2010-16

The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118-2439

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary

Elin M. Howe
Commissioner

Area Code (617) 727-5608
TTY: (617) 624-7590

, 2010

MA

Re: Appeal of - Final Decision

Dear :

Enclosed please find the recommended decision of the hearing officer in the above appeal. A fair hearing was held on the appeal of your client's eligibility determination.

The hearing officer made findings of fact, proposed conclusions of law and a recommended decision. After reviewing the hearing officer's recommended decision, I find that it is in accordance with the law and with DDS regulations. Your client's appeal is therefore ALLOWED and the Department's decision is REVERSED.

Sincerely,

Elin M. Howe
Commissioner

EMH/ecw
cc: Jeanne Adamo, Hearing Officer
Marianne Meacham, General Counsel
Barbara Green Whitbeck, Assistant General Counsel
Paula Potvin, Regional Eligibility Manager
Amanda Chalmers, Regional Director
Patricia Shook, Psychologist
Victor Hernandez, DDS
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES

In Re: Appeal of [redacted]

This decision is issued pursuant to the regulations of the Department of Developmental Services 115 CMR 6.30 – 6.34 (formerly known as Department of Mental Retardation, hereinafter referred to as "DDS" or "Department") and M.G.L. c. 30A. A fair hearing was held on [redacted] 2010 at the [redacted] in [redacted], Massachusetts.

Those present for all or part of the hearing were:

[redacted]	Appellant
	Mother of the Appellant
	Father of the Appellant
	Counsel for the Appellant
	Counsel for the Appellant
	Certified School Psychologist
Ph. D.	Licensed Clinical Psychologist
Ph.D.	Licensed Forensic Psychologist
Barbara Green Whitbeck, Esq.	Counsel for DDS
Patricia Shook. Ph. D.	Licensed Psychologist
Paula Potvin	Observer, DDS Eligibility Manager

The Fair Hearing proceeded under the informal rules concerning evidence with approximately four and one-half hours of testimony presented. The Appellant's evidence consists of nine exhibits along with sworn oral testimony from the Appellant, the Appellant's mother, and three expert witnesses: Mr. [redacted], Dr. [redacted], and Dr. [redacted]. The evidence presented on behalf of the Department consists of thirteen exhibits along with three joint exhibits and sworn oral testimony from the Department's expert witness, Dr. Patricia Shook.

At the close of the Fair Hearing, the Parties requested and were granted additional time to submit post hearing briefs to the Hearing Officer. The Appellant was allowed fifteen days and the Department was allowed an additional fifteen days to respond. Subsequent to the Fair Hearing the Department submitted a motion for an extension of time. The Hearing Officer found good and sufficient cause to grant the Department's motion. As a result, the Department's motion for an extension of time was allowed and the record remained open until [redacted], 2010.

ISSUE PRESENTED:

Whether the Appellant is eligible for DDS services by reason of Mental Retardation as defined in 115 CMR 6.04(1)

BACKGROUND:

The Appellant, Mr. [redacted], is an eighteen year old, totally blind young man who lives with his parents in [redacted], Massachusetts; the Appellant is not under legal guardianship. He was born in [redacted] and moved to the United States with his parents when he was two years old to begin instruction at the [redacted]. He has received all of his education at [redacted] School, where he is currently enrolled in their secondary program. [redacted] is the primary language of his parents, and both English and [redacted] are spoken in the Appellant's home. The Appellant learned both English and simultaneously and reportedly has conversational ability in both languages. However, the Appellant receives all his school instruction in English and Braille.

Appellant was diagnosed with a brain malformation at birth; he was born without a Septum Pellucidum, with dilated ventricles, and with a small optic chiasm and was thought to have experienced oxygen deficiency during labor. At [redacted] months of age he was diagnosed with Septo-Optic Dysplasia (SOD). The Appellant reportedly had echolalic speech and limited meaningful communication at three years of age, and at age six he reportedly exhibited behaviors comparable to a diagnosis of PDD spectrum disorder. Nonetheless, the Appellant exhibited an early interest in music which was encouraged and supported with piano lessons beginning at approximately age four.

The Appellant suffered his first seizure at age fourteen, reported to be a generalized tonic-clonic seizure lasting 3-4 minutes. He continued to experience significant grand mal seizure activity and was treated over an extended period of time with several different anti-seizure medications until one was found that satisfactorily mitigated seizure activity and also allowed the Appellant to remain alert enough to function at home and at school. An MRI taken at age fourteen revealed further brain anomalies; he was found to have: Polymicrogyria (PMG); Transmantle Heterotopias; mild to moderate enlargement of cerebral ventricles; and mild to moderately diminished white matter. The Appellant's diagnosis was revised from SOD to SOD, Polymicrogyria, and Transmantle Heterotopias and classified as an SOD Plus Syndrome, a rare developmental anomaly of the brain.

The Appellant was found to have significant variability in cognitive test results, testing extremely low in most all areas but extremely high in a few. He has been described as having savant characteristics with an excellent memory for some limited types of information and a gifted musical talent; [redacted] Due to his blindness and significant cognitive testing variability, a valid Full Scale IQ score could not be calculated.

The Appellant applied for DDS adult services on [redacted] 2009 and was found to be ineligible based on a failure to meet the criteria for a diagnosis of Mental Retardation as defined in 115 CMR 2.01. An appeal of the denial of services was submitted and an Informal Conference was held on [redacted] 2009, at which time the Appellant's ineligibility ruling was upheld. The Appellant appealed that decision and a Fair Hearing was held on [redacted] 2010. The Appellant was present at the hearing along with his parents. The Appellant was represented by Attorney [redacted] and Attorney [redacted] from the firm of [redacted].

OPENING STATEMENTS:

Appellant's Opening Statement:
Attorney [redacted] represented the Appellant stating that the Appellant's diagnosis is extremely rare and his particular situation is atypical; he is a totally blind person with multiple significant deficits who also exhibits savant abilities. His unique situation as a totally blind person with multiple deficits has made it impossible to perform IQ testing that would allow a reliable calculation of a Full Scale IQ. However, the inability to obtain a reliable Full Scale IQ should not disqualify him from receiving DDS services. Three expert witnesses will testify as to their professional assessment of the Appellant's cognitive ability. In addition, the Appellant's mother will testify as to the Appellant's diagnostic history, and the Appellant will also testify. After hearing from the Appellant and after all the evidence is pulled together for consideration, it will be shown that the Appellant is Mentally Retarded and should be found eligible for DDS services.

DDS's Opening Statement:
Attorney Barbara Green Whitbeck represented the Department stating that this is an unusual case and there will be an extraordinary number of clinical experts discussing clinical issues in this matter. However, although this case is atypical, Dr. Patricia Shook has analyzed the psychological testing conducted on the Appellant and will review those test results during the course of the hearing to show why the Appellant does not meet DDS eligibility requirements. While the Appellant may have some cognitive deficits and is in need of supports, Dr. Shook has determined that he does not meet the qualifications necessary for eligibility for DDS services.

SUMMARY OF THE EVIDENCE PRESENTED:

EXHIBITS:
The Department submitted the following exhibits which were accepted into evidence:

DDS Exhibit #1
Curriculum Vita of Patricia Shook, Ph. D.

DDS Exhibit #2
Excerpts from 115 CMR 6.04 General Eligibility

DDS Exhibit #3
Excerpts from 115 CMR 2.01 Definitions

DDS Exhibit #4
DDS's Eligibility Determination Notification for [redacted], dated [redacted] 2009.

DDS Exhibit #5

Letter to the Appellant's parents, [redacted] and [redacted], from Veronica Wolfe, Regional Eligibility Manager, dated [redacted], 2009, notifying the Appellant's parents of the results of the Informal Conference and the right to appeal the Department's finding of ineligibility.

DDS Exhibit #6

DDS's Notice of Receipt of Fair Hearing Request sent from Elisabete Wolfgang, DDS Hearing Administrator, to the Appellant's attorney, [redacted] Esq., dated [redacted] 2009.

DDS Exhibit #7

DDS's Fair Hearing Schedule Notice sent from Elisabete Wolfgang, DDS Hearing Administrator, to the Appellant's attorney, [redacted] Esq., dated [redacted] 2009.

DDS Exhibit #8

A Psychological/ Developmental Assessment of the Appellant at the Appellant's age of 8 years [redacted], with the results of a WISC-III Verbal Scale, and other verbal evaluation test results, conducted by [redacted], Ph.D., over the course of five sessions in [redacted] and [redacted] of 2000.[1]

DDS Exhibit #9

[redacted] School [redacted] Psychoeducational Evaluation Addendum for the Appellant, with the results of a Slosson Intelligence Test-R3 and the Communication Domain of the Vineland-II Adaptive Behavior Scales, conducted at the Appellant's age of 18 years [redacted], by School Psychologist, [redacted], N.C.S.P., L.E.P., dated [redacted] 2009.

DDS Exhibit #10

An Administrative Data Sheet for the Appellant's Individualized Education Program (IEP) at the [redacted] School [redacted] for the period of [redacted] 2009 to [redacted]. 2010.

DDS Exhibit #11

The Appellant's Application for DMR Eligibility submitted by [redacted] and received by DDS on [redacted] 2009.

DDS Exhibit #12

Table 5.21 of the Wechsler's Manual noting Mean Performance of Intellectual Disability- Mild Severity and Matched Control Groups.

[1]Upon review of the evidence the Hearing Officer found that DDS Exhibit #8 was submitted as a double sided Exhibit meant to contain 8 pages. However, due to an apparent collation error, DDS Exhibit #8 was submitted as a nine page document with a duplicate of page 4 out of sequence within the exhibit. The notation on the enclosed original exhibit correcting the oversight was made by the Hearing Officer subsequent to the Fair Hearing and therefore will not appear on other copies given out at the Hearing.

DDS Exhibit #13

Excerpt of the Wechsler's Manual- page 34, General Administration Guidelines.

The Appellant submitted the following exhibits which were accepted into evidence:

Appellant Exhibit #1

Curriculum Vita of [redacted], M.A.

Appellant Exhibit #2

Curriculum Vita of [redacted], Ph.D.

Appellant Exhibit #3

Curriculum Vita of [redacted], Ph. D.

Appellant Exhibit #4 (jointly submitted with DDS)

Psychoeducational Evaluation of the Appellant, with results of a CTB, WISC-IV and Vineland-II, conducted in [redacted] 2007 by [redacted], School Psychologist, at the Appellant's age of 15 years [redacted].

Appellant Exhibit #5 (jointly submitted with DDS)

Neuropsychological Examination Report by [redacted], Ph. D., with results of a Reynolds Intellectual Assessment System (RIAS) and other and other evaluations, administered on in [redacted] 2007 at the Appellant's age of 15 years, [redacted].

Appellant Exhibit #6 (jointly submitted with DDS)

Psycho-educational Evaluation of the Appellant, with subtest results of a the WAIS-IV Verbal Comprehension Domain and Working Memory Domain along with the results of a Vineland-II, conducted in [redacted] 2009 [redacted], School Psychologist, at the Appellant's age of 17 years [redacted]

Appellant Exhibit #7

A Neurology Clinic Report by Dr. [redacted] M.D. Ph.D. regarding a neurological assessment conducted by the Comprehensive Brain Malformation Program, dated [redacted] 2009 .

Appellant Exhibit #8

The Vineland-II Survey Interview Report conducted on [redacted] 2010, 2009 by Dr. [redacted], with the Appellant's mother, Ms. [redacted] as the respondent.

Appellant Exhibit #9

The Vineland-II Survey Interview Report conducted on [redacted], 2010 by [redacted], with the staff from [redacted] School [redacted] as the respondents.

SUMMARY OF EVALUATIONS IN EVIDENCE:

- DDS Exhibit #8

The first cognitive evaluation in evidence is a Psychological Assessment (DDS Exhibit#8), conducted by a Licensed Psychologist, [redacted], Ph.D., at the Appellant's age of 8 years, [redacted] which resulted in an overall cognitive developmental skill level determined to be at the 5 ½ to 6 years level; the McCarthy Scales placed the Appellant at the 6 year level, the Reynell-Zinkin at the 5 year level, and the WISC-III within the Borderline range when comparing his performance with other children of his chronological age. However, the WISC-III showed wide scatter on subtests from significantly below average to above average on one sub-test of auditory memory. Both the WISC-III and the WPPSI-R indicated significant weakness on the comprehension subtests which assess practical knowledge, social judgment and verbal comprehension. The Appellant reportedly had particular difficulty in answering "why" questions; he did not understand for example why people wash their hands, why we need clocks, why we need to eat food, why cars have seatbelts, etc.. However, the WISC-III demonstrated a significant strength in one area: the area of auditory memory, where his score was above average for his age. In the Digit Span subtest from the WISC-III the Appellant was consistently able to recall series of digits both forward and in the reversed direction. This evaluation indicated improvement over the first evaluation reportedly conducted at the Appellant's age of 6 years. Nonetheless, his overall cognitive developmental skill level was determined to be three years behind his peers.

- Appellant Exhibit #4 (jointly submitted with DDS)

The second cognitive evaluation in evidence is a Psychoeducational Evaluation (Appellant Exhibit #4), conducted at [redacted] School [redacted], by a Licensed School Psychologist, [redacted], at the Appellant's age of 15 years, [redacted]. One complete cognitive testing instrument, the CTB, along with sections of the WISC-IV and sections of the Vineland-II Adaptive Behavior Scales were used for this evaluation; however, a Full Scale IQ could not be determined due to the extreme variability in test scores.

A complete CTB (Cognitive Test for the Blind) was administered to the Appellant; the CTB is a cognitive test that was developed specifically for use with visually impaired and blind students and adults. The CTB subtest results showed highly significant differences that made it impossible to calculate a valid Verbal or Performance Scale score as the extreme range in subtest results makes any calculation an unreliable indicator of the Appellant's potential. The discrepancy of score results was extreme, from the 1st percentile to the 99th percentile. For example the Auditory Analysis and Sound Repetition subtests in the Verbal Scale section of CTB were above average in the 99th percentile which clearly substantiates the Appellant's aptitude and gifted ability with musical instruments, yet he performed extremely poor, in the 1st percentile, in other tested areas. And the Appellant's ability to define words in the Vocabulary subtest resulted in a score in the low average range, yet, at the same time, the

Appellant's score in the Language Comprehension and Memory subtest where he was required to listen to stories and answer questions about story content, showed a considerable, significant deficiency; the score was within the 1st percentile. The Language Comprehension and Memory subtest requires receptive language, memory for verbal detail and basic expressive language; the Appellant's result in this test show an exceedingly significant impairment and a major contrast to his word knowledge.

The Appellant's subtest results in the Performance Scale section of the CTB similarly showed the same pattern of extreme range with the Appellant scoring very well in a test of rote immediate memory and exceptionally low in all other testing. The Haptic Memory Recognition subtest which measures immediate tactile memory was found to be in the above average range whereas the Spatial Pattern Recall subtest which measures complex immediate memory as well as the Spatial Analysis subtest which measures spatial organization and analysis, both had extremely low scores that only fell within the 1st percentile.

A full WISC-IV could not be administered due to the Appellant's blindness. However, the Comprehension subtest of the WISC-IV was administered with results indicating that the Appellant's practical reasoning and understanding of social mores are severely impaired.

- Appellant Exhibit #5 (jointly submitted with DDS)

The third cognitive evaluation in evidence is a Neuropsychological Assessment (Appellant Exhibit #5), conducted at [redacted] Hospital, by a Pediatric Neuropsychologist, Dr. [redacted], at the Appellant's age of 15 years, [redacted]. The evaluation, administered only three months after a comprehensive Psychoeducational Evaluation had been administered, was conducted to assist in planning interventions for the Appellant, particularly because of the Appellant's recent onset of seizures.

A variety of psychological tests were performed including the following:

Reynolds Intellectual Assessment System (RIAS)
Test of Language Competence (TLC)
Recalling Sentences, Clinical Evaluation of Language Fundamentals (CELF-4)
Selected subtest, Children's Memory Scale (CMS)
California Verbal Learning Test-Children's Version (CVLT-C)
Selected subtests, Delis-Kaplan Executive Function System (D-KEFS)

The assessment reports that the Appellant continues to have seizures every two to three months, that he has an Individualized Educational Plan (IEP) and has both an academic and music curriculum. Dr. [redacted] states in her report that "a very thorough psycho-educational evaluation in [redacted] 2007" was administered and that the Appellant "demonstrated a substantial degree of variability in cognitive skills". Dr. [redacted] reiterates Mr. [redacted]'s caution that because of the Appellant's "very widely scattered abilities and impairments, most aggregate IQ index and factor scores are not reliable or useful as indicators of his potential and ability and should not be used for educational planning services or for eligibility for adult services." In the "Review" section of Dr. [redacted]s report, under "General Presentation", Dr. [redacted] states the following:

> "although [redacted] was quite cooperative with this evaluation, because of his vision impairment and the use of psychological assessment tools not specific for individuals with blindness, this evaluation may provide a

minimum estimate of his functional capacity. For an additional estimate of [redacted]'s ability, please see his most recent cognitive evaluation through [redacted] School [redacted] in 2007."

Dr. [redacted] again qualifies her testing results in the "General Cognitive Abilities" section of her report where she notes that she administered the Verbal Scale of the RIAS but instructs the reader to see the [redacted] School psycho-educational evaluation for a more detailed assessment of the Appellant's intellectual functioning; the RIAS was in the low average range based on the Appellant's ability to define words.

Dr. [redacted] notes variable performance throughout her report and states that the results should be interpreted with caution. Her stated purpose is to generate recommendations for clinical management. She states that "the Neuropsychological protocol as a whole highlights neurobehavioral disorder in the context of a specific brain malformation, Septo-Optic Dysplasia as well as recent onset of epilepsy. This disorder is characterized by a high degree of variability in the cognitive skills assessed." Dr. [redacted] goes on to report that "the likely etiology of [redacted]'s social and cognitive difficulties is very likely his history of Septo-Optic Dysplasia that is associated with an absent Septum Pellucidum as well as hypoplasia of the optic nerves and tracts, and a mildly thinned corpus callosum." In the "Impressions" section of her report, Dr. [redacted] opines that the Appellant does not demonstrate mental retardation due to the high variability in cognitive skills but that his presentation is consistent with symptoms associated with Autism Spectrum Disorder. Dr. [redacted] ends her report with a recommendation for a referral to the Massachusetts Department of Mental Retardation stating that the Appellant is likely to qualify for services based on his limited activities of daily living as well as his diagnosis with Autism Spectrum Disorder.

- <u>Appellant Exhibit #6 (jointly submitted with DDS)</u>

The fourth cognitive evaluation in evidence is a Psychoeducational Evaluation (Appellant Exhibit #6), conducted at [redacted] School [redacted], by Licensed School Psychologist, [redacted], at the Appellant's age of 17 years, [redacted]. Two sections of the WAIS-IV and two sections of the Vineland-II Adaptive Behavior Scales were used for this evaluation. The evaluation was reportedly conducted to assess the Appellant's current cognitive abilities. Mr. [redacted] noted a diagnosis of Septo-Optic Dysplasia, Autism Spectrum Disorder, grand mal seizure disorder and a recent diagnosis of hypothyroidism.

A Verbal Comprehension Index (VCI) and Working Memory Index (WMI) were calculated from the WAIS-IV. As in past evaluations, there was significant scatter of subtest scores; the Appellant's cognitive abilities were widely divergent, limiting the reliability of aggregate scores as indicators of general ability. However, a comparison of the WAIS-IV to the previous testing in 2006 with the WISC-IV, reveal significant differences; the Appellant's current test results were lower by 13 points in the VCI and by 16 points for the WMI. These differences reflected a three point drop of the Vocabulary subtest scaled score, a four point drop for Similarities, a four point increase for Information, a nine point drop for Digit Span, and a nine point increase for LNS. Mr. [redacted] reported that it is not uncommon to see a decrease among visually impaired students who have been relying on rote memory strengths. These strengths continue to be useful for memorizing facts but the Vocabulary and Similarities test items become increasing abstract. Mr. [redacted] opined that these scaled-score decreases suggest that the Appellant's cognitive abilities are not progressing at the same rate as those of other students his age and may have "plateaued". The Appellant's adaptive functioning results from the Vineland-II domains tested were very low, reported to

be within the 1st percentile and almost three standard deviations below the mean. Mr. [redacted] reported that this score is much lower than is expected for a visually impaired student; the Appellant's scores reflect the presence of severe impairment.

- DDS Exhibit #9

The fifth cognitive evaluation in evidence is a Psycho-educational Evaluation Addendum (DDS Exhibit #9), conducted at [redacted] School [redacted], by Licensed School Psychologist [redacted], at the Appellant's age of 18 years, [redacted]. A Slosson Intelligence Test-R3 (SIT-R3) and the Communication Domain of the Vineland-II Adaptive Behavior Scales were used for this evaluation. The SIT-R3 was used as a measure of general verbal cognitive ability because it does not rely heavily on visually loaded test items or test items that must be seen to be used. The SIT-R3 evaluation was conducted to provide information for comparison to the previous WAIS-IV results; the Vineland-II was conducted to assess how the Appellant applies his intelligence and abilities in the real world.

The SIT-R3 resulted in a Total Standard Score (TSS) of 59 with a 95% confidence interval of the TSS falling between 52 and 66; a TSS of 59 is equivalent to a Wechsler IQ of 62. A SIT-R3 of 59 and its Wechsler IQ equivalent of 62 fall at the 1 Percentile, within the Mild range of Mental Retardation and with a Mean Age Equivalent of 11.0 years. The Vineland-II results fell in the Low Level of overall adaptive behavior with an Adaptive Behavior Composite score of 58; an Adaptive Behavior Composite score of 58 is within the 1st percentile, more exactly, within the first three-tenths of the first percentile and represents adaptive functioning over 2.5 standard deviations below the mean. This Composite Score is significantly lower than expected for a visually impaired student.

- Appellant Exhibit #8

The next evaluation in evidence is a score summary and narrative report from a Vineland-II Adaptive Behavioral Scales assessment conducted on the Appellant at age 18 years, [redacted] by Dr. [redacted] with the Appellant's mother, Ms. [redacted], as the respondent. This testing resulted in an Adaptive Behavior Composite Score of 57, a range that falls within the 1st percentile, in the Low level of adaptive functioning.

- Appellant Exhibit #9

A second Vineland-II Adaptive assessment was conducted by Dr. [redacted] using the Staff from [redacted] School as the respondents. This testing also resulted in an Adaptive Behavior Composite Score of 57, a range that falls within the 1st percentile, in the Low level of adaptive functioning.

SUMMARY OF TESTIMONY OFFERED INTO EVIDENCE:

- The Appellant

The Appellant was the first to testify. He was fully cooperative and appeared to be trying his best to answer all questions. However, he did not appear to understand the question asked of him when sworn in to testify under oath; he had to be prompted to answer "I do". The Appellant testified regarding his studies at [redacted] stating that he

was studying water in his chemistry class and that he enjoyed this class along with his math and computer classes. When asked to give examples of food that must be placed in the refrigerator, and only after thinking for some time, the Appellant was able to list some items that must be placed in the refrigerator. However, when asked why these items must be placed in the refrigerator, even after taking some time to contemplate the answer, the Appellant said he did not know why they need to be placed in the refrigerator. When asked to list the steps needed to make a peanut butter sandwich, the Appellant, after thinking carefully, was successful in listing the basic steps. He was not able to answer the question "Where does food come from?" The Appellant was able to list out the medications that he took daily.

The Appellant testified regarding his musical abilities stating that he began playing the piano at age four, [redacted]. The Appellant testified that he continues to takes piano lessons which he very much enjoys. He testified that he reads music using Braille and that he studies music with his piano teacher. The Appellant left the hearing with his father immediately after testifying in order to attend his programs at [redacted] School.

- Ms. [redacted]

The Appellant's mother, Ms. [redacted], testified regarding her son's developmental history recalling the many diagnoses that he received and what was done to help him. Ms. [redacted] stated that her son exhibited an exceptional ability in rote memory and music from an early age but was not capable in all other areas. Ms. [redacted] stated that although she and her husband were told shortly after birth that their son was blind and had developmental disabilities, for many years they held onto the hope that with the proper instruction and treatment, he would be able to attain a level of ability that would allow him to care for himself. Ms. [redacted] testified that she and her husband had ensured that her son received the best instruction possible to help him develop to his fullest potential, but that even with all that has been done, her son's cognitive limitations cannot be overcome. Ms. [redacted] recalled that her son was asked to leave [redacted] due to his cognitive limitations; he was not able to follow the directions that other blind children could and as a result required one to one attention that was well beyond what was typically necessary for a blind child. Ms. [redacted] stated that her son has SOD plus syndrome and because of his limitations, he is not able to do the things that other blind people can do and that is evident both at home and at school. Ms. [redacted] testified that her son does have an exceptional ability with memory and with music. Mr. [redacted] testified that her son began playing the piano at age four [redacted]. Ms. [redacted] testified [redacted] However, he has difficulty staying focused, which interferes with his playing music; he is not able to perform any complete musical composition without making errors even though he is able to correctly perform any one part of the musical piece when he plays only one section of the composition.

- Mr. [redacted], Licensed Educational Psychologist

Mr. [redacted] testified that he is a master's level Licensed Educational Psychologist, Nationally Certified as a School Psychologist for all levels. He has been at [redacted] School [redacted] as a School Psychologist for approximately thirty-four years, has worked with the Appellant for several years, and has tested the Appellant on multiple occasions over that period of time. Mr. [redacted] has worked with blind individuals who do not have other disabilities and with blind individuals who do have multiple disabilities. It is Mr. [redacted]s stated professional opinion that the Appellant does not have the level of cognitive ability expected of blind peers of the same age and that the Appellant functions at the level that is consistent with other blind individuals who are also mentally retarded. Mr. [redacted] is very familiar with the Appellant and the Appellant's cognitive ability; it is his professional opinion that the Appellant is mentally retarded.

Mr. [redacted] formed an opinion as to the applicability of the testing instrument used by Dr. [redacted] in Dr. [redacted]'s 2007 neuropsychological assessment of the Appellant; Mr. [redacted] stated that because the Appellant is blind, the results of the Reynolds Intellectual Assessment System (RIAS) used in that neuropsychological assessment should be interpreted very cautiously. Although the use of the RIAS is a professionally acceptable instrument to gain information about neuropsychological functioning, the verbal subtest result should be interpreted very cautiously for visually impaired students when used to guide placement or eligibility decisions.

Mr. [redacted] referred to the following concerns that are listed in his 2009 evaluation: the RIAS verbal subtests do not assess all aspects of cognition; the questions in the GWH subsection of the RIAS are not adapted for blind individuals; the limited number of questions presented in both subsections of the RIAS is cause for concern when assessing a handicapped student who is so different from the national and clinical standardization groups for this test; and the test results may be misleading if used as a screening instrument. In Mr. [redacted]'s professional opinion as a psychologist who has extensive experience testing visually impaired and blind individuals, Dr. [redacted]'s use of the RIAS to form an opinion about cognition raises concern, and Dr. [redacted]'s description of the Appellant's cognitive ability to be "generally within the Low Average Range" requires further analysis with other testing instruments that are more adaptable for use with visually impaired and blind students. Mr. [redacted] recommends that the RIAS should not be used to guide placement or eligibility decisions for blind students.

Mr. [redacted] formed an opinion as to the use of the Wechsler Scales to assess blind individuals testifying that in his experience, problems can arise when the Wechsler Verbal subtests are used with blind and multi-handicapped individuals. Mr. [redacted] testified that the development of "concepts" is one of the most critical learning concerns for blind students; the development of concepts is defined as mental representations, images or ideas of tangible and concrete objects and intangible ideas and feelings. Mr. [redacted] testified that he has known and evaluated many blind students who had wonderful verbal memory strengths but they did not have a well-developed understanding of concepts. It has been his experience that these blind students were not assessed well by the Verbal IQ's calculated from past versions of the Wechsler Intelligence Scale for Children; these past versions tended to emphasize crystallized knowledge and because tactual performance abilities were also not assessed with the Wechsler scales, future adaptive success and level of independence

were not well predicted by the Wechsler scales.

Mr. [redacted] testified that the latest versions of Wechsler Scales, the WISC-IV and WAIS-IV, provide some very useful information, however, Domain and Full Scale IQ's cannot be calculated for blind individuals. Index scores for Verbal Comprehension and for Working Memory can be calculated but these scores are based on a small number of subtests (three for Verbal Comprehension and two for Working Memory). Mr. [redacted] advises caution when using the WISC-IV and the WAIS-IV Index scores for placement and eligibility decisions concerning blind individuals. He states that the use of multiple sources of information is recommended because the information provided by the Wechsler scales does not cover all aspects of cognition and because the Wechsler tends to provide inaccurate verbal scores for the subgroup of students, like the Appellant, who have extraordinary verbal memory strengths.

Mr. [redacted] raised an additional concern about the use of the WAIS-IV testing instrument for blind students stating that it not possible to use the test as instructed in the WAIS-IV manual for individuals who are blind. Mr. [redacted] explained that the usual practice for individuals who are not suspected to have a general intellectual deficiency is to begin at the typical starting point, and if one of the first two Vocabulary or Arithmetic questions is answered incorrectly, the examiner reverses direction and presents the preceding test item. This practice is not possible for blind individuals because the preceding test items uses pictures and no substitute materials or questions are provided. Additionally, the manual states that "examinees suspected of an intellectual disability or general intellectual deficiency should start with item 1"; it is not possible for a blind person who is suspected of an intellectual disability to begin at the first question (item 1) because pictures are used in all the questions preceding the typical start point .

Mr. [redacted] concluded that since it is not possible to start at question 1 with blind individuals suspected of an intellectual disability, the blind student cannot score below a scaled score of 3 for Vocabulary and a scaled score of 4 for Arithmetic. Mr. [redacted] opined that these subtest results are likely to inflate and possible invalidate the test results for blind students who have an intellectual disability. Mr. [redacted] stated that one of the three verbal cognitive subtests, the Information subtest, can be fully presented to blind students; however, this subtest is designed to be primarily a measure of crystallized knowledge and the use of the Information subtest when calculating the VCI can be expected to inflate the scores of the subgroup for blind students who have extraordinary verbal memory strengths. Mr. [redacted] testified that memory strengths do not correlate well with a blind student's problem solving ability or their ability to transfer learned skills to new situations. Mr. [redacted] opined that these considerations reduce the usefulness and accuracy of the Appellant's WAIS-IV scores and argued that the Appellant's WISC-IV and WAIS-IV scores should be compared to other tests of cognition and to his functioning as assessed on an adaptive behaviors scale.

Mr. [redacted] testified that, unfortunately, there are few tests that can be use for assessing the cognitive ability of blind individuals; tests for the blind and visually impaired are scarce. Mr. [redacted] formed an opinion as to the use of the Cognitive Test for the Blind (CTB) testifying that the CTB is useful for providing information about *some* aspects of cognitive and neuropsychological functioning in both verbal and performance areas, but the test developers had difficulty developing a valid CTB subtest for assessing abstract reasoning. An abstract reasoning subtest was not included in the final version of the CTB, and therefore, in Mr. [redacted]'s opinion, the CTB should not be used as the sole measure of intellectual

potential for placement purposes. (DDS Exhibit #9)

Mr. [redacted] formed an opinion as to the use of the Stanford-Binet-IV (SB-IV) verbal subtests with blind students testifying that the older version, the SB-IV, was very helpful to identify discrepancies when compared to the Wechsler scores and served as an indicator that a student's academic, cognitive, and adaptive functioning should be assessed further and monitored closely. However, the newer version, the Stanford-Binet-V is not useful for assessing the intellectual potential of blind students. (DDS Exhibit #9)

Mr. [redacted] formed an opinion as to the use of the Slosson Intelligence Test for Children and Adults-third revision (SIT-R3) testifying that the SIT-R3 provides a measure of general verbal cognitive ability that does not rely heavily on visually loaded test items or test items that must be seen to be used. The SIT-R3 includes six substituted test questions and tactually raised, heavily bolded stimulus items for use with blind or visually impaired individuals (Testimony, DDS Exhibit #9); it assesses the following six cognitive domains:

- General Information
- Similarities and Differences
- Vocabulary
- Comprehension
- Quantitative
- Auditory Memory

Mr. [redacted] testified that he has been using the Slosson Intelligence Test with children and adults since before he began working at [redacted] in 1976, and like the older version of the Stanford-Binet (Stanford-Binet IV), the SIT-R3 Total standard Score (TSS) correlates well with the Wechsler IQ. Mr. [redacted] testified that the Slosson provides useful information when used with the Vineland-II and when compared to the Wechsler score. Mr. [redacted] uses score discrepancies between the SIT-R3 and the Wechsler scale as an indicator that a student's academic, cognitive, and adaptive functioning should be assessed further and monitored closely. It should not be used as the sole source of information for placement and eligibility decisions.

It is Mr. [redacted]'s professional opinion that the Appellant is Mentally Retarded but because of the Appellant's widely scattered abilities and impairments, most aggregate IQ. index and factor scores are not reliable or useful as indicators of the Appellant's potential and ability. (Appellant Exhibit #4 & Testimony Mr. [redacted]) Mr. [redacted] testified that multiple testing results must be assessed to make a determination as to a blind student's cognitive capacity especially for an individual such as the Appellant who also has a congenital brain syndrome, a seizure disorder, and Autism Spectrum Disorder with savant like abilities in rote memory and in music.

- [redacted], Ph. D.

Dr. [redacted] testified that he is a Ph.D. Licensed Clinical Psychologist with extensive experience evaluating and testing mentally retarded individuals who are dually diagnosed with autism disorders or mental health disabilities. He is licensed to practice in the states of [redacted] and Massachusetts. Dr. [redacted] testified that he has over fifteen years of experience as a Clinical Psychologist and has substantial teaching experience having been on the faculty at [redacted] and [redacted] University. He is

involved with some forensic work but is primarily a diagnostician, currently working at [redacted] Massachusetts.

Dr. [redacted] testified that he researched the neurological disorder that the Appellant has been diagnosed with and also reviewed the Appellant's clinical record. The research indicates that the Appellant is absent some parts of the brain that are needed to process information. To determine the extent of the Appellant's disability, Dr. [redacted] assessed the Appellant's current level of functioning both at home and at school using a separate Vineland II Behavior Assessment tool for each. Dr. [redacted] met with the Appellant, and then performed a Vineland II Behavior Assessment using the Appellant's mother as the informant in order to evaluate the Appellant's functioning at home. Dr. [redacted] then performed a second Vineland II assessment, interviewing [redacted] School instructors that work with the Appellant to evaluate the Appellant's functioning at school. Dr. [redacted] testified that the results of the two Vineland II tests show that the Appellant is functioning extremely low, almost three standard deviations below the mean, in all areas.

Dr. [redacted] testified that a Full Scale IQ is difficult if not impossible to obtain for someone like the Appellant. Dr. [redacted] stated that the definition of intelligence basically is how a person can process information and problem solve in a variety of different areas. The definition requires that different areas must be assessed and compiled or combined into an overall IQ score. The problem with assessing the Appellant is that only a portion of his abilities can be assessed and that he has splinter skills; we do not have all the pieces and without all the pieces it is difficult to equate to an IQ score. Dr. [redacted] stated that in the absence of a Full Scale IQ score one must look at adaptive functioning; it is the mechanism to look at the Appellant's problem solving ability through adaptive behavior. Looking at adaptive functioning allows the clinician to make inferences about intelligence.

The results of the Appellant's Vineland II showed deficit in every area. Dr. [redacted] testified that he is familiar with DDS's definition of Mental Retardation, and as a diagnostician it is his opinion that the Appellant meets DDS's criteria for a diagnosis of Mental Retardation. The Appellant has incredible gifts in music and recall but these gifts do not in any way exclude or put in question his classification as a person with Mental Retardation. The Appellant's gifts speak to the way that his brain is uniquely wired and speaks to how hard his mother and father worked to develop those few areas of his brain.

Dr. [redacted] testified that the presence of the Appellant's gifts in music and rote memory do not alter his cognitive profile so as to exclude a diagnosis of Mental Retardation; individuals with savant abilities could meet the Full Scale IQ required for a definition of Mental Retardation. There are some individuals who have these gifts and are Mentally Retarded. Autism Spectrum Disorder and Mental Retardation can and do exist together; they are not mutually exclusive; it is not an either or situation and many autistic individuals have splinter skill gifts.

On Cross exam Dr. [redacted] acknowledged that adaptive function could be affected by other factors such as blindness; however, he added that in assessing the Appellant's abilities, he (Dr. [redacted]) was careful to compare the Appellant's level of ability to other blind individuals of the same age. Dr. [redacted] stated that the Appellant is not able to function as other blind individuals his age function. When asked if it was fair to say that the Appellant's cognitive subtest scores could in fact be used to determine a full picture of the Appellant's cognitive functions, Dr. [redacted] testified that he could not assess the Appellant's overall cognitive

intelligence functioning by looking at some of the cognitive subtests. Dr. [redacted] testified that intelligence has to do with a very broad combination of skills across a broad area of many types of skills. Dr. [redacted] stated that one cannot consider individual subtest scores to determine the Appellant's overall cognitive functioning; one can use individual subtest scores to make an assessment on certain aspects of the Appellant's cognitive functioning but cannot use a subtest score to generalize to overall cognitive intelligence functioning.

- [redacted], Ph.D.

Dr. [redacted] testified that he is a Ph.D. Licensed Clinical Psychologist with expertise in the field of Mental Retardation and a span of experience in Mental Retardation of over forty years that includes working directly for the Massachusetts Department of Mental Retardation in developing programs and systems of community services for individuals with Mental Retardation. Dr. [redacted] has extensive experience as a clinical practitioner primarily as a forensic psychologist but also as a clinical diagnostician, evaluating individuals with special needs. Dr. [redacted] has a professional affiliation with [redacted] School and [redacted] Hospital and currently has a private practice based at [redacted] in [redacted], Massachusetts. (Appellant Exhibit #3)

Dr. [redacted] has researched the Appellant's very rare neurological disorder, reviewed all of the Appellant's clinical reports, reviewed all cognitive and adaptive functioning testing that have been conducted on the Appellant, read a statement written by the Appellant's mother regarding her son's development and history, interviewed the Appellant's mother, the Appellant's father and the Appellant, and has spoken directly with [redacted] staff who work with the Appellant including the following: his English teacher, his case manager, his social worker, and Mr. [redacted].

Dr. [redacted] testified that the Appellant has a very atypical disorder and presents with a very unusual profile as an individual who appears much more competent than he actually is. The Appellant will tell you about all the things that he does but after looking at the Appellant's test results and speaking to his teachers, it becomes clear that he con-fabricates and is not actually doing what he says. The Appellant has very significant global deficits that require constant teaching and guidance and monitoring. Dr. [redacted] testified that the Appellant can memorize but cannot generalize; he cannot take information and use it. The Appellant can "parrot back" information but does not know the "why" answers. Dr. [redacted] opined that the Appellant has received the best possible instruction both at [redacted] and at home by his parents who do remarkably well teaching him. Nonetheless, the Appellant is extremely far behind at school; he is passed along from year to year but is not at all performing near the level of his peers.

Dr. [redacted] testified that in his clinical opinion, the Appellant is clearly a person with Mental Retardation; he is unable to process the instructions that he receives and is unable to make use of information, even information that he is able to "parrot back". The Appellant does have a remarkable skill in music; he can play the piano well because it is a rote learning experience. Dr. [redacted] opined that the Appellant's MRI explains why the Appellant can function in some areas and not at all in other areas; the MRI shows significant damage to areas of the Appellant's brain.

Dr. [redacted] testified that the literature regarding the Appellant's disorder reports a high

incidence of Autism, Mental Retardation and seizures associated with this disorder and the Appellant has all three. Dr. [redacted] testified that he is familiar with DDS's definition of Mental Retardation, and in his clinical opinion the Appellant solidly meets the Department's definition of Mental Retardation. He stated that his opinion is based on the testing material he has reviewed, the Appellant's MRI results, and the interviews of the Appellant, the Appellant's parents, and his teachers. Dr. [redacted] testified that the Appellant's results are typical of a person with Mental Retardation, and the absence of an ability to determine a Full Scale IQ does not change his opinion. Dr. [redacted] testified that the guidelines for a definition of Mental Retardation are just that, guidelines for clinicians. In his clinical opinion, in spite of the fact that the Appellant has areas of brilliance in rote memory and [redacted], he is a person with Mental Retardation. Dr. [redacted] testified that although not common, there are a number of individuals who are Mentally Retarded and who have extraordinary abilities. Dr. [redacted