for meeting date April 19, 2019.
- Incident summaries for dates November 13, 2018
- Meltdown documentation worksheet from October 2018.
- ASD Behaviors in the classroom evaluation sheet dated September 18, 2018.
- Behavior Intervention Plan dated October 17, 2018.
- Behavior Intervention Plan dated February 21, 2019.
- Applied Behavior Analysis Observations and Recommendations dated April 3, 2019.
- Parent Information form dated December 3, 2018.
- Request for additional evaluation (FBA) dated December 10, 2018.
- Document titled Services Provided During Special Education Suspension, dated December 11, 2018.
- OT Discharge Summary dated December 17, 2018.
- Disciplinary Action Review form dated December 17, 2018.
- Wall Picture Schedule Task Analysis document, year not provided, appears to span January 19 to May 28.
- Detailed instructions for shaping behavior according to objectives (e.g., matching, responding to name).

- Form titled Challenging Behavior Data Sheet, spanning February 13, 2019 to March 11, 2019.
- IEP for targeted review date of September 21, 2020.

ii. K.M.

- K.M. academic records related to first and second grade schoolwork, grades, and some weekly progress charts.
- Copy of K.M.'s mother's handwritten notes from a classroom observation on January 25, 2018.
- Behavior performance updates, and BIP data reviews, from November 2017 to February 2021.
- Staff Response Guide, submitted October 19, 2018 and continued March 1, 2019.
- Psychological evaluation by Teresa Erby Robinson, Certified School Psychologist, dated August 31, 2016.
- Assistive Technology Evaluation summary dated October 8, 2017.
- Educational Evaluation Reports dated October 31, 2016, and November 27, 2017, by Carrie L. Amelie, Special Education Specialist for Kanawha County Schools.
- Psychological Evaluation Report dated November 17, 2017, by Lynn Bell, Ed.S., Certified School Psychologist.
- Speech Language Testing Update report dated September 21, 2016.
- Psychological Evaluation dated February 27, 2019, by Ashley Basford, M.A., Ed.S.
- FBAs from November 2016, March 6, 2019, and April 26, 2019.
- Behavior documentation forms and sample forms from 2018 and 2019.
- Incident reports with summaries for six incidents in 2018.
- Correspondence including emails between KM's parents and school personnel in 2017, and administrative IEP documents from 2016 and 2017.
- Document titled "Notes from Christina (ACC) about changes in exit IEP."
- Student discipline summary spanning August 2016 to July 2019.
- Documents related to the April 5, 2019 suspension.

- Journal article titled "Addressing challenging behavior in children with Down syndrome: The use of applied behavior analysis for assessment and intervention."
- IEP documents dated October 21, 2013, October 3, 2014, April 17, 2015, May 7, 2015 (progress review), October 10, 2015 (progress review), March 25, 2016, May 31, 2016, October 13, 2016 (progress review), January 10, 2017 (progress review), February 8, 2017, June 1, 2017, September 28, 2017, November 16, 2017, April 13, 2018, October 18, 2018, May 2, 2019, February 27, 2020, and January 5, 2021.
- Handwritten notes titled "Outcomes IEP Meeting Notes" for September 28, 2017.

B. INTERVIEWS

I conducted the following interviews:

i. G.T.

I interviewed G.T.'s mother for 45 minutes on October 17, 2020, for 35 minutes on December 16, 2020, and for 30 minutes on April 6, 2021. The last call included a brief discussion with G.T. as well. I asked G.T.'s parents about their experiences and needs in the context of seeking and refining special education services provided to G.T. I asked G.T. about his favorite school subjects, subjects of interest to him more generally, and his subjective perspective of how school was going since he returned to in-person instruction.

ii. K.M.

I interviewed K.M.'s mother twice in person at her home for about thirty minutes on March 18, 2019 and 30 minutes on August 25, 2019; I also met with K.M. that day. I interviewed K.M.'s mother, father, and K.M. for 30 minutes on October 14, 2020 and his mother for 30 minutes on November 3, 2020. I interviewed K.M.'s mother for 30 minutes on April 6, 2021. I asked K.M.'s parents about their experiences and needs in the context of seeking and refining special education services provided to K.M. I asked K.M. about his interests inside and outside of school and his plans and expectations inside and outside of school.

C. OBSERVATIONS

I have observed both students. Observations in 2021 were performed virtually due to the COVID-19 pandemic. Specifically:

i. G.T.

I observed G.T. in his classroom at Bridgeview Elementary School on March 24, 2021. The observation took place for 30 minutes while he was briefly in the emotional behavior disorder classroom and then transitioned to the music classroom.

In the music classroom, the children were receiving didactic instruction from a teacher accompanied by a classroom aide. G.T. was prompted with questions and provided short answers. In this classroom, he appeared to maintain a physical orientation and eye contact consistent with relatively good attention to the instructor, however, he did not make spontaneous comments or spontaneously participate.

After a 30-minute break, I observed G.T. for another 30 minutes, starting in the resource room and moving to the emotional behavior disorder classroom about midway through. I performed this observation virtually via Zoom, while G.T. attended school in person.

G.T. did not appear to have a one-on-one aide during the times I observed him. G.T. was wearing headphones for much of the observation, consistent with his noise sensitivity as indicated in his record. In the emotional behavior disorder classroom and the resource room, G.T. appeared to be completing independent academic instruction using his iPad. During this time, he did not have many substantive interactions with adults or children until the end of the class period, when he was prompted to have a snack and use the restroom. At that time, he spontaneously expressed a desire to go outside.

During the second observation, G.T. spent much of his time leaning forward with his right arm on the table, the tablet on his lap under the table, and his forehead on the edge of the table looking down at the tablet. He responded to and oriented himself toward a teacher who called his name at least twice. I did not see any adults prompt G.T. to engage in social interactions with other children in either classroom or during transitions between classrooms.

ii. K.M.

1. Home Observations

I observed K.M. at his home on March 18, 2019, for about 75 minutes. During this time, I asked K.M. and his mother various questions, including whether K.M. was experiencing any changes to his sleep, appetite, or medication. I asked K.M. about what he likes to do for fun, how he feels about school, and what his typical routine is after school. I asked his mother about K.M.'s preferred rewards for staying on task. During my observation, I saw K.M. play with a cash register; I asked him questions about what he was doing with the cash register and asked his mother about K.M.'s ability to pay attention when he is playing. One of K.M.'s parents' attorneys came to pick me up at the end of the observation and I observed K.M. interacting with her.

As discussed below, I also conducted assessments with K.M. at his home on August 24 and 25, 2019.

2. Classroom Observations

I observed K.M. on March 18, 2019 for about 75 minutes in a "resource" room for students with disabilities at his school, Alum Creek Elementary School. During that time, I observed him interacting with his teachers, his aide, and the school principal. I observed him participating in at least two different categories of academic tasks, one relating to reading and one relating to mathematics. I used a standard method for conducting classroom observations, the Achenbach System of Empirically Based Assessment ("ASEBA"). Using the ASEBA[1], I noted K.M.'s behavior during two 10-minute periods, including describing his behavior and noting whether he was on or off task. This is a generally accepted form for recording observations of a child's behavior.

I also observed K.M. in his classroom at Alum Creek Elementary School on March 25, 2021 for 68 minutes in two different classrooms. I performed this observation virtually via Zoom, while K.M. attended school in person. K.M. was already in the classroom when I began the observation,

[1] The ASEBA tool is meant to measure a child's behavior in short increments. I used the ASEBA tool when observing K.M. because his record indicates greater frequency of unwanted behaviors. I did not use the ASEBA tool when observing G.T., since G.T.'s records indicate that his unwanted behaviors are not as frequent and, therefore, the tool would not have been useful.

so I did not observe his transition into his first classroom, but did observe his transition into the second. Both classrooms included only other students with disabilities.

The first classroom was a resource room. In this room, there was more intensive, one-on-one instruction for K.M., and the teacher worked with K.M. to use his tablet. In the second classroom, there was no instruction taking place, and K.M. worked independently on his tablet. As in 2019, I utilized the ASEBA process to assess K.M.'s behavior in 3-minute increments over a thirty-minute period.

D. OTHER DOCUMENTS

I also reviewed complaints, hearing transcripts, and opinions from G.T. and K.M.'s due process hearings, reports for G.T.'s due process proceedings authored by Carol Quirk and Mary Jo Dare, and reports for K.M.'s due process proceeding authored by Mary Jo Dare and myself. I also reviewed the federal court complaint, the first amended complaint, and deposition transcripts and related exhibits for Melanie Meadows and Dr. Kate Porter.

I have also reviewed Dr. Judy Elliott's report. The report's discussion of KCS's systems for serving students with disabilities who need behavior supports and experience disciplinary removals from the classroom are consistent with my review of G.T.'s and K.M.'s records and my observations of G.T. and K.M. in the classroom. It is also consistent with my opinions in this report about the adequacy of the instruction, services, and supports provided to G.T. and K.M.

I have also reviewed the following texts: Fisher, W.W., Piazza, C.C., & Roane, H.S. (2011). *Handbook of Applied Behavior Analysis*. The Guilford Press: New York; Steege, N.W., Pratt, J.L., Wickerd, G., Guare, R., & Watson, T.S. (2019). *Conducting School-Based Functional Behavioral Assessments*, *Third Edition*. The Guilford Press: New York; and Cipani, E. (2018). *Functional Behavioral Assessment, Diagnosis, and Treatment: A Complete System for Education and Mental Health Settings, Third Edition*. Springer Publishing Company: New York.

These data-gathering methods are typically used by consultants who evaluate educational programs for students with disabilities and are my standard methods for reviewing such educational programs.

IV. TERMINOLOGY AND CONCEPTS

I refer in this document to two different components of effective behavior support. These are explained briefly below.

A functional behavioral assessment ("FBA") is an assessment process to identify factors contributing to a student's challenging behavior(s). The FBA identifies specific behaviors of concern (often called target behaviors), events occurring prior to a given behavior (antecedent events and specific triggering events), and events after a behavior has occurred (consequence events or reinforcements). The FBA is also designed to generate hypotheses about the purpose of a student's challenging behavior.

A high quality FBA provides information to a school team that is specific to the individual student, is readily understandable, and can serve as a foundation for an effective behavior intervention plan. If the information in the FBA is not focused on the child's specific behaviors, it is rarely useful as a foundation for an effective behavior plans. The FBA should address whether there are specific situations (antecedents) that consistently precede certain unwanted behaviors and increase the likelihood that the behavior will occur. Once these antecedents are identified, they can be managed and addressed to prevent unwanted behavior. This is referred to as "antecedent management." The FBA can also provide guidance with respect to potential pro-social replacement behaviors that the child can use to meet their needs while avoiding challenging behaviors.

The FBA needs to encompass observations at home and at school and to the extent relevant, travel between home and school. Out-of-school observations are critical to ensure consistency across environments, because the student's experiences and behavior at home may cause or relate to the student's behavior at school.

A behavior intervention plan ("BIP") is a plan to support the student's positive behavior growth. The BIP uses information obtained through the FBA. The BIP takes the FBA's hypotheses about the student's behavior(s) and identifies needed changes in staff strategies to address the antecedents and consequences of the student's unwanted behaviors. The BIP should identify replacement behaviors that the student will be taught as alternatives to the targeted unwanted behaviors. For example, if the function of the student's challenging behavior is to express

frustration, then an effective replacement behavior should provide a more constructive way to express frustration.

The BIP should identify any specific skills a student needs to build in order to engage in replacement behaviors. The BIP should also contain baseline data regarding the frequency or intensity of the current target behavior(s), and should identify the behaviors or activities that staff will monitor through additional data collection, what methods of data collection will be used, and specific staff responsibilities for collecting data and teaching replacement behaviors.

The BIP should be implemented as written to ensure all aspects of the plan are implemented as intended (often referred to as "implementing with fidelity"). Data collection and monitoring methods must be identified in order to provide staff a way to monitor the effectiveness of the BIP and make changes when appropriate. Schools should review and revise the BIP as needed, especially when the student's behavior deteriorates or fails to improve after implementation of the plan, or if environmental conditions significantly change, such as a change in a student's placement. Revisions to the BIP can also address new behaviors that may warrant different supports.

The FBA and BIP process is meant to provide staff with an understanding and context for a student's unwanted behaviors. If developed using very specific information and precise direction, the BIP provides practical guidance to staff about how to implement supports. The BIP is a fluid document that should be reviewed on a consistent basis and modified as needed. The plan enables every adult in the classroom and elsewhere in the school and home to understand (and to contribute to the understanding of) what triggers a student's problem behavior and what steps to take to respond to and prevent such behavior. The manualization (clear and explicit guidance) of adult responses and prevention strategies also ensures consistency across the child's environments.

V. THE INDIVIDUAL STUDENTS

As described in detail below, I see a number of issues in how KCS has failed to develop appropriate and effective behavior supports for G.T. and K.M. Although both of these students are children with disabilities who require behavior supports and have experienced disciplinary removals from the classroom, neither of them has received effective behavioral supports from KCS. If KCS

provides the behavior supports they need, I believe that both G.T. and K.M. can be educated successfully in general education classrooms.

A. G.T.

i. G.T.'s Background

G.T. is ten years old and in fourth grade at Bridgeview Elementary. His parents are separated. He lives with his mother, brother, and sister, and visits his father on Mondays and Wednesdays.

G.T. has many strengths, which should help him achieve success in his educational program. He is pleasant, curious, and has many interests, all of which present significant advantages in an educational setting. He exhibits relatively stronger social skills in his interactions with adults as compared to peers. G.T.'s parents are supportive of him and want to be involved in ensuring he is successful in school.

G.T. also experiences challenges. He has been diagnosed with autism, and many of his behaviors are typical of autistic children. Many autistic children have attachments to certain routines and patterns based on schedules. When these are disrupted, this can lead to difficulty with transitions and emotional regulation because the child has certain expectations and then has difficulty adapting when circumstances change. G.T.'s primary challenge is with disruptions to his routines and anticipated schedule. He becomes anxious when he is overwhelmed or when placed in unfamiliar situations, or when he encounters feared objects (like bees or flies) or aversive sensory experiences. Virtually all of his disciplinary incidents occurred during a change to his routine. G.T. also has challenges with executive functioning, which is used to plan activities and evaluate problems.

I do not believe that all of G.T.'s strengths have been identified. His testing results show specific impairments with respect to language and communication, but he has relatively strong fluid reasoning skills and reading abilities. I believe that KCS would see more of G.T.'s strengths if he were provided with more effective supports.

I also believe that G.T.'s functioning and academic skills acquisition would improve if school personnel showed greater willingness to incorporate his strengths into educational and behavior support planning. For example, G.T. would likely benefit from increased use of assistive

technology for communication purposes. He is very motivated to use his tablet, but is not receiving direction or assistance to use it to aid his communication. He could also benefit from the use of a dictation program, since he struggles significantly with writing.

His school has expressed concerns about G.T.'s comprehension regarding matters that he lacks interest in, but I do not see that staff have worked with him on matters he is interested in to build his comprehension skills.

ii. School Experience

1. Schools Attended

G.T. was enrolled in KCS's Dunbar Primary Center beginning in pre-kindergarten and transferred to Bridgeview Elementary in August 2016.

2. Diagnostic and Assessment History

G.T. was referred for early intervention at age two. His pediatrician diagnosed him with autism around age three. In 2014, his school performed an autism assessment, which produced scores indicative of a moderate degree of autistic features. IQ testing conducted in 2015 showed a verbal IQ in the third percentile. His total adaptive behavior composite score was in the first percentile. In 2015, an occupational therapy eligibility report noted developmental delays in all areas and that G.T. had significant difficulty regulating sensory input and displayed fine motor deficits.

In 2016, the school performed another autism assessment, which showed significant social affect impairments, behavioral rigidity, sensory sensitivity, and challenges with attention and self-regulation consistent with an autism diagnosis. Updated IQ testing from 2016 indicated that G.T.'s verbal IQ was low and total adaptive behavior was in the fourth percentile. In other words, his adaptive functioning is about what would be expected, given his tested intellectual ability at that time.

In 2016, another KCS evaluation stated that G.T.'s autism did not adversely affect his educational performance. It also noted that he lacked features of behavioral and cognitive rigidity and included the finding that G.T. might not meet criteria for autism, but he nonetheless required special education services. Based on this report, G.T.'s IEP team changed his special education eligibility classification to intellectual disability. G.T.'s receptive and expressive language testing results that

year produced scores indicating these skills were at an age equivalent of three. In 2018, G.T.'s parents requested a reevaluation for autism. Later that year, after completing the requested reevaluation, KCS changed his classification back to autism.

3. IEPs

The first IEP in G.T.'s records is from 2015. At that time, his team agreed that G.T. would be retained in pre-kindergarten rather than starting kindergarten. The IEP noted G.T.'s difficulties with attention. The IEP states that he "does not greet peers or adults unless prompted." The IEP indicated a limited ability to follow instructions and that his parents described him as hyperactive at home. Goals included naming objects, following directions up to three steps, increasing length of his verbal statements, working for longer duration on fine motor skills, toileting, sitting in a large group setting for 5-10 minutes, playing with peers independently for 5-10 minutes, greeting peers and adults, and improving verbalization and articulation.

At this time, G.T.'s placement was 28 hours per week in Dunbar's regular early childhood program with other students without disabilities, where he received the majority of his special education hours. This particular time period appears to reflect a significant degree of success with interventions provided to G.T. These interventions included detailed and manualized recommendations for teaching him needed skills, such as responding to his name when called.

G.T.'s April 2016 IEP noted that G.T. had some impulsive behaviors and needed "constant reminders of things that might be dangerous both inside and outside of the classroom." The IEP included goals related to expressive language development, following directions, fine motor development, and math and reading goals. G.T. was placed in general education for 80% of his day and special education for 20% of his day.

In August 2016, G.T.'s IEP team proposed that his placement change to 10% time in general education and 90% time in special education due to "cognitive delays." G.T.'s 2017 IEP indicates that his placement was changed per this recommendation. His 2018 IEP noted that he was in the self-contained "Mild/Moderate ID" classroom at Dunbar.

The September 25, 2018 IEP meeting review noted that G.T. made "significant progress" in his self-contained special education classroom, and that this meeting would determine G.T.'s "ability

to return to the regular education setting with resource support." The IEP review notes that G.T. had begun reintegrating into a general education classroom in the 2017 school year, and was functioning independently with regard to toileting, walking, waiting in line, eating, and using his locker. G.T.'s IEP goals focused on expressive language, transitioning between school environments, fine and gross motor skills, and academic objectives. At this time, G.T.'s placement was 76% in the general education classroom and 24% in the special education classroom.

The April 19, 2019 IEP reviewed historical testing results and noted that G.T. was discharged from occupational therapy, evidently based on his progress with motor skills development. Speech was likewise discontinued because G.T. "reached mastery on his speech goals." The parents' statement noted that G.T.'s "strengths are his reading skills and imagination. His needs are that he needs to follow a routine." Testing results indicated social and executive functioning difficulties, that G.T. was below grade expectations for reading, and that his academic achievement testing showed below average or low scores in all domains except basic reading.

The IEP further stated that G.T. "has consistently struggled with his behavior in the general education setting which has an adverse impact on his education and that of peers." Aside from noting that G.T. "can become upset" when "the daily schedule deviates from the norm" and that G.T. "will engage in escalated behaviors for longer periods of time if he is given attention from staff or peers," little detail was provided about the antecedents, specific behaviors, or consequences of G.T.'s behavior. Transitions were noted as a challenge for G.T. without reference to specific frequencies or numbers of incidents. Staff "noticed an improvement in [G.T.'s] behaviors overall," but no details of how this was measured are provided.

With respect to academic goals, the IEP noted that, "math uses the iPad as part of instruction, and [G.T.] seems to thrive on the visual cues provided," but there is no discussion about how this observation might be applied to other subjects or goals. As with the other IEPs, behavior grade expectations are described in a general sense (for example, children in grade two "will learn to distinguish themselves from others, understand others' needs and wants, and to realize that rules, routines, and boundaries help create an environment that is safe and equitable."), but these expectations are not tailored to G.T.'s functioning or specific goals and objectives.

The IEP notes that G.T. "has issues with following directions and task completion. He also has his issues interacting with peers and adults," but no specific follow up is recommended in terms of assessment or intervention. Two behavior goals were specified: "By February 2020, given social skills strategies for conversation, [G.T.] will stay focused and on task during conversations with 80% accuracy as documented by the classroom teacher weekly;" and "By February 2020, given a visual schedule that follows his daily routine, [G.T.] will follow the daily schedule, including transitions, without becoming upset over changes that may occur with 90% accuracy, as documented weekly by the classroom teacher." At this time, G.T.'s placement was 35% in the general education classroom and 65% in the special education classroom.

G.T.'s September 21, 2020 IEP contained a checklist indicating that G.T. does not have communication needs but does have behavior problems and requires assistive technology. The IEP noted that G.T. could read on grade-level, but that comprehension is more difficult for him. According to the IEP, G.T. can develop ideas verbally but "struggles to get those ideas written on paper or typed onto a computer."

The IEP indicated that G.T. was to receive live instruction and help sessions from his classroom teacher during time spent learning remotely. The IEP also notes the need for children his age to "engage in experiences that promote positive social and communication skills." No social goals are identified in the plan. A description of his behavior notes a slight decrease in refusals and disruptive behavior and a slight increase in elopement and physical aggression. The IEP also notes that the "Autism Itinerant" (teacher for autistic children who travels between classrooms to provide supports) has been working on reciprocal communication with G.T."

During the current school year, G.T.'s placement has been 50% time in the "Emotional/Behavior Disorder" classroom, and 50% time in a "resource" room. In both placements, G.T. only spends time with other students with disabilities.

4. FBAs and BIPs

The first referral for an FBA appears in G.T.'s records on December 10, 2018, after he had been suspended for 10 days. A largely "indirect" FBA, based on interviews with teachers and a few direct observations of G.T.'s behavior, was conducted in early 2019. This document notes G.T.'s

recent changes in placement. Forms were sent to his parents to obtain additional information, but it is not clear if these were completed.

To the extent that behaviors were observed, they appeared to revolve around transitions between classrooms and tasks; G.T. struggled to transition from break to reading groups with other children. He stated that he was "too tired." He covered his ears at times. The FBA hypothesized that challenging behaviors were associated with schedule changes and transitions, aversive tasks and instructions, higher numbers of people present, high noise levels, and being taken to the office. It hypothesized that suspending G.T. may be reinforcing his attention seeking and escape behaviors. The FBA recommended supports including earning rewards, teaching him to utilize breaks at the first sign of less challenging behavior, a visual schedule, limiting use of verbal prompts, and allowing him time to himself when he begins to display concerning behaviors.

The first BIP in G.T.'s records is dated October 17, 2018. Targeted behaviors included "meltdowns" characterized as "screaming and/or crying and sometimes physical aggression that includes damaging school property (ex: table or desk)." The BIP included goals for G.T. to decrease tantrums, "comply with adult directives without losing control," "verbalize feelings, concerns, and thoughts rather than acting them out," and identify the need for a cool down period prior to a "meltdown."

Some preventative strategies were identified to address these behaviors, including "Teacher will give the student forewarning regarding changes in routine and schedule, when possible" and providing G.T. reminders to "verbalize thoughts and feelings rather than acting them out," to help G.T. with "appropriate coping skills such as counting to ten, and/or taking deep breaths," and developing a "procedure" for G.T. to take a break. Negative consequences for unwanted behaviors included removal from class and not providing a reward.

The plan recommended that G.T. receive candy at the end of the day if he had no meltdowns that day. Home interventions included "parent will maintain regular communication with teachers, administrator, and school…Parent will provide rewards/consequences at home to follow up with day at school." The plan indicated that a daily behavior sticker chart would be utilized to "determine progress."

G.T.'s most recent BIP from February 21, 2019 identifies target behaviors as refusals and disruptive behavior, elopement, and physical aggression. Replacement behaviors included G.T. asking for a break, using a visual schedule, G.T. keeping his hands and feet to himself, and staying in his assigned area. The BIP continued to note that G.T. requires an undefined "specific procedure" to ask for a break. Antecedent management strategies included a visual schedule, preparing G.T. for changes in his schedule in advance, changing the reinforcement schedule to a random intermittent pattern, and ensuring that G.T. is in sight of teachers at all times.

The plan recommended allowing G.T. to choose an item from a prize box at the end of the day and using reward stickers when he met his plan goals. A summary of behaviors from his teacher stated that G.T. earned rewards approximately once every three days. He did not receive rewards for two out of three days in the observation period. Negative consequences for unwanted behaviors were largely unchanged from the 2018 BIP. A crisis plan recommended using Crisis Prevention Institute personal safety techniques if G.T. posed a threat to himself or others.

In early April 2019, Jennifer Carpenter, a Board Certified Behavior Analyst (BCBA), completed an observation of G.T. and provided recommendations related to Applied Behavior Analysis strategies that could be used for G.T. Recommendations included daily assessments and rank ordering of free time activities, a visual list that G.T. can choose from when completing work independently, and increasing use of timers.

5. Suspensions

G.T. has experienced numerous suspensions, including the following:

- October 1, 2018: G.T. refused his teacher's instruction to get out his reading book and turned his desk over. The teacher stated that he "gets upset when he loses a dojo point." This resulted in a one-day out-of-school suspension.
- October 3, 2018: One day after returning from being suspended the day before, G.T. was in the library for a book fair. He tried to push a table over. He was removed from class. This resulted in an out-of-school suspension of two and a half days.
- November 13, 2018: G.T. "refused to do any work today." He was sent to the office twice, and was "screaming," and running from adults. He also kicked a trashcan,

ran to the office, took his shirt off, and reportedly told the Vice Principal that he "was going to beat her ass." This resulted in a one-day out-of-school suspension.

- November 16, 2018: G.T. had a "meltdown" in P.E. class. The gym was being used for another purpose, so the class needed to be moved to a different room. G.T. was sobbing and physically aggressive when approached. He was carried to the office where he tried to throw things. This resulted in an in-school suspension.
- December 11, 2018: G.T. had two "meltdowns" when his father stopped by the school to give him money for the Santa's Workshop. The first occurred when G.T. realized he did not bring money for Santa's Workshop and started to run around and throw things. He was taken to the office. G.T. wanted to leave with his father and ran away after him. The father grabbed G.T. by the arm and G.T. tried to bite his father. This resulted in a ten-day out-of-school suspension.

iii. Behavior Supports

1. Lack of Adequate Data and Specificity

KCS has not adequately assessed the antecedents of G.T.'s behaviors, which are common to autistic students, nor developed an appropriate plan for addressing those behaviors.

G.T.'s FBA does not provide meaningful, practical, and concrete guidance to teachers and other staff working with him, or his parents, because it does not describe with adequate specificity the antecedents of G.T.'s disruptive behavior, or the consequences of the behavior, both of which are necessary to identify hypotheses about why G.T.'s behaves the way he does. It does not appear that the school regularly sought sufficient information about G.T.'s behavior from his parents or from G.T. to incorporate into the FBA. G.T.'s teacher collected data for the FBA; it would have been better if data collection was completed by independent observers to avoid introducing subjectivity into the process with the preconceived notions of someone who knows him well.

G.T. requires an updated FBA, with revised hypotheses supported by data about the functions of his behavior in his current environment, in order to be adequately supported at school. After identifying and beginning implementation of behavior supports, KCS should collect more data to test those hypotheses, determine whether the supports worked, and reevaluate the plan as needed.

Because the FBA in G.T.'s plan is inadequate, the BIP based on that FBA is also inadequate. G.T.'s BIP does not provide his teachers with sufficient guidance as to how to implement supports to address his concerning behaviors. It does not meaningfully identify target behaviors or the purpose of the behavior. It does not address what replacement behaviors G.T. will be taught that will address the purpose of the challenging behavior or sufficiently address how G.T.'s teachers should attempt to prevent challenging behaviors or mitigate them when they arise. In the BIP, KCS tends to frame G.T.'s unwanted behaviors as his failure to self-regulate rather than the school's failure to help him meaningfully address these behaviors.

2. Lack of Clear, Measurable Goals

Behavior goals must be clear and measurable in order to be able to assess progress in any meaningful way. The behavioral goals in G.T.'s IEPs and BIPs are not adequate and reflect a lack of understanding about how to identify and achieve behavioral goals for students like G.T.

For example, each behavioral goal in the IEPs that I reviewed notes a level of accuracy that G.T. is expected to meet, such as "practicing positive communication skills with 80% accuracy," "demonstrating positive behaviors with 90% accuracy," and "refraining from harming himself or others with 100% accuracy." However, it is unclear what constitutes "positive communication skills" or "positive behaviors." It is also unclear what KCS staff will do to determine whether G.T. has met the level of accuracy stated in the goal, and for what time period. An example of a reasonable, measurable goal would be "the child will have no episodes of self-injury or threats to self-injure for a one-week period." Or "the child will display appropriate communication (i.e., not interrupting, taking pauses) on an identified topic of interest with a familiar peer for five minutes."

G.T.'s latest IEP indicates that he struggles with motivation to continue participating in school after 1:00 p.m., and that this causes behaviors such as outbursts and aggression. But the IEP does not include any goals or plans to address this, or identify what the school's response to this behavior has been thus far. A behavior report from January 2020 notes a slight decrease in refusals and disruptive behavior, and a slight increase in elopement and physical aggression, but does not provide a meaningful window into G.T.'s behavior. It does not appear that G.T.'s IEP team has developed goals or plans to address these issues.

3. Lack of Planning for Disruptions to Routine

G.T.'s suspensions reveal a pattern, in that most behavioral incidents occurred during a disruption to his routine, but KCS has not planned ways to support G.T. when his routine is changed.

For example, in December 2018, G.T.'s father came to his school to give him money for a "Santa's Workshop" event. This was different from G.T.'s usual routine and he was not prepared for it, which led him to become upset and want to leave school with his father. He may have been confused and thought that his father showing up meant that it was time to go home. G.T.'s "elopement" that day was likely G.T. running after his father. On another occasion, he had a meltdown when his P.E. class was moved from one room to another, because the gym was being used for a spelling bee, another change to his routine. A similar set of behaviors occurred during a book fair, another example of a change to G.T.'s routine.

G.T.'s IEP does not contain any goals for managing these disruptions or establish how the school will teach him to approach them differently. His FBA and BIP do not identify specific supports that he will be provided, or tools he will be taught to manage this challenge. Because KCS has not collected sufficiently detailed behavior data after implementing behavior supports, there is no way to assess how successful any given support has been. Staff appear to abandon strategies, such as G.T.'s visual calendar, after few attempts to use them.

A visual calendar is a standard tool in antecedent management. It helps prepare the child for changes by showing a visual representation of what will happen. Consistent use of a visual calendar at home and at school could help G.T. prepare for and anticipate changes in his schedule, but it does not appear that KCS has used this intervention consistently in the classroom.

For planned schedule disruptions, like "Santa's Workshop" and the book fair, KCS can prepare G.T. so he is not surprised and better able to handle the changes. There is no indication that KCS did anything to prepare G.T. for changes related to these events, or evidence that they have taken steps to prepare him for other disruptions to his routine.

4. Lack of Crisis Planning

Developing a crisis plan as part of the IEP, for what staff will do when behaviors escalate, is essential for a child such as G.T., because the plan provides staff with a considered approach for assessing the child's stress levels and addressing them before they escalate into unwanted behaviors.

G.T.'s IEP does not contain an individualized and meaningful crisis plan and his BIP does not include strategies for addressing any perceived crises that may occur, or a method of identifying when G.T. may be becoming distressed that would allow staff to address challenges early on and more easily identify if his behavior is escalating. The crisis plan that is included is derived from the Crisis Prevention Institute which teaches techniques to deescalate conflict, to deflect physical aggression, and to safely contain an individual who may be behaving aggressively. This is a general technique, not an individualized plan tailored to G.T.

A crisis plan based on a continuum of distress and physiological activation provides staff with the opportunity to work with G.T. on his communication skills, and to intervene earlier in the escalation process. His teacher could use a visual thermometer to help G.T. communicate how he is feeling at different stages. For children with communication impairments like G.T., "using his words" becomes even more challenging when they are under significant stress. A visual thermometer can be helpful to allow him a mode of communication that does not require speaking or responding to verbal communication from others.

For example, when G.T. is feeling calm his hands may be relaxed, and he does not rock back and forth. These are examples of observable, concrete behaviors that should be easily recognizable to adults working with G.T., even if those adults have not worked with him before. When he is feeling a certain level of stress, G.T. might clench fists or his face might turn red. If G.T.'s teachers know how to identify these initial signs of distress, and anticipate antecedents that are likely to evoke distress, they could then show G.T. a picture of a thermometer to help him communicate about how he is feeling and what he wants to do. This is consistent with recommendations from educational specialists that G.T. be provided with a visual choice menu.

KCS should also teach G.T. strategies for managing his anxiety, including observing when G.T. appears to employ those strategies and offering positive reinforcement when he does. Once he

learns some successful self-management strategies, and has the opportunity to practice them under low stress conditions, he can later try to use them in more challenging situations. G.T.'s BIP should also address how to avoid unplanned schedule disruptions when possible, along with cultivating opportunities for G.T. to demonstrate flexibility, and provide him positive reinforcement for that behavior.

iv. Family Engagement

It is critical that KCS engage the families of children like G.T. who experience challenging behaviors. G.T.'s parents have expressed a number of concerns to his school over the years about G.T. not receiving appropriate instruction and being segregated from other students in ways that impede his development. But KCS has not meaningfully incorporated their input into G.T.'s IEPs and have not identified specific ways in which the school will work with G.T.'s family to help them implement G.T.'s behavior plan at home.

Parents have critical knowledge and understanding about a child's strengths, challenges, and behaviors. For G.T. and other autistic children, it is very important to have as much consistency as possible across environments. Everyone needs to be aware of the supports identified in his BIP, and familiar with how to respond in various situations. To achieve this, good communication with his parents is a necessity. The school should seek input from G.T.'s parents and incorporate that information into the IEP and BIP. KCS should seek help from G.T.'s parents in developing the plan and support them in implementing the plan at home. There should be routine scheduled communications outside of crises. School staff should invite G.T.'s parents to talk regularly about G.T.'s progress. This can take place weekly, or more or less often as needed to develop a strong working relationship.

Improved communication would also benefit the school. For example, if G.T.'s parents have identified behavior management strategies that work well for him at home, the school could use this information to inform his plan at school. G.T.'s parents are also familiar with his interests; with their help, his school can focus instruction on G.T.'s areas of interest, which could help him maintain interest in learning, and avoid unwanted behaviors. When we visited, G.T.'s mother mentioned that his favorite topics to talk about are history, World War I, and World War II. She

suggested that KCS integrate history-reading materials for G.T. to maintain his motivation in class, but KCS told her they could not do that.

G.T.'s parents do not feel that KCS adequately prepared them to manage his remote learning during COVID-19. When the IEP was updated to indicate a remote learning plan for COVID-19, there was no outreach to G.T.'s parents to send them a specific plan, teach them about the plan, or inform them how to obtain support from the school if they had difficulties implementing G.T.'s remote learning. During COVID-19, G.T. did not receive consistent educational services. His parents felt very confused about what was expected of him and when, due to lack of communication from the school.

To prepare G.T. for success in returning to the classroom in person, the school should have communicated more often with G.T.'s parents within at least one month of his return to school, about what they could do at home to ensure a smooth transition. This would have allowed his family to implement a visual calendar at home so G.T. could count down the days and begin preparing. His family could have worked with him to gradually create a positive association with school. G.T.'s sensory sensitivities should have been considered and planned for. He would also have benefited from using a visual thermometer at home to help him communicate about how he is feeling about returning to school. I am not aware that any of this type of planning has taken place for G.T.'s return to the classroom.

Now that G.T. has returned to in-person instruction at his school, there needs to be a grace period during the transition to allow him time to adjust. KCS should work with G.T.'s parents to identify opportunities for staff to accommodate G.T. in the classroom and to provide positive supports to reduce the probability that he will engage in challenging behaviors. KCS should also proactively communicate with G.T.'s parents so they have a sense of how he is doing and what interventions are being attempted. Currently, his parents often feel they have to rely on G.T.'s self-report in order to know what happened that day.

If KCS communicated consistently and effectively with G.T.'s parents outside of crisis situations, and treated them as collaborative partners, this could go a long way toward rehabilitating their relationship with the school.

v. Coordination with other Providers

When KCS does not have in-house knowledge or understanding of a given issue, it is important for them to consult with G.T.'s other providers, including to inform development and implementation of his behavior plan so that it is effective.

Because G.T. takes medication that affects his behavior, it would be appropriate for the school to coordinate with his doctors. For example, the school should know if G.T.'s medication dose is changed or if he was on a medication holiday over a school break. The school could also benefit from more in-depth consultations with occupational therapists to determine whether there are sensory interventions, such as swings, rubber bands, fidget toys, or other items or activities that could help G.T. calm down when needed. If G.T. has a positive association with an activity, rather than only doing it after he melts down, this could help prevent the meltdown from happening in the first place.

G.T. also needs an updated occupational therapy assessment from someone who specializes in working with autistic children, to get a current, more accurate picture of his sensory sensitivities and recommendations for a sensory diet or other interventions that might help him regulate his overall physiological arousal level around outside stimuli he is likely to encounter at school. Additionally, G.T. could benefit from an updated assessment of his cognitive and learning strengths and challenges. The results of these assessments may indicate that a full neuropsychological assessment is needed.

vi. Placement

During COVID-19, G.T. mostly learned from his home. He transitioned back to in-person learning at school in October 2020. When I observed G.T. in his classroom on March 25, he was in a segregated classroom.

G.T.'s IEP includes a goal of improving G.T.'s reciprocal communication, but I did not observe G.T.'s teacher or anyone else prompting him to interact with other children or prompting any of the children to interact with each other. No prompts were given to G.T. for any type of social communication, including greeting people or saying goodbye. The children all sat next to each

other during class, but there was no interaction between them. The children were almost like little robots, with no opportunities for normalized, informal human interaction.

School is not only about acquiring academic skills, but also about acquiring social skills. G.T.'s mother has communicated to the school that G.T. is capable of social interaction and regularly engages socially with his siblings at home. She has requested that KCS facilitate social interactions through participation in activities of interest for G.T. I did not observe this happening during my classroom observation.

I saw that G.T. was attentive during music class, with his body oriented toward the instructor, though he did not otherwise do much to participate in the class and was not prompted to do so. Instruction mostly involved the teachers talking at the kids and playing a video. There was not much reciprocal conversation. G.T. only spoke when prompted. One instructor did some "hand over hand" instruction with him during the music class, used to help G.T. to illustrate a musical notation by drawing it in the air with his hand. In the resource room, there did not appear to be any instruction and G.T. worked independently.

Other than one instance of a teacher saying "good job" to G.T., I did not see anyone provide G.T. with positive reinforcement for his work. Positive communication goals are discussed in his IEP, but I did not observe G.T. receiving any support to achieve these goals or any staff documenting his communication during class. Prior to snack time, the teacher asked G.T. if he wanted to talk while he eats, but the teacher did not ask what G.T. wanted to talk about, or suggest a topic, or indicate how long they would talk. For G.T. to engage in social opportunities there needs to be specific prompts. I observed another child approach G.T. in the classroom, but G.T. ignored him and I did not observe any teachers help to make the interaction more successful. I did not see G.T. engaging in unwanted behaviors during my observation.

It is unclear why G.T. is not in a general education classroom. The cognitive delay noted in his record is not an adequate reason to remove him from the general education environment. Isolating G.T. with only other students with disabilities means that he does not have access to a wider array of student behaviors from which to model his own conduct. It is well established that integrating children with developmental disabilities with children without disabilities benefits all students, not

just those with disabilities. Placing G.T. in an "Emotional/Behavior Disorder" classroom stigmatizes him and makes socializing even more difficult.

It is important for G.T. to be in a general education classroom because placement in a more restricted environment will limit his ability to engage in pro-social behaviors with non-disabled peers. As he gets older, he will be highly sensitive to peer influence and the most significant social influence will be the other children around him. It is important to ensure that he is spending time with other children who can model positive social skills for him and provide more variety of examples in social-emotional expressiveness.

There is nothing wrong with G.T. being around other autistic children, but it is important that he have the opportunity to interact with children who have different strengths and challenges than he does rather than only being around other children with similar behavioral challenges. Seeing other models of learning and social interaction is critical for G.T.'s development. Keeping him segregated means that his opportunities for social and academic development will be limited and he will not develop foundational skills he needs for junior high. This will only get harder as he gets older.

Now that G.T. has returned to school, his goals should be a full-time placement in a general education classroom. It is critical that the school create a plan for G.T. that will help him succeed in that environment. If the school does a poor job of transition planning for G.T., this may be used as evidence that he cannot function in the general education classroom, but it is instead evidence that adequate planning did not take place to prepare him for success.

vii. Conclusion

With appropriate behavior supports, G.T.'s teachers and school administrators can help him avoid or manage his challenging behaviors and prepare him for success in a general education classroom.

G.T. will benefit from opportunities to learn and practice social skills with non-disabled peers in a general education environment, so that he can interact more appropriately with other students and teachers. Instead of providing needed behavioral supports, KCS has restricted G.T.'s opportunities for learning, including but not limited to his frequent suspensions. G.T. has spent too much time in separate special education classrooms where he has limited opportunities to learn and build

social skills. KCS has not planned for nor provided the instruction, services, and other supports G.T. needs to be served in a general education classroom in his neighborhood public school.

In my opinion, the educational supports, including behavioral supports, provided to G.T. were not sufficiently tailored and detailed to capitalize on his strengths and effectively address his challenges. The overall trend toward more time in special education versus general education settings combined with the suspensions means that G.T. has not been receiving his education with non-disabled students to the maximum extent appropriate to his needs as a child with a disability. In fact, he seems to have done best at times when he was most integrated with non-disabled students.

The FBA and associated behavior plans used to guide educator responses to G.T.'s behavior and the interpretation of intellectual testing results were substantially flawed. Since these procedures were used to determine what services G.T. should receive and the restrictiveness of the environment where he will receive his education, his resultant placement is excessively restrictive and behavioral interventions are not as effective as they could be.

G.T.'s parents have not been provided with opportunities for meaningful and regular communication with school personnel. Consequently, they have not been provided with sufficient information and assistance to effectively challenge the identification, evaluation, and placement decisions or to incorporate behavioral and educational objectives into their parenting strategies to support G.T.'s overall functioning, including academic functioning. In addition, it does not appear that school personnel have consulted, or endeavored to consult with, G.T.'s medical care providers, including his prescribing physician.

B. K.M.

i. Background

K.M. is eleven years old and in the fifth grade at Alum Creek Elementary. His parents are separated and his father and his new partner are expecting a child this spring. K.M. lives with his mother and occasionally stays with his father. It is important for KCS to be aware of these changes in K.M.'s life so they can be aware of any potential home stressors and adequately support K.M. through these transitions at school.

K.M. has significant strengths. He is able to learn and focus on completing tasks and following directions. K.M. is able to assert himself and advocate for himself by clearly articulating what he wants to do and what he does not want to do. This is an important strength, though at times it has presented challenges to adults around him, because he can seem intractable and inflexible regarding what he wants to do when it conflicts with what the adults around him want him to do. He is creative and motivated. He spends a lot of time on activities in which he is interested, like watching videos and playing the drums, and enjoys talking about them. He is gratified by positive adult attention. During my observations, he was pleasant, polite, and funny.

K.M. has been diagnosed with Down syndrome, which typically is associated with some degree of intellectual disability. He is also treated by his physician for Attention Deficit Hyperactivity Disorder ("ADHD"), and he exhibits almost all of the behavioral criteria for ADHD. Additionally, there were notations in his records of behaviors that are typically associated with autism, such as disinterest in engaging with peers, social difficulties, a history of being a picky eater, and other indications of sensory sensitivity. K.M.'s records do not include up-to-date diagnostic testing results. He has not been assessed for autism, but he should be. ADHD is very common in children with autism.

K.M. has difficulty focusing on tasks that adults tell him are important to complete if he does not have some intrinsic interest in the activity. K.M. has a lot of energy, which makes it a challenge for him to sit still. I saw him engage in some rocking behavior, which is another possible indicator of autism. He appears to have some fine motor challenges with manipulating small objects. He also has some challenges with verbal expressive language and is below the first percentile of children his age. This suggests that his behavior is a primary form of communication. Some of what school staff call challenging behavior may be a product of his frustration that he cannot verbalize.

ii. School Experience

1. Schools Attended

K.M. has attended Alum Creek Elementary since pre-kindergarten.

2. Diagnostic and Assessment History

K.M. was diagnosed with Down syndrome in his early childhood and was found eligible for special education services as a child with "Other Health Impairment," which continues to be his classification. He has not had IQ testing completed by school personnel since 2015.

A 2017 psychological evaluation noted that his expressive language was below average. Another assessment showed very low adaptive functioning skills. Other assessments have shown challenges across all domains, including social skills, academic difficulties, language, math, and hyperactivity. In 2017, an educational evaluation showed K.M.'s listening comprehension, oral expression, and early reading skills all fell below the first percentile. A 2019 psychological evaluation by Ashley Basford offered an opinion that K.M. presented a "medium risk," without apparent utilization of evidence-based strategies for assessing risk or threat in children. The report did not identify the risk with any specificity (i.e., risk to whom? Of what?) or specific strategies for managing existing risk.

I conducted IQ testing with K.M. in August 2019. I used subtests that are part of the Wechsler Intelligence Scale for Children, 5th Edition (WISCV). The WISC is a standard set of assessments of cognitive ability that is used across the country among schools and in other contexts. Given the low test scores in academic performance that were noted in his educational records and the relatively higher frequency of cognitive impairment in children with Down syndrome, I thought it was important to develop a current understanding of K.M.'s intellectual functioning.

K.M. completed all but two of the WISC subtests; he did not complete subtests related to measuring his processing speed, which rely on the use of fine motor skills. I measured his full scale IQ as 44. This is very low, but in my opinion underestimates his potential and his level of cognitive functioning.

K.M did not appear to be motivated to complete all of the subtests to the best of his ability. I am concerned that he has had so many failure experiences at school that he does not engage in certain tasks if he believes he will fail at them. I asked him if he did not want to complete the tests because they were too hard, and he said yes. I believe that if he performed to his full potential, with motivation, K.M.'s full-scale IQ score on the WISC would be at least 55-65. I base this on my years of interactions with children with intellectual and developmental disabilities who have had

numerous academic failure experiences. K.M.'s verbal ability and adaptive functioning was similar to other children in that IQ range. His performance on the vocabulary subtest, which was relatively strong, appeared to be influenced in part by a greater degree of confidence and sense of competence compared to most other subtests.

3. IEPs

K.M.'s 2017 IEP goals include staying in his assigned area 100% of the time, engaging in teacher-directed activities without exhibiting challenging behavior, and development of motor skills, expressive language, speech, math, and reading goals. At this time, K.M.'s placement was 75% time in the general education classroom and 25% time in the special education classroom.

K.M.'s 2018 IEP goals focused on saying in his assigned area 100% of the time and noted that he should be "given a reinforcement system and a scripted behavior intervention plan." Other goals included "attending to or engaging in a teacher-directed activity without challenging behaviors with 75% accuracy," and "successfully transitioning from activities outside the classroom into the classroom 75% of the time." Other goals were focused on fine motor, expressive and receptive language, speech articulation, and interacting socially with peers during playtime with 80% accuracy. There were also academic goals related to math and reading.

The IEP noted issues with sleepiness at school: "since the beginning of the school year, [K.M.] has slept in class approximately two to three times per week for an average of two hours…The Teacher Mentor states that, during classroom observations which she conducted, [K.M.] was asleep for two hours on one occasion and one hour on another occasion…The IEP team suggests that a shortened school day may improve K.M.'s behaviors, sleeping behaviors, focusing on instruction and assignment completion while he is at school." At this time, K.M.'s placement was 63% time in the general education classroom and 37% time in the special education classroom.

K.M.'s 2019 IEP goals included similar behavior goals, such as "given a positive behavior intervention plan, and daily monitoring of behaviors, K.M. will remain seated appropriately within his designated area within the school setting with 75% accuracy daily." Goals also included "keeping hands, feet, other body parts and objects to himself." Other goals remained similar to prior IEPs. No social skills goals were included. The IEP notes that sleepiness at school remains

an issue for K.M. At this time, K.M.'s placement was 46% general education and 54% special education.

K.M.'s 2020 IEP included two behavior-related goals, one of which related to following staff directives (remaining seated in his designated area, keeping hands, feet, etc. to himself); the other behavior goal related to "appropriate, routine behaviors," including "appropriate bathroom behaviors," and "appropriate behaviors while transitioning through the school setting." The IEP included a goal to utilize his iPad and keyboard to complete classroom assignments "with minimal cues and supervision." The IEP also included speech-language goals and goals to "greet peers and staff" and "participate in group activities." Academic goals related to mathematics and reading were also included.

K.M.'s 2021 IEP noted that K.M. did not complete schoolwork and met no learning objectives while learning remotely in 2020 during COVID-19. The IEP notes that K.M. "rarely engages with his peers. He does not socialize with other students" and includes a goal that K.M. "will begin working on social skills as he transitions to in person learning." The IEP also includes goals for K.M.'s academics, speech development, using his iPad and keyboard to complete classroom assignments, and "follow[ing] the staff directive as given" 75% of the time. The IEP includes a summary of a recent assistive technology evaluation, but I did not see a detailed report or any IEP goals related to the use of the assistive technology.

The IEP also states that K.M. should attend a functional program that is focused on social skills. At this time, K.M.'s placement is 37% time in the general education classroom and 63% time in the special education classroom.

4. FBAs and BIPs

KCS conducted FBAs for K.M. in November 2016, March 2019, and April 2019, with updates provided in April 2020. The 2016 FBA consisted of informal interviews, some direct observations by a BCBA and ABA intern, and a record review from 2015 to the time of the assessment. The FBA identified challenging behaviors, including "noncompliant/disruptive behavior," running away, and incontinence. Triggers and cues for challenging behavior included transitions, a staff directive to complete a task, poor quality sleep, and task demands related to areas of particular difficulty for K.M. (e.g., fine motor tasks).

This initial assessment found that K.M. was less likely to exhibit challenging behaviors during less academically demanding times of day, such as recess and lunch. Factors noted to be maintaining the behavior were staff attention toward K.M. when he refused to complete tasks, and removal of the task demand when K.M. refused to perform the task.

KCS updated K.M.'s FBA in March 2019. K.M.'s instructors were interviewed, and they provided similar observations with respect to triggers and cues for the challenging behavior, and the nature of the challenging behavior (refusals to perform tasks, disruptive behaviors, and elopement). A description of physical aggression behaviors were also noted (e.g., kicking, pushing and shoving with feet and/or hands). In addition to interviews with teachers, the BCBA conducting the FBA conducted some observations of K.M. at school, and also relied on some of the disciplinary incident reports from 2018.

The FBA noted that K.M.'s challenging behavior was maintained by a desire to escape "non-preferred activities and academic tasks that are too hard for" K.M. The attention he was given when he engaged in challenging behavior was described as a factor that was reinforcing and maintaining the behavior. Recommendations included "set[ting] realistic expectations and criteria to earn rewards. Currently, [K.M.] has to wait too long in order to earn a reward; therefore, engaging in challenging behavior, escaping demands, and responses from others are immediately reinforcing. He needs to be able to contact reinforcement early and promote success." Other recommendations included use of a timer, and "not waiting until challenging behavior occurs to offer rewards."

The revision to K.M.'s behavior plan in February 2020 included a section summarizing information from the 2019 FBAs and included updates to some descriptions. The skills assessment section included a recommendation that staff use a standard assessment tool, the Assessment of Basic Language and Learning Skills, to assess K.M.'s language skills as well as academic, self-help, and motor skills. The plan identified replacement behaviors, including incorporating computer-aided instruction when K.M. was refusing to go to a location to work. Recommendations included to "catch him being good" and providing praise or other positive reinforcement, providing KM with choices, and "presentation of easier tasks (tasks that K.M. can already do) first to ensure success."

This summary noted that the reinforcement schedule for K.M.'s constructive behavior that had recently been attempted had not been effective, and an intermittent "less predictable" schedule was recommended. There was a note that the "ABA Specialist will provide initial training and continued training as needed throughout the implementation of the BIP." The plan also included IEP team self-reviews at least once per grading period to ensure that the BIP was being followed.

K.M.'s 2021 BIP notes that he did not attend school earlier in 2020 when the pandemic began and the school shifted to remote learning. Changes to the BIP include decreasing the intervals required to earn rewards like stickers. The BIP also notes that K.M. has been refusing to enter his general education classroom since returning to school and that he is "continuing to exhibit challenging behaviors but is showing an improvement with how often he is engaging in the behaviors."

The BIP also recommends that teachers focus more on K.M.-led (rather than teacher-led) activities in the classroom in order to increase K.M.'s engagement and provide fewer opportunities for challenges to occur. The BIP indicates that a BCBA will review K.M.'s plan each semester and will conduct weekly observations to ensure the plan is implemented with fidelity. It also indicates that there will be a team meeting every nine weeks to review K.M.'s plan. The plan also states that "The Kanawha County School's BCBA consultant was contacted as directed to review the current FBA and it was determined that a new FBA is not needed at this time."

5. Suspensions and other Disciplinary Incidents

Beginning in August 2016, K.M. experienced numerous disciplinary incidents, including:

- August 16, 2016: K.M. said, "I'm gonna kill you," to a transition aide. He said he would not say it again after an administrator spoke with him. This resulted in a reprimand.
- September 20, 2016: K.M. refused to attend P.E. class and eloped from the cafeteria to the sidewalk. He sat down outside and refused to get up. This resulted in a reprimand.
- November 18, 2016: K.M. told his teacher he was cold, snuggled up against her, and then bit her. This resulted in a warning.

- December 13, 2016: K.M. ran away from P.E. class and went back to his classroom. This resulted in a warning.
- December 14, 2016: K.M. eloped from the classroom and his teacher chased him. Another teacher stopped him from exiting the building. This resulted in a reprimand.
- January 23, 2017: K.M. used a school iPad to Facetime another iPad, which caused all iPads in the building to ring and "disrupt instruction." The school had to remove all iPads from students to determine who did this. This resulted in a reprimand.
- February 11, 2017: K.M. repeated the Facetime incident from January 23. This resulted in a conference with K.M.'s parents.
- March 10, 2017: K.M. "smashed a book onto the fingers of a teacher's aide. When the teacher redirected him, he kicked her…[K.M. also] pinched a teacher's aide." The principal spoke with K.M. and K.M. was ineligible for Behavior Reward Club that day. This resulted in a reprimand.
- May 4, 2017: K.M. "intentionally" spit on a teacher's aide. K.M. was also called to the office earlier that day for "pointing and touching the bra of a teacher's aide." This resulted in a reprimand.
- October 5, 2017: K.M. "put his hands on an adult (teacher's aide) multiple times." He also reportedly "pushed/moved" furniture and "deliberately" stepped on an adult's toes. This resulted in a reprimand.
- January 11, 2018:
    - K.M. caused his iPad to malfunction when he "repeatedly pushed hard on the screen of his iPad until it stopped working." iPad had to be sent for repair and replacement. This resulted in a ten-day detention.
    - K.M. locked himself in the bathroom and refused to come out. This resulted in the school calling K.M.'s parents.
    - K.M. "threw down his belongings" and tried to run away from an adult. He stopped and sat in the rocking chairs in front of the school and refused to get up. This resulted in a conference with K.M.'s parents.

- January 12, 2018: K.M. pushed his chair away from his desk, turned the keyboard upside down, removed his headphones, and refused work. He did not go to lunch when class was dismissed. This resulted in a one-day in-school suspension.
- January 22, 2018: K.M. went to the top of the slide in the playground and refused to come down when asked. He then ran away from the teacher through the mud. This resulted in a one-day out-of-school suspension.
- January 26, 2018: K.M. would not leave the playground. He got into the leaves and refused to get up for twenty minutes. This resulted in a parent-teacher conference and K.M.'s parents being asked to pick him up from school.
- August 21, 2018:
    - K.M. hid under the table in the classroom and cafeteria. He pushed his chair at other students and "grabbed the teacher's basket and refused to let go of it." This resulted in a reprimand.
    - K.M. eloped during dismissal and locked the door behind him. "While inside the room alone, K.M. answered and talked on a teacher's cell phone and turned on/used a computer." This resulted in a conference with K.M.'s parents.
- August 24, 2018: K.M. made "loud sound and motions pretending to urinate on the carpet in the classroom. He also inappropriately touched himself while on the carpet." This incident occurred while his class was in an elective arts class, but K.M. refused to leave the room. A second incident occurred when the class went outside later in the day. K.M. ran away from his teacher to the playground, where he remained for forty minutes. He then willingly came to the office and remained there through the lunch period. He threw objects, climbed on furniture, talked to himself, laughed, and sang. These incidents resulted in a one-day out-of-school suspension.
- September 11, 2018: K.M. refused to do work. He crawled under tables, pushed chairs over, and tried to run out the door. K.M. "used his fists to push down on an adult's toes and then ran his hands up her legs, trying to flip her skirt up." K.M. later "shoved a stool at a student as well as at an adult and teacher." K.M. got under the table and remained there despite prompts to come out. Parent contact.

- September 12, 2018: K.M. "touched an adult on the breast, in an intentional manner." He disrupted a guest-instructor from NASA, went to the office, and remained there for 45 minutes refusing to leave. K.M. ran into the workroom, touched phones, the copy machine, papers, and fax machine, and ran from the principal. In speech therapy, K.M. grabbed game pieces, hid under a table, ran away, and played in the staff lounge for nearly an hour. This resulted in a three-day out-of-school suspension.
- September 24, 2018: K.M. attempted to pull the television from the wall and pulled other materials off shelves. He "attempted to touch several other students in the classroom. The touching appeared to be unwanted, on multiple body parts of multiple students, and intentional." He also sloped from the classroom several times. This resulted in a reprimand.
- October 2, 2018: K.M. ran out of the resource room. He refused to return to class, "despite reminders and 'choices.'" He eloped from building "multiple times." He went into the women's staff bathroom, took off his clothes, and remained there for about 30 minutes. He returned to class where he stood on desks and ran around room. This resulted in a reprimand.
- October 8, 2018: K.M. refused to leave his music class. He went to the office instead of his classroom, and then locked himself in the bathroom for thirty minutes. In the bathroom, K.M. removed his clothing and sat unclothed in front of the door, refusing to come out. This resulted in a one-day suspension.
- October 11, 2018: K.M. arrived late, refused to leave the restroom, and soiled his pants. He eloped to the office "and refused to move." He remained in the office for more than 30 minutes all morning through lunch and pushed an emergency button. This resulted in a two-day out-of-school suspension.
- November 14, 2018: K.M. "pushed/shoved an adult (teacher's aide) in an effort to get past her to elope. He did this two times." He said he was "playing a 'flip-flop' game." This resulted in a one-day out-of-school suspension.
- December 4, 2018: K.M. refused to do academic work. He ran away from teachers, took off his shoes, and climbed onto furniture. K.M. "refused to go to lunch,

grabbed and 'bothered' the teachers items in the classroom and did not complete work." This resulted in a reprimand.

- January 9, 2019: K.M. unrolled "a full roll of toilet paper" and put it in the toilet. K.M. "admitted doing it intentionally." This resulted in calling K.M.'s parents.
- January 28, 2019: K.M. threw pencils and markers at an adult. He climbed under the table and "ruffled pages" in teacher's manuals. He turned the power strip off and on and unplugged the internet. K.M. eloped from the cafeteria at lunch. He went into the office and refused to leave. K.M. "shoved a chair into the teacher's legs, causing bruising and red marks on both shins. He also threw books at classmates, and he threw apples into the toilet." This resulted in a seven-day out-of-school suspension.
- April 1, 2019: K.M. put an entire roll of toilet paper in the toilet and flushed, causing the toilet to overflow. He took off his pants, underwear, socks, and shoes, and threw them over the stall door. K.M. was asked to apologize to maintenance personnel who had to clean the bathroom. This resulted in a reprimand.
- April 5, 2019: K.M. "pushed a lever which caused a chair to fall out from underneath a teacher." The teacher injured her leg in the subsequent fall. This resulted in a two-day out-of-school suspension.

iii. Behavior Supports

1. Lack of Updated Assessments and Appropriate Curriculum Modifications

It is important for K.M.'s school to perform an updated academic achievement assessment in order to have a current picture of his academic, cognitive, and emotional strengths and needs, so that it can design individualized specialized instruction and accommodations for him that match his intellectual functioning, including effective behavior supports.

Academic tasks must be structured in a way that minimize reliance on areas of weakness and capitalize on strengths so that task demands are in the zone of K.M.'s proximal development. This means that KCS should be striving for a level of academic challenge which is sufficiently difficult to help K.M. generate a sense of competence and mastery as he learns the task, but not so difficult that it is not achievable, with the result that K.M. has repeated failure experiences, and becomes

excessively discouraged. When task demands are outside this zone, challenging behaviors can ensue due to frustration and lack of engagement.

Asking K.M. to do work beyond his level has set him up for failure over the years, by decreasing his motivation to perform at school and inadvertently motivating his escape behaviors. KCS has historically relied on preschool testing that was years out of date and performance on classroom assessments to develop K.M.'s IEPs. While K.M. may have demonstrated inattentiveness in past testing, this is something that can be easily accommodated by, for example, providing more breaks and increased time for testing.

It is also critical that KCS work with K.M. to learn how to use his assistive technology in a meaningful way, as this could improve both his communication and his behaviors. Children with expressive language difficulties often rely on behaviors to communicate. The more tools K.M. has to express himself in a positive way, the less he has to rely on behavior to get his point across. While I see that an assistive technology evaluation was performed, I do not see a detailed report or meaningful plan for teaching K.M. how to use this technology in his record.

My expectation is that, if appropriate supports are provided, K.M.'s academic achievement will gradually improve so that he can work on the same academic areas and general content as his peers. However, in the short term his work should be modified so that it is less difficult, but not so easy as to be tedious. As he succeeds at lower level work, he will build up confidence and see that the benefit is worth the effort. Eventually, he will develop more motivation to perform higher-level work, but this will take some time. Academic success is correlated to improved behaviors – if K.M. can see that his efforts are worthwhile and has positive engagement with teachers and peers at school, this can go a long way toward reducing unwanted behaviors.

2. Lack of Adequate Data and Specificity

KCS has never performed an adequate FBA that would help school staff understand the functions of K.M.'s behavior and what he tries to communicate through his behavior.

KCS has not collected sufficient behavior data from a variety of domains, including at school and at home, and times of day that can help explain the unwanted behaviors that most interfere with K.M.'s learning, the antecedents or triggers for those behaviors, and the consequences for the

behaviors. This lack of data may lead to school staff inadvertently reinforcing what K.M. is trying to achieve through his behavior, which only exacerbates his unwanted behaviors and is ultimately harmful for him. For example, one function of his behaviors may be to escape from activities he does not like. If KCS responds by removing him from classroom activities, and from the classroom itself, this may reinforce for K.M. that behaving in certain ways will help him escape from things he does not want to do.

I saw a chart with three "faces"—smiley, neutral, and sad—in K.M.'s records, but these charts are useless for collecting data, as they fail to provide enough objective information about what the behavior is, and where, when, and with whom it is taking place. More recent data collections appear to be somewhat more detailed, but are still insufficiently concrete and specific to be useful for the purpose of informing the BIP.

To be effective, the FBA must provide more objective information and explain what K.M. is doing, without judgment. KCS tends to place all of the onus on K.M. to improve his behavior rather than taking responsibility for collecting data and using the information collected to develop effective behavioral supports.

An updated FBA is also necessary because of the time that has passed since the last one that was performed, and the intervening significant event of the pandemic which substantially interrupted in-person schooling opportunities. K.M. has grown and developed new skills and interests that need to be accounted for. Moreover, it is critical that an updated FBA include data from both of K.M.'s parents' households. His parents have separated, and consistency across both of K.M.'s home environments will be very important. The FBA should also consider that K.M. will have a new sibling soon, and anticipate some stressors and behaviors related to that change.

Because KCS has not conducted an adequate FBA, it has not developed an effective BIP for K.M. Instead, the BIP focuses on compliance with a very narrow vision of how students should behave, which does not take into account K.M.'s individual needs and challenges. K.M.'s record does not indicate that staff has collected information about implementation of behavioral interventions. Now that K.M. has returned to school, the school needs to collect data about the relative effectiveness of the different interventions staff is trying with K.M., and then revise his BIP so that it includes effective interventions and discards or modifies ineffective ones.

K.M.'s current BIP refers to certain behaviors, such as inappropriate touching, as "intentional," but this is a subjective and speculative interpretation of his behavior that is not appropriate to include in a BIP. K.M. is a young boy and it is not uncommon for children to touch themselves at times, including, for example, when they need to go to the bathroom. It is inappropriate to assign intent to K.M.'s touching of himself without knowing more about what occurred and why, particularly given K.M.'s communication challenges.

Similarly, there is a psychological evaluation in K.M.'s record noting that K.M. is a "medium" safety risk, but no standardized assessment tools were used to perform this assessment and, therefore, the conclusions are meaningless. It is harmful to K.M. to have these inappropriate characterizations in his record since they prime adults who review these documents to see him as a dangerous child, which influences how they perceive him and what they expect from him.

The BIP's summary of recent behavior shows that there are particular days where K.M. is having difficulties, but there is no examination of why that may be. Is it because they happened to be collecting more data on those days or was there actually something out of the ordinary that may have affected K.M.'s behavior on those days that could be addressed and prevented in the future? The summary is not sufficiently detailed to understand what the behaviors are and why they occur.

K.M.'s current BIP notes that a BCBA will review K.M.'s plan each semester and will conduct weekly observations to ensure the plan is implemented with fidelity. This is a positive development and provides an opportunity for the BCBA to teach all of the adults in K.M.'s environment, including his parents, how to follow K.M.'s behavior plan and promote consistency in expectations and adult responses across his environments.

3. Lack of Clear, Realistic, or Measurable Goals

Behavior goals in a student's IEP or BIP must be clear, measurable, and realistic in order to be able to assess progress in any meaningful way, but the goals developed for K.M. do not meet these criteria. For example:

- One of K.M.'s goals is that he will follow a staff directive "with 75% accuracy," but this is not a meaningful goal and requires more specificity. How complex are the staff directives? What is the vocabulary level? Will the directives be delivered

verbally or in writing? A better goal would be to identify a specific staff person (ideally, his favorite teacher or aide) and expect K.M. to follow a single step directive. It can gradually become more challenging (i.e., following directives from teachers he does not like as much or following two-step directives).

- K.M.'s IEP notes that he should use assistive technology and his colored keyboard to complete 95% of his assignments. Given that KCS just performed an assistive technology assessment, but does not appear to have developed a plan for K.M. to learn to use his keyboard or other technology, this goal is unrealistic, and could lead K.M. to engage in unwanted behaviors out of frustration with his inability to meet this goal. A more meaningful goal would be "K.M. will be provided with his colored keyboard for 15 minutes each day and he will use it for 3-5 minutes to access the type for fun app." The initial goal should not be about using it correctly, just using it at all.
- Another goal notes that K.M. will engage in "age appropriate social interactions with 70% accuracy." This is not specific enough to be meaningful and is not measurable. The goal must define social interaction, such as specifying reciprocal conversation as a goal, and explain how this will be modeled for K.M. K.M. should be given a script and prompts. It should also clarify whether the expectation for social interactions is with peers, adults, or both.

K.M.'s most recent BIP does not identify any new behavior goals. It notes his refusal to enter the general education classroom, but it is not K.M.'s decision whether he attends class, and his plan does not identify a goal or any "shaping" intervention to assist him in becoming more comfortable entering the classroom. Shaping refers to a process of rewarding successive approximations of what we want the child to do to create a more positive association with the activity. For example, the BIP could provide a gradual plan to assist K.M. by offering him a sticker to walk up to the classroom and touch the door, the next time he could receive a sticker for opening the door, and the next time he could receive a sticker for walking into the classroom. It needs to be a gradual process with positive reinforcements.

4. Lack of Reinforcements and Engagement

It is critical that any adult be able to read K.M.'s plan and easily understand what positive behaviors have been identified that K.M. should be engaging in, but this has not been done.

Throughout K.M.'s records, there is too much focus on the negative (eliminating challenging behaviors) rather than the positive (developing constructive behaviors). For example, his behavior goals include that K.M. should keep his hands, feet, and objects to himself and remain in his seat. However, these goals do not say anything about what K.M. *should* be doing instead of refraining from these unwanted behaviors. Part of K.M.'s behavior plan should involve identifying positive reinforcements for desired behaviors, and identifying for staff how to ignore certain behaviors that are not particularly disruptive or destructive.

One way to achieve this is to ensure that K.M. receives significant praise and encouragement even for behavior that staff may think does not warrant praise. Negative reactions to attention-seeking behaviors can lead to power struggles that reinforce these behaviors and harm him by conveying that K.M. will receive the attention he wants by engaging in unwanted behavior. Even when K.M. has something he wants to do, he often says "no" at first. This needs to be incorporated into his behavior planning and used to determine the best way to deliver rewards for K.M.

When I observed K.M. in 2019, I saw staff using tangible rewards such as stickers for compliant behavior. K.M.'s mother told me that staff also uses candy as a reinforcer for K.M. Tangible rewards are good for helping students accomplish some tasks, but K.M. also needs verbal rewards and praise, some of which I observed in my more recent observation this year. When to praise and how to praise should become apparent as KCS conducts a new FBA for K.M., and develops, implements, and revises his BIP based on the FBA. It is essential that school be a place that K.M. wants to go. If the school takes a harsh disciplinary approach and does not provide constant positive reinforcement, K.M. will be averse to going to school.

KCS should also be focusing on ways to positively engage K.M. in activities that he is intrinsically interested in to ensure that he stays engaged with assigned tasks rather than engaging in unwanted behaviors because he is bored. For example, K.M. enjoys playing videos. There could be opportunities to integrate video production of some kind into his instruction and IEP goals, such as by having K.M. create a YouTube talk show and interviewing people. He likes to play the drums

and sing, which could provide an avenue for him to engage in music class and speech language interventions.

iv. Family Engagement

Consistency in how adults respond to K.M., and what they expect of him, is needed across all of his environments. This requires good communication between school and home. KCS should engage in routine, regular conversations with K.M.'s parents outside of situations involving behavior incidents. Sharing information about K.M.'s interests and reinforcers K.M.'s parents use with him at home would be useful to school staff developing supports to use with K.M.

K.M.'s mother told me that she and K.M.'s father have not felt included by K.M.'s school in the development and implementation of his IEP. K.M.'s mother indicated that there is no comfortable line of communication between her and K.M.'s school. Whenever K.M.'s mother asks for something from the school, she receives a negative response. K.M.'s mother believes that the school is just biding its time until K.M. leaves school rather than attempting to meaningfully accommodate and support him.

In addition to listening to and incorporating their input in the IEP planning process, K.M.'s school should regularly inform his parents about what the school is doing and why. There are no parent training minutes including in K.M.'s IEPs. KCS would benefit from learning more from K.M.'s parents about what works for K.M. at home, particularly because K.M. appears to be happier and more engaged with learning at home than at school. Children with ADHD tend to function differently in different environments, but if something is working well at home, it should be tried at school, and vice versa.

Over the course of K.M.'s time spent learning remotely during COVID-19, K.M.'s mother noted that KCS did not provide meaningful assistance to help her teach K.M. to learn remotely. K.M. received the same virtual learning packet that every other student received without curriculum modifications. While there is generally not an issue with asking K.M. to perform the same work as other students, he should not receive the same packet as other students, because he requires modified instruction.

K.M.'s parents were forced to figure out how to instruct him largely on their own. They repeatedly tried to contact the school to get more assistance but were told that the accommodation in K.M.'s IEP is just a decreased workload. Providing K.M. with less work is not the same as providing him with a modified curriculum and does not do anything to help him learn or stay engaged. K.M.'s parents received some assistance from a virtual aide, but the aide did not know K.M. before working with him, and had very limited time to assist K.M.'s parents, so his parents do not feel that they benefited much from this service. As his IEP notes, K.M. did not progress academically during his time at home in 2020, which makes it even more critical that KCS provide adequate supports and modifications, in consultation with his parents, upon his return to school this year.

Obtaining more concrete examples from K.M.'s parents of what K.M. is doing at home would help the school design goals and interventions for K.M. that are more likely to help him make academic progress and reduce unwanted behaviors. Similarly, the school could give K.M.'s parents more information about successful interventions at school that they could try at home.

It is critical that KCS involve K.M.'s parents in his planning and respect their input. KCS will benefit from what they understand about his strengths, interests, and needs. K.M.'s family's interactions with the school now will affect how he feels about school, but also how his parents feel about advocating for him. K.M.'s parents will be his advocates for years, in school and likely in adult life, and the more successful the planning process and service delivery is now the better they will feel about continuing as advocates in the future.

v. Coordination with Other Providers

KCS should coordinate with K.M.'s medical providers to ensure his behavior supports are well informed and effective, but I did not see any evidence that they are doing so.

K.M. is currently taking medication, and his school should understand how his medication is metabolized, and how this effects K.M. throughout the day. The school should know whether K.M. takes medication holidays, and what that means for his return to school. K.M.'s medical provider, and especially any psychiatrist treating K.M., should be able to obtain information about how prescribed medication is affecting him at school, including whether medication is making him sleepy or irritable. Such information (for example sleeping at school or quality of sleep at home) should be documented along with other behavior data collection.

K.M. has sometimes fallen asleep or seems sleepy at school, which can affect his ability to engage in academic tasks and may lead to increased unwanted behaviors. The sleepiness may be medication related. I recommended to K.M.'s mother that she keep a record of his sleep and any sleep disruptions. It would be useful to look at his sleeping patterns at home with behavior data from school, but she did not indicate that the school had asked her about this. In my opinion, it is likely that K.M.'s treating physician would find data about his school functioning and behavior to be helpful in the development and evaluation of his medication treatment plan. KCS has more recently asked K.M.'s family to consult with his doctor regarding his sleep issues, but there is no reason the school could not consult with his doctor directly to address how these issues are affecting K.M. at school, with permission from his parents.

vi. Placement

When I observed him in 2019, K.M. spent significant time in both a general education classroom and a resource room, but did not appear to interact with his classmates in either setting.

In the resource room, K.M. was seated at a separate table apart from his classmates. Some children were engaged in a rotating small group activity in which K.M. did not participate. Other children not working in the small group activity were working on their tablets, but K.M. was not prompted to interact with those children either. K.M. was seated with his back toward the small group of children, or sitting at the back of the classroom, engaged in an entirely separate task. Engagement with peers is critical for K.M.'s social development and academic advancement, but I did not see any interactions with peers when I observed K.M. in 2019. His records did not indicate that this was a goal for K.M. that had been identified, with supports to be implemented to help achieve it. Further, KCS was not engaging K.M. in activities he likes, including with objects (such as the cash register) that he has previously shown an interest in, which would help him engage in reading, writing, and mathematics.

During my 2019 observation in the resource room, I saw no indication that staff differentiated instruction for K.M. I observed four different adults work with K.M. during the 75 minutes that I was in the resource room. Each of the adults took a different approach to working with him. Nothing that any of them did appeared to relate to his IEP goals. I did not see the adults collaborate with each other or implement a cohesive plan. Their instructional method appeared to be whatever

the adult working with K.M. at the time felt like doing. It is difficult to maintain focus with teachers swapping in and out like that. Consistency is important for children in general, but especially for children with an intellectual disability and ADHD.

K.M. returned to in-person schooling on January 11, 2021. When I observed K.M. in the classroom in 2021, he was more engaged with the material and his teacher was praising him appropriately and giving him time to ask questions. He had more positive interactions with adults than when I saw him last. The match between the academic task demand and what he can actually do was closer to the zone of proximal development. These are positive developments and demonstrate what K.M. can do when provided supports.

Still, there could have been more consistent and frequent reinforcement for specific positive behaviors from K.M.'s teacher. Though the BIP notes that there should be a focus on K.M.-led (rather than teacher-led) activities to increase his engagement, I did not observe this taking place. Further, K.M. was in a resource room with only other students with disabilities. No one is prompting him to interact with classmates and I did not observe any spontaneous interactions between K.M. and the other children. A separate classroom is harmful to K.M. because it prevents him from interacting with and learning from peers with a different set of strengths and challenges than him.

K.M. does not belong in a classroom with only other students with disabilities. Because my recommendations were misstated by the hearing officer, K.M.'s IEP misstates my recommendations from his due process proceedings, indicating that I would support K.M. being placed in a small classroom with intensive behavior supports. This is not accurate and is actually the opposite of what I recommended in 2019 and what I recommend now.

K.M. is entering an age when peer influence is particularly salient and powerful. Educating K.M. in a general education classroom would promote opportunities for him to engage in typical, social skills-promoting encounters with a variety of peers, including peers who model prosocial behaviors. Segregating children in separate classrooms runs the risk of creating self-fulfilling prophecies, whereby the children adopt and live up to the negative labels imposed on them by adults. It is concerning that K.M.'s IEP appears to want to move him to a new school that is focused on only functional and social skills for students with intense behavior support needs. This indicates

that KCS believes K.M. is not educable, does not expect much from him, and are giving up on teaching him academic skills. There is no justification for this and changing K.M.'s placement in this way would be harmful to K.M.'s development.

On the day that I observed K.M. in 2021, he arrived late to school. His mother explained to me that she has begun taking him to school one hour late because of his sleep issues. KCS begins school at 7 a.m. each morning. This is very challenging for K.M. K.M. has seen improved alertness at school after arriving one hour late and his mother has asked his school to accommodate this, but it has refused. KCS has instead offered to end his school day early, but this would do nothing to address K.M.'s need for more sleep in the morning.

On the day that I observed K.M. in 2021, he exhibited far more sustained alertness than when I saw him in 2019, indicating that K.M.'s mother is correct about this. It is unclear why the school will not work with K.M.'s mother to achieve a workable solution that could significantly increase K.M.'s engagement at school and decrease unwanted behaviors, at least in the short term while K.M.'s doctor explores whether a medication change might also help. Goals around school attendance that reflect a slightly later arrival should be included in K.M.'s IEP. School should incorporate recognized accommodation for KM to come to school an hour later. This can be revisited if medication changes are implemented that reduce KM's morning sleepiness.

From a behavioral perspective, K.M. benefited from being at home during COVID-19 because school was not a positive place for him. He enjoyed being at home, but continued virtual schooling is not conducive to his overall growth and development. It is critical that KCS ensure that the school environment is a positive place for K.M. to spend time. At the same time, it is important that the school be mindful of K.M.'s lack of progress academically over the last year, since academic challenges can lead to behavior issues.

With an adequate FBA and behavior plan based on the FBA, K.M. can be supported in the general education classroom. It might take a few weeks for staff to learn how to implement the plan (and some of this time may need to be in the resource room) so that he can benefit from it, but KCS should be capable of adequately supporting K.M. in a general education setting. I have observed and evaluated children who have had more significant cognitive impairments than K.M. who were

able to be appropriately served in general education classrooms, with effective evidence-based supports.

vii. Conclusion

K.M. has faced challenges at school related to his behavior, but I believe these challenges have often related more to the inadequate supports provided to K.M. by his school, rather than to K.M.'s abilities. I believe that with appropriate supports, K.M. can be educated in a general education classroom.

KCS must provide effective behavioral supports to K.M., including revising its FBA for him and developing and implementing with fidelity a behavior plan based on that FBA. KCS must also provide accommodations with respect to cognitive and academic assessments, and these assessments should be updated on a regular basis. It must also modify and adapt instruction for K.M., so that he can be successful, build confidence, and develop motivation to perform more challenging tasks in the classroom. With these supports, K.M. can be successful in school and as he transitions to adult life.

In my opinion, the educational supports, including behavioral supports, provided to K.M. were not designed to meet his individual education needs. The proposed changes for future educational settings and the overall trend toward more time in special education versus general education settings combined with the suspensions means that K.M. has not been receiving his education with non-disabled students to the maximum extent appropriate to his needs as a child with a disability.

The evaluation procedures used to determine what services he should receive and the restrictiveness of the environment where he will receive his education were inadequate and outdated. His parents have not been provided with opportunities for meaningful and regular communication with school personnel. Consequently, they have not been provided with sufficient information and assistance to effectively challenge the identification, evaluation, and placement decisions or to incorporate behavioral and educational objectives into their parenting strategies to support K.M.'s overall functioning, including academic functioning.

It does not appear that KCS has consulted with or made an effort to collect information from K.M.'s treating physicians or other providers with respect to medical or medication considerations

that should be taken into account to inform academic accommodations or behavioral interventions. This may be particularly important with respect to investigating and managing K.M.'s daytime sleepiness at school.

VI. CONCLUSIONS

Both G.T. and K.M. are students with disabilities, attending two different KCS schools, who require behavior supports and have experienced disciplinary removals from the classroom for behaviors related to their disabilities. This has impeded their acquisition of academic skills, led to their placements in inappropriately restrictive learning environments, and caused both G.T. and K.M. to miss out on educational and social development opportunities. Additionally, some of the behavioral interventions attempted appear to have actually reinforced challenging behavior. For example, the use of suspensions was identified as a consequence that actually reinforced challenging behavior in both children.

Rather than taking a proactive and preventative approach, KCS has responded with discipline to challenges that could be effectively addressed through the provision of behavior supports. KCS places the onus on the students to improve their behavior rather than taking a step back to evaluate what changes staff can make to support them.

KCS has attempted an FBA for both students, but their FBAs are inadequate. KCS has not consistently collected useful data through the FBA process to (1) understand which specific behaviors the school should target for behavior supports; (2) develop working hypotheses about the function of specific behaviors to provide staff with some explanation for why the students engage in these specific behaviors; and (3) provide staff with sufficiently detailed guidance to be able to implement consistent and effective responses to challenging behavior, including appropriate reinforcement.

Both G.T. and K.M. have behavior plans that should be informed by an adequate FBA, but are not. The BIPs for both students were of low quality for a number of reasons. The BIPs did not contain appropriate individualized interventions that targeted specific student behaviors. They did not identify with adequate specificity how staff should respond to student behavior. They did not identify appropriate replacement behaviors or the skill training needed to support new replacement and adaptive behaviors. They did not identify which staff members would implement interventions

or what methods would be employed to help the students develop new social or self-regulation skills. In both cases, this meant that staff who were expected to implement the BIPs either did not know who was responsible for teaching critical skills or would not know what methods would be used to teach those skills.

There is also no indication of a regular process of reviewing and revising the students' BIPs in light of FBA findings or updated data related to the working hypotheses. This leaves staff and parents with no information about how to assess whether a given plan is working or to make changes if new behaviors emerge or initial behaviors became less of a concern. For children with challenging behaviors, progress reviews and revisions in support strategies need to take place regularly until it becomes clear that the behavioral interventions in place are effective. This has not happened consistently for G.T. or K.M.

KCS should ensure that all adults involved with these students are informed about their behavior support needs and can implement their behavior plans, and require continuing education for staff to ensure they understand commonly-accepted practices regarding the development of behavior supports for children with disabilities. The BCBAs who provide behavior support services and assessments to students at KCS represent an important potential resource for the school system to draw upon in order to generate detailed and precise BIPs that are iterative in nature. The BIPs should be living documents, constantly being revised and updated to reflect current behavior, updated and effective reinforcers, and clear instructions for adults in these children's lives.

In order to provide the support students like G.T. and K.M. require, there also needs to be an active partnership between the family and the school. In both of these cases, KCS did not treat the parents as meaningful partners in developing supports for the students. From the records I reviewed and conversations I had with G.T.'s and K.M.'s parents, it is clear that KCS has not engaged them in the planning and development of behavior supports.

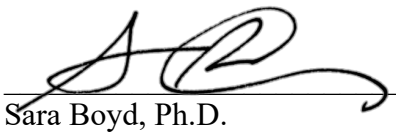
Both sets of parents reported to me that they felt detached from the development of behavior supports. They also reported that they experienced strained and at times adversarial relationships with the school teams that attempted to support their children. These parents know and appreciate their children and their strengths and challenges. It was evident that the parents were confused by the expectations of them and their children during the pandemic and were not provided with

sufficient guidance and opportunities to access resources that could have permitted them to enrich and facilitate their children's virtual learning experiences while they were out of school.

It is important that KCS encourage a culture in which input from parents is actively sought out and incorporated into planning. KCS should also provide training to parents on implementation of behavior supports to ensure consistency across environments. Both schools and families will benefit from a stronger working relationship, and this will allow greater consistency across environments and effective strategies at home to be implemented at school and vice versa.

It is also important that KCS consult with and make an effort to collect information from both students' treating physicians and other providers with respect to medical or medication considerations that should be taken into account to inform academic accommodations and behavioral interventions. It does not appear that school personnel have consulted, or endeavored to consult with, either student's medical care providers, including their prescribing physicians.

G.T., K.M., and other students with disabilities need behavior supports to progress in school, build skills, and prepare for adult life. When children are repeatedly removed from their classrooms for behaviors related to their disabilities, they are not receiving effective supports that help them learn to manage their behavior and stay focused on learning. This can lead the student to experience negative association with school and ongoing feelings of failure, with long-term consequences. Without these supports, G.T., K.M., and other students with disabilities are harmed because they do not make progress in school and in social skills needed to succeed in educational and community environments. This can lead to a host of negative repercussions as these children transition to adult life.



Sara Boyd, Ph.D.

April 16, 2021

Date

APPENDIX 1

BOYD FORENSIC PSYCHOLOGY SERVICES

Sara Boyd, Ph.D. Licensed Clinical Psychologist

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Institute of Law, Psychiatry, & Public Policy at the University of Virginia, &
Boyd Forensic Psychology Services, LLC

EDUCATION

Graduate:

Doctor of Philosophy, Clinical Psychology**,** University of Kentucky, August 2013.

Master of Science, Clinical Psychology, University of Kentucky, 2010.

Master of Science, Counseling Psychology, University of Kentucky, 2005.

Certificate in Developmental Disabilities, University of Kentucky, 2005.

Undergraduate:

Bachelor of Science, Psychology, University of Illinois, May 2003.

PROFESSIONAL LICENSES & CREDENTIALS

Diplomate, American Board of Professional Psychology (ABPP), Forensic Specialty, November 2019 to present. Diploma no. 9023

Licensed Clinical Psychologist, Virginia Department of Health Professionals, July 3, 2014 to present. License number: 0810005036

Licensed Clinical Psychologist, District of Columbia Department of Health Professional Licensing, February 10, 2015 to present. License number: PSY1001030

Licensed Clinical Psychologist, West Virginia Board of Examiners of Psychologists, August 24, 2016 to present. License no. 1149

Licensed Psychologist, Kentucky Board of Examiners of Psychologists, October 20, 2020 to present. License no. 251807

National Register Health Psychologist #54431

CLINICAL EXPERIENCE & EMPLOYMENT

Institute of Law, Psychiatry, and Public Policy, University of Virginia Health System, Licensed Clinical Psychologist/Forensic Evaluator. Charlottesville, Virginia. June 2016 to Present.
Providing forensic evaluation and consultation in adult and juvenile criminal and civil matters. Supervising postdoctoral fellows and graduate students, and developing professional trainings for forensic evaluators and attorneys.

Woodbridge Psychological Associates, P.C., Licensed Clinical Psychologist, Woodbridge, Virginia, September 2014 to June 2016.
Providing forensic evaluation and consultation in adult and juvenile criminal and civil matters.

Institute of Law, Psychiatry, and Public Policy, University of Virginia Health System, Forensic Psychology Postdoctoral Fellow, Charlottesville and Staunton, Virginia, August 2013 to August 2014.
Postdoctoral fellowship consisted of two primary assignments: Western State Hospital, and the Institute of Law, Psychiatry, and Public Policy forensic clinic at the University of Virginia.

Western State Hospital—Virginia Department of Behavioral Health and Developmental Services

- Conducted mental state at the time of offense and competency to stand trial evaluations in an inpatient forensic setting.
- Provide training and consultation on intellectual disability, forensic, domestic/sexual violence, and LGBTQ-related topics for mental health providers.

Institute of Law, Psychiatry, and Public Policy

- Conducted gender dysphoria evaluations for Virginia Department of Corrections, general psychological evaluations, sex offender risk assessment, violence risk assessment, mental state at the time of offense, and competency to stand trial evaluations in an outpatient forensic clinic.
- Developed and provided training and consultation services to private and public mental health professionals.

Westchester Jewish Community Services, APA-Accredited Internship, Psychology Fellow, Yonkers and Hartsdale, New York, July 2012 to July 2013.
Pre-doctoral Internship at community mental health agency composed of rotations in a treatment and evaluation program for juvenile sex offenders, court assessment program, treatment center for survivors of trauma and abuse, a program for individuals with developmental disabilities (DD), an autism evaluation clinic, and a learning center. Provided consultation to multidisciplinary teams on such matters as psychological assessment, research, and empirically-supported treatment.

Treatment Center for Trauma and Abuse

- Utilized Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Prolonged

Exposure, behavioral activation, and other empirically-based methods to treat child, adolescent, and adult survivors of trauma, sexual and physical abuse, and domestic violence.

- Conducted focal and comprehensive psychological assessments to assist in treatment planning. Provided feedback to clients, families, and clinicians.

Autism Evaluation Program

- Assessed and determined diagnoses of adults and children referred due to suspected Autism Spectrum Disorders (ASDs). Utilized ADOS-2, adaptive functioning, intellectual ability, achievement and neuropsychological measures, in addition to in-depth clinical interview, collateral interviews, and record review.

Developmental Disabilities Program

- Utilized cognitive-behavioral therapy (CBT) and parent management training interventions with children and adults with intellectual and developmental disabilities (ID/DD) and their families.
- Provided diagnostic clarification, crisis management services, and psychotherapy to individuals recently discharged from inpatient settings.
- Co-led a social skills group for 5- and 6-year-old children with ASDs.

Juveniles Starting Over Program

- Conducted risk and safety assessments, including ERASOR, for adjudicated juvenile sex offenders and children and adolescents with sexual behavior problems.
- Provided individual and family therapy to adjudicated juvenile sex offenders and non-adjudicated youth with sexual behavior problems.

Court Assessment Program

- Co-evaluated custody/visitation, termination of parental rights, delinquency, abuse/neglect, and probation cases.
- Co-performed specialized evaluations of juvenile sex offenders.
- Consulted to psychiatrists, judges, court staff, and guardians.
- Conducted brief psychoeducational screenings.

Learning Center

- Conducted comprehensive and focal cognitive, educational, and personality assessments of children, adolescents, and adults.
- Evaluated individuals with potential learning disabilities, executive function deficits,

Attention-Deficit Hyperactivity Disorder (ADHD), and other psychiatric diagnoses.

- Developed comprehensive educational, social, and vocational recommendations as part of an integrative written report, and provided feedback to clients, families, and clinicians.

Bluegrass Mental Health/Mental Retardation Board, **Eastern State Hospital, Forensic/Inpatient Psychology Trainee**, Lexington, Kentucky, June 2010 to July 2011.
Provided forensic assessments to individuals with serious mental disorders in an inpatient setting. Assisted in evaluations of competency to stand trial and criminal responsibility for misdemeanors and felonies. Consulted to psychologists on forensic cases involving individuals with ID/DD. Administered adjunct malingering and neuropsychological testing for the supervising forensic psychologist. Other rotations included assessment and individual and group therapy on a high-risk unit, geriatric/medically fragile unit, and a day treatment program. Developed special expertise in intervention and testing of dually diagnosed consumers with ID/DD and severe mental illness.

University of Kentucky, **Harris Psychological Services Center, Graduate Student Therapist**, Lexington, Kentucky, July 2007 to July 2011.
Assessed risk as part of employment screening for weapons-handling personnel at an international security company. Conducted integrative assessments for ADHD and learning disabilities. Provided individual psychotherapy for clients with ASDs, major depression, adjustment disorder, conversion disorder, generalized anxiety disorder, post-traumatic stress disorder, and borderline personality disorder.

University of Kentucky, **Harris Psychological Services Center, Social Skills Group Co-Leader**, Lexington, Kentucky, September 2008 to December 2008.
Conducted intakes for potential group members, and co-led a manualized skills-based intervention group for children with social impairments. Met with parents to exchange feedback, and conducted pre- and post-intervention behavioral assessments. Group members had ASD and/or anxiety disorders.

University of Kentucky, **Harris Psychological Services Center, Assessment Coordinator**, Lexington, Kentucky, July 2007 to August 2008.
Responsible for all aspects of outpatient clinic testing. Supervised assessments; performed intakes; participated in administrative meetings to determine the appropriateness and disposition of potential clients; reviewed clinic policies and procedures; researched, identified, and ordered new instruments; engaged in community outreach; and maintained clinic assessment records.

Bluegrass Rape Crisis Center, **Crisis Counselor**, Lexington, Kentucky, September 2005 to September 2006.
Provided crisis counseling services at a community agency for survivors of sexual assault. Accompanied survivors (including survivors with disabilities) to the local emergency room, provided advocacy and support throughout the medical examination and detectives' questioning, and answered crisis line calls.

Center for Women, Children, and Families, **Counseling Psychology Trainee**, Lexington, Kentucky, January 2006 to May 2006.
Led psychoeducational groups for adult survivors of domestic violence who had lost custody of their children and were seeking reunification. Conducted intakes and provided individual CBT to children and adults. Diagnoses included Fragile X and other developmental disabilities, post-traumatic stress, adjustment, acute stress, and major depressive disorders.

PROFESSIONAL & COMMUNITY SERVICE ACTIVITIES

Virginia Department of Behavioral Health and Developmental Services, Structured Measures of Intellectual Functioning Review Panel. Commonwealth of Virginia, 2020 to 2021 (death penalty was abolished in Virginia in 2021).
Invited to join the five-member professional panel, selected by the DBHDS Forensic Evaluation Oversight Manager, to provide guidance with regard to updating the list of psychological measure of intellectual functioning for use in death penalty cases in Virginia, as required by § 19.2-264.3:1.1 and 19.2-264.3:1.2.

University of Kentucky, Department of Psychology, Diversity Committee Founding Member, Lexington, Kentucky, February 2012 to August 2012.
Identified need, and assisted in assembling members and faculty support for, a graduate student-led committee to revise departmental policies relating to sexual and gender minority students and Psychology Department clinic clients. Advised faculty and community supervisors regarding training requirements, materials, and procedures. Developed multimedia training materials ultimately implemented in graduate curriculum.

Project SAFE (Safety and Accessibility for Everyone), Coordinator, Frankfort, Kentucky, September 2005 to September 2006.
Created project to increase physical and attitudinal accessibility of domestic violence shelters and rape crisis centers in Kentucky. Identified and invited representatives from state agencies addressing domestic and sexual violence, disability rights, and crime victim advocacy to provide project leadership. Scheduled and led meetings. Project SAFE became an ongoing organization and was awarded a three-year Department of Justice Violence Against Women Act grant for $750,000 in 2008.

Consumer Advisory Council of Kentucky, **Board Member**, Frankfort, Kentucky, November 2006 to November 2008.
Assisted in senior level decision-making regarding priorities and policies of the Human Development Institute, with special emphasis on creating an inclusive environment for people with disabilities. Reviewed and provided feedback on Institute research, funding, and grant applications. Monitored organization's compliance with the strategic plan.

RESEARCH EXPERIENCE

Westchester Jewish Community Services, Co-Principal Investigator, "Sexual Knowledge and Attitudes of Adolescents and Young Adults with Developmental Disabilities, Before and After a Psycho-Educational Intervention." White Plains and Hartsdale, New York, July 2012 to July 2013.
Co-originated study concept, developed methodology, identified appropriate assessment instruments, and generated hypotheses for a study examining outcomes for adolescents and young adults with ASDs who participated in a psycho-educational healthy sexuality group.
Variables include sexual knowledge and attitudes, Axis I psychopathology, and intellectual functioning.

University of Kentucky, Principal Investigator, "General Personality, Personality Disorder, Psychopathology, and Adaptive Functioning in Adults with Intellectual Disabilities." Lexington, Kentucky, October 2011 to August 2013.
Wrote literature review, developed study methodology and hypotheses, obtained IRB approval, recruited participants from vulnerable populations, and collected, analyzed, and interpreted data. Dissertation.

University of Kentucky, Co-Investigator, "Gender Identity, Sexual Orientation, and Personality." Lexington, Kentucky, September 2012 to 2013.
This project is comprised of three studies examining the relations among non-normative gender identity, personality, and sexuality. Generated research idea, developed study methodology, obtained IRB approval, and collected, analyzed, and interpreted data for study one. Co-principal investigator: Tory Eisenlohr-Moul, Ph.D.

University of Kentucky, Widiger Personality Laboratory, Graduate Researcher, Lexington, Kentucky, September 2005 to July 2012.
Administered the Personality Disorder Interview-IV and Structured Interview for the Five Factor Model to participants in studies of personality disorders; generated ideas for laboratory research; co-developed methodology for studies of Five Factor Model personality; coded semi-structured interviews for reliability; read and critiqued papers submitted for publication; and identified test items for use in Five Factor Model research. Principal Investigator: Thomas Widiger, Ph.D.

University of Kentucky, **Department of Behavioral Sciences**, **Graduate Research Assistant**, Lexington, Kentucky, June 2008 to May 2010.
Collected, analyzed, and interpreted data, co-authored manuscripts, and wrote annual reports for funding sources.

University of Kentucky, Preservice Health Training Project, Research Assistant, Lexington, Kentucky, August 2005 to June 2008.
Assisted in a project evaluating outcomes of online training modules for health professionals serving people with disabilities. Co-authored six manuscripts published in peer-reviewed journals; collected, analyzed, and

interpreted data; co-developed study methodology; and coordinated and edited contributions by co-authors. Principal Investigator: Harold Kleinert, Ed.D.

University of Illinois, Korol Sex Steroids and Behavior Rodent Laboratory, Research Assistant, Lexington, Kentucky, May 2002 to August 2002.
Assisted in a study of rodent spatial navigation strategies, resulting in a *Neuroscience* publication. Performed rodent surgeries, including ovariectomy and cannulae implantation in the striatum and hippocampus, tested rodent behavior, and performed histology on frozen brain tissue. Principal Investigator: Donna Korol, Ph.D.

PUBLICATIONS

Boyd, S. E. (2012). Five Factor Model personality functioning in adults with intellectual disabilities. In T.A. Widiger & P.T. Costa (Eds.), *Personality Disorders and the Five Factor Model of Personality* (3rd ed.) (pp. 209 - 217). Washington, D.C.: American Psychological Association.

Adams, Z., and **Boyd, S.E.** [shared first-authorship] (2010). Ethical challenges in the treatment of individuals with intellectual disabilities. *Ethics and Behavior*, *20*, 407-418.

Boyd, S., Sanders, C., Kleinert, H., Huff, M., Lock, S., Johnson, S., et al. (2008). Virtual patient training to improve reproductive healthcare for women with intellectual disabilities. *Journal of Midwifery and Women's Health, 53*, 453-460.

Kleinert, H. K., Fisher, S., Sanders, C., & **Boyd, S.** (2007). Improving physician assistant competencies in developmental disabilities using virtual patient modules. *Journal of Physician Assistant Education, 18*, 33-40.

Kleinert, H. K., Sanders, C. B., Mink, J., Nash, D., Johnson, J., **Boyd, S.,** et al. (2007). Improving student dentist competencies and comfort in delivering care to children with developmental disabilities using a virtual patient module. *Journal of Dental Education*, *71*, 279-286.

Knudsen, H. K., Studts, J. L., **Boyd, S. E.,** & Roman, P. M. (2010). Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. *Journal of Addictive Diseases, 29*, 294-305.

Knudsen, H. K., **Boyd, S. E.,** Studts, J. L. (2010). Substance abuse treatment counselors and tobacco use: a comparison of comprehensive and indoor-only smoking bans. *Nicotine and Tobacco Research, 12,* 1151-1155.

Sanders, C. L., Kleinert, H. K., Free, T. F., Slusher, I., Clevenger, K., Johnson, **S., Boyd, S.** E. (2007). Caring for children with intellectual and developmental disabilities: Virtual patient instruction improves students' knowledge and comfort level. *Journal of Pediatric Nursing*, *22*, 457-466.

Sanders, C. L., Kleinert, H. K., Free, T. F., Slusher, I., Clevenger, K., **Boyd, S.,** et al. (2007). Caring for children with intellectual and developmental disabilities: Virtual patient instruction improves students' knowledge and comfort level. *Journal of Pediatric Nursing*, *22*, 457-466.

Sanders, C. L., Kleinert, H. K., **Boyd, S. E.** Herren, C., Theiss, L., & Mink, J. (2008). Virtual patient instruction for dental students: can it improve dental care access for persons with special needs? *Special Care Dentistry, 28,* 205-213.

Sanders, C. L., Kleinert, H. K., Free, T. F., Slusher, I., Clevenger, K., **Boyd, S.,** et al. (2008). Developmental disabilities: improving competence in care using virtual patients. *Journal of Nursing Education, 47,* 66-73.

Widiger, T. A., & **Boyd, S.** (2009). Personality disorder assessment instruments. In J. N. Butcher (Ed.), *Oxford handbook of personality assessment (3rd ed.)(pp. 336-363).* New York: Oxford University Press.

Zurkovsky, L., Brown, S. L., **Boyd, S.,** & Korol, D. L. (2007). Estrogen modulates learning in female rats by acting directly at distinct memory systems. *Neuroscience, 144*, 26-37.

TEACHING & TRAINING EXPERIENCE

Capital Area Immigrants' Rights (CAIR) Coalition, Detained Children's Program webinar presenter: Detention Conditions, Health Impact of Detention on Children, & Legal Issues of Children's Detention. Washington, DC, July 2019.
One of three presenters providing overviews of legal, health, and psychological realities and risks for immigrant children in detention. Webinar attendees were stakeholders and grant foundations.

University of Virginia Health Services, Panelist: How Experience Might Inform Ethical Practice. Transgender Youth and Systems-Level Reforms for Girls. Charlottesville, VA, April 2019.
One of three panelists reviewing potential ethical considerations, and responding to training participant questions, regarding forensic assessment of transgender and gender non-conforming individuals.

District of Columbia Department of Behavioral Health, Training Presenter. Washington, D.C., December 2018.
Developed training materials and presented on the topic of adjudicative competency restoration for adults with Intellectual Disabilities.

National Legal Aid & Defender Association Presenter. Philadelphia, PA, June 2018.
Developed training materials, and co-presented with Joette James, Ph.D., as well as presenting (solo) regarding accommodations-related assessments for defendants with cognitive and psychiatric disabilities, and about psychopathy and Antisocial Personality Disorder, respectively.

Georgetown Juvenile Justice Initiative and National Juvenile Defender Center Symposium: Race and Juvenile Justice 50 Years after *Gault* Presenter/Panelist. Washington, D.C., May 2017.
Co-panelist with Daniel Murrie, Ph.D., for discussion of race and risk assessment of juveniles.

Georgetown Juvenile Justice Center Presenter. November 2016.
Developed and presented a training for public defenders regarding common errors in risk assessment reports and strategies for critical reading of risk assessment evaluations.

Superior Court Judicial and Senior Manager Spring Conference Presenter. Washington, D.C., April 2015.
Developed and presented training materials for Superior Court Judges as part of a panel on risk assessment of juvenile and adult defendants.

Training for Attorneys Preparing to Represent Defendants on the Prince William Mental Health Court Docket. Manassas, Virginia, April 2015, April 2016, & April 2018.
Prepared and presented a training for attorneys and judges about psychiatric disorders and forensic psychology considerations relevant to defendants with suspected or confirmed psychiatric disorders.

Institute of Law, Psychiatry, and Public Policy, Presenter. Charlottesville, Virginia, 2014 to present.
Developed and presented training curriculum for forensic evaluators assessing risk-related online behaviors in juveniles.

Institute of Law, Psychiatry, and Public Policy, Presenter. Charlottesville, Virginia, October 2014 to present.
Developed and presented training curriculum for evaluating competency to stand trial and mental state at the time of offense in defendants with intellectual disabilities and borderline intellectual functioning.

Institute of Law, Psychiatry, and Public Policy, Training Faculty. Richmond, Virginia, and Charlottesville, Virginia, May 2015 and September 2014.
Developed and presented a one-day training curriculum on assessing online behavior of forensic evaluees, with emphasis on issues relevant to problematic sexual behavior online, applicable statutes, and recommendations for supervision.

Washington, District of Columbia, Department of Behavioral Health, Presenter. August 2014.
Developed and presented a training curriculum on evaluating adjudicative competency of defendants with intellectual disabilities. Trainees were forensic psychologists and psychiatrists employed by the Department of Behavioral Health.

Department of Behavioral Health and Developmental Services, Presenter. August 2014.
Developed and presented a grand rounds for mental health service providers at Western State Hospital; topic was introduction to internet culture, and how and why to query online activities of individuals with severe mental illness.

Department of Behavioral Health and Developmental Services, Presenter. July 2014.
Developed and presented Psychology Department inservice training concerning adapting empirically-supported PTSD treatments for inpatient forensic populations.

Department of Behavioral Health and Developmental Services, Training Facilitator, Richmond, Roanoke, and Newport News, Virginia, April 2014 to May 2014.
Developed and presented a training curriculum on customizing outpatient restoration of competency to stand trial services for individuals with intellectual disabilities. Trainees were community mental health providers.

Institute of Law, Psychiatry, and Public Policy, Presenter. Charlottesville, Virginia, March 2014 to present.
Developed and presented training curriculum on assessing online behavior of forensic evaluees, with emphasis on issues relevant to problematic sexual behavior online.

Western State Hospital, Department of Behavioral Health and Developmental Services, Presenter, Staunton, Virginia, November 2013.
Developed and presented a grand rounds for mental health providers, concerning personality disorders in adults with intellectual disabilities, also developed and presented a psychology department inservice training focused on adapting evidence-based trauma treatment interventions for inpatient forensic populations.

Westchester Jewish Community Services, Instructor, Yonkers and Hartsdale, New York, September 2012 to July 2013.
Developed training curriculum on assessing online activity of children, adolescents, and young adults. Presented training to an outpatient trauma treatment center, a violence intervention and prevention program, and a program for teen parents.

University of Kentucky, University Center for Excellence in Developmental Disabilities, Curriculum Development and Project Coordinator, Lexington, Kentucky, January 2012 to July 2012.
Originated concept, generated learning objectives and teaching strategies, and developed content for an inter-disciplinary, multi-media online training for mental health professionals to provide more competent and ethical care to adults with ID/DD. Wrote scripts, cast actors, and filmed and edited illustrative video vignettes. Applied for and obtained continuing education credits from the Kentucky Psychological Association.

University of Kentucky, Human Development Institute, Instructor, Lexington, Kentucky, 2008 to 2011.
Lectured on sexual abuse of adults with disabilities to students enrolled in the interdisciplinary Graduate Developmental Disabilities Certificate Program. Converted lecture to online format for the distance learning section of program.

Migrant Network Coalition, Workshop Co-Leader, Lexington, Kentucky, August 2010.
Researched and developed materials and co-led a training workshop on the intersection of disability and immigration status.

University of Kentucky, **Department of Behavioral Sciences**, **Graduate Student Trainee**, Lexington, Kentucky, August 2007 to May 2009.
Developed training materials and facilitated *in vivo* experiences to prepare medical students for treating patients with DD and their families. Developed student/family mentorship program, still in use by the medical school.

University of Kentucky, Human Development Institute, Project Supervisor, Lexington, Kentucky, November 2007 to July 2008.
Researched and developed instructional content of a multi-media online training package for direct service professionals who support adults with DD. Coordinated marketing and distribution of training program to Medicaid waiver providers. Funded by the Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities.

University of Kentucky, Preservice Health Training, Project Assistant, Lexington, Kentucky, August 2005 to June 2008.
Helped identify training needs of professionals (e.g., dentistry, nursing, women's health) treating individuals with ID/DD; researched and wrote content for training materials; and co-scripted video vignettes for an award-winning series of online, multi-media, interdisciplinary training modules.

Project SAFE (Safety and Accessibility for Everyone), Coordinator, Frankfort, Kentucky, September 2005 to September 2006.
Created and presented three trainings on the topic of sexual and domestic violence perpetrated against individuals with disabilities. Audience included team members from a coalition of state agencies dealing with sexual assault, domestic/interpersonal violence, disability rights, and crime victims' advocacy.

Commonwealth of Kentucky, Coalition of State Disability and Employment Agencies, Training Facilitator, Frankfort, Kentucky, April 2005 to June 2005.
Coordinated disability-awareness trainings, led by facilitators with disabilities, for state employees of Kentucky One-Stop Job Centers.

PRESENTATIONS

Boyd, S., Brodsky, S. (chair), Murrie, D.M., & Stejskal, W.J. (2016, March). *Bias in Forensic Mental Health Evaluations*. Symposium at the American Psychology-Law Society Conference. Atlanta, Georgia.

Boyd, S., Barretto, R., & Zelle, H. (2015, June). *Using Advance Directives for Self-Advocacy and Planning: An Overview and Example of the Process*. Presentation at the 14th Annual Philadelphia Trans Health Conference. Philadelphia, PA.

Boyd, S. (2010, November). *Personality, motives, and adaptive functioning in adults with intellectual disability*. Poster presented at the Association of University Centers on Disability conference, Crystal City, VA.

Boyd, S., & Adams, Z. (2008, April; shared first authorship). *Ethical considerations in the treatment of individuals with Intellectual Disability*. Award Presentation session at the annual American Psychological Association conference ,Boston, MA.

Boyd, S. (2008, month) *Traits, motives, and behavior: comparing the NEO PI-R and the Reiss Profile.* Poster Presented on September 26 at the 2008 Society for Research in Psychopathology conference, Pittsburgh, PA.

Kleinert, H. K., Caldwell, S., **Boyd, S.** (2006, October). *Interactive virtual training for residential physicians and student dentists on caring for patients with developmental disabilities.* Concurrent session presented at the annual Association of University Centers on Disability conference, Washington, D.C.

SUPERVISION

Institute of Law, Psychiatry, & Public Policy Graduate Student and Postdoctoral Fellow Supervisor, Charlottesville, Virginia. August 2017 to present.
Supervised graduate students and postdoctoral fellows in reviewing and conducting forensic psychological evaluations. Presented at case conferences for student and practitioner attendees.

Westchester Jewish Community Services, Clinical Psychology Extern Supervisor, Hartsdale, New York, September 2012 to July 2013.
Supervised a graduate-level psychology extern in providing evidence-based treatments to a clinic population. Discussed differential diagnoses, case formulations, treatment goals, interventions, and collateral services. Provided ongoing feedback and conduct formal written evaluations.

University of Kentucky, Student Supervisor, Lexington, Kentucky, May 2008 to June 2012.
Supervised four undergraduate student assistants in laboratories investigating psychopathology, personality, and self-regulation. Oversaw data collection and analysis, manuscript preparation, and conference presentations. Provided guidance on professional development, including graduate school applications.

HONORS

2012 Research Endowment Award, from the Human Development Institute, University of Kentucky.

2011 Research Funding Award, from the Department of Psychology, University of Kentucky.

2008 Winner, American Psychological Association (APA) of Graduate Students ethics paper contest. Awarded at the APA annual conference in Boston, MA, August 2008. Paper, co-authored with Z.W. Adams, titled: Ethical Considerations in Psychotherapy with Adults with Intellectual Disabilities.

2008 Research Funding Award, from the Department of Psychology, University of Kentucky.

2007 Burberry Award, from the Human Development Institute, University of Kentucky, a University Center for Excellence in Developmental Disabilities.
This award recognizes outstanding academic achievement and advocacy efforts in graduate student trainees.

2006 Travel Award, from the Department of Psychology, University of Kentucky.

2006 Anne Rudiger Award, from the Association of University Centers on Disability (AUCD).
This national award recognizes academic and advocacy-related achievement among graduate student trainees in the AUCD network.

1998-1999 James Scholar Honors Program, University of Illinois.

PROFESSIONAL MEMBERSHIPS

American Psychological Association (APA)
- APA Division 25: *Behavior Analysis*
- APA Division 33: *Intellectual and Developmental Disabilities/Autism Spectrum Disorders*
- APA Division 35: *Society for the Psychology of Women*
- APA Division 44: *Society for the Psychology of Sexual Orientation and Gender Diversity*
- APA Division 46: *American Psychology-Law Society*
- APA Division 56: *Trauma Psychology*

American Association on Intellectual and Developmental Disabilities (AAIDD)

Association for the Treatment of Sexual Abusers (ATSA)

Fellow, American Board of Forensic Psychology (ABFP)

APPENDIX 2

EXPERT CONSULTATION APRIL 2017 – PRESENT

- 2017 Charlottesville Circuit Court; *Commonwealth of Virginia v. James Sprouse*, CR16000058-01
- 2017 Fairax County Circuit Court; *C.W. v. Kerianne Frickel*, FE-2016-871
- 2017 Gordon County Superior Court; *State of Georgia v. Tabatha Lynn*, 26204
- 2017 Prince William County Circuit Court; *Commonwealth of Virginia v. Edgard Cruz*, CR17000252-00
- 2017 Prince William County Circuit Court; *Commonwealth of Virginia v. Oleh John Kuziw*, CR16002828-00
- 2017 Prince William County Circuit Court; *Commonwealth of Virginia v. Troy Vandiver*, CR16000625-01
- 2017 Superior Court of the District of Columbia; *United States v. Hunt, William S. MFR*, 2014 CF1 001927
- 2018 Alexandria Circuit Court; *Commonwealth of Virginia v. Gregory Murphy*, CF000517
- 2018 Fairax County Circuit Court; *C.W. v. Adam Agostini*, FE20170001146
- 2018 Fairax County Circuit Court; *C.W. v. Joaquin Ramey*, FE-2016-419
- 2018 Loudoun County Circuit Court; *Commonwealth of Virginia v. Ian Florance*, CR00031218-00
- 2018 Loudoun County Circuit Court; *Commonwealth of Virginia v. Trevon Rector*, CR01025427-00
- 2018 Superior Court of the District of Columbia; *United States v. Taylor, Antonio MCL*, 2013 CF1 021375
- 2018 THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA; *USA v. Dobbins*, 4:17-cr-00129-MSD-RJK
- 2018 Winchester County Circuit Court; *Commonwealth of Virginia v. James Armel*, CR17000443-00
- 2019 23rd Judicial Circuit Court; *W.V. v. Devin Michael Collin*, 16-M19F-00361
- 2019 23rd Judicial Circuit Court; *W.V. v. Molly Jo Delgado*, CC-0202017-F-149
- 2019 23rd Judicial Circuit Court; *W.V. v. Seth Beathard*, CC-33-2019-F-3

- 2019 Charleston WV Spec Ed. Due Process No. 19-020
- 2019 Escambia County Circuit Court; *Timothy Lee Hurst v. State of Florida*, 1998-CF-001795
- 2019 Fairax County Circuit Court; *Normand v. Brown*, CL2018-07653
- 2019 Prince William County Circuit Court; *Commonwealth of Virginia v. Robert Campbell*, CR17004221-00
- 2019 THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA; *Doe v. Fairfax County School Board*, 1:18-cv-00614-LO-MSN
- 2019 THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ALABAMA; *USA v. Hooks et al*., 2:18-cr-00249-LSC-JHE
- 2019 Winchester County Circuit Court; *Commonwealth of Virginia v. Nicholas Hamman*, CR18000746-00
- 2019 Shelby County Circuit Court; *Fortner v. Runyon*, CT-001847-11
- 2020 Superior Court of the District of Columbia; *United States v. Smith, Preston G JAS*, 1991 FEL 010665
- 2020 THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA; *USA v. Boutros*, 1:20-cr-00082-APM
- 2020 THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA; *USA v. Johnson et al*., 1:19-cr-00351-RDA-1
- 2020 THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA; *USA v. Sizemore*, 3:19-cr-00120-JAG
- 2021 Arlington Circuit Court; *Commonwealth of Virginia v. Rodolfo Rivera-Valencia*, CR19000179-00
- 2021 Fayette County Circuit Court; *Commonwealth v. Rodriguez, Tammy Marie*, 19-CR-01493
- 2021 Logan County Circuit Court; *Commonwealth v. Roberson, Demetrius*, 17-CR-00220
- 2021 Prince William County Circuit Court; *Commonwealth of Virginia v. John Pleasant Johnson Jr.*, CR20000938-00
- 2021 Richmond County Circuit Court; *Commonwealth of Virginia v. Justin Harvey*, CR18F03463-00

- 2021 Richmond County Circuit Court; *Commonwealth of Virginia v. Mary Purviance*, CR19F01179-00

- 2021 Superior Court of the District of Columbia; *United States v. Byrd, Brandon A MJD*, 2016 CF1 012762

- 2021 Superior Court of the District of Columbia; *United States v. Winston, Marcus K MO*, 1997 FEL 004943

- 2021 THE UNITED STATES DISTRICT COURT DISTRICT OF MARYLAND; *Dinardo v. It's My Amphitheater, Inc.*, 8:19-cv-01841-CBD

Juvenille Court Cases Sealed – Not Publicly Available

- 2017 Prince William County Circuit Juvenile Court

- 2017 Superior Court of the District of Columbia Juvenile Court (In re. J.G.)

- 2018 District of Columbia Civil Commitment Commission

- 2018 Superior Court of the District of Columbia Juvenile Court (In re. D.L.)

- 2018 Superior Court of the District of Columbia Juvenile Court (In re. D.S.)

- 2021 District of Columbia Juvenile Court (In re. D.M.)

- 2021 District of Columbia Juvenile Special Ed. Due Process (In re. E.J.)

- 2021 Superior Court of the District of Columbia Juvenile Court (In re. W.B.)

- 2021 THE UNITED STATES DISTRICT COURT DISTRICT OF MARYLAND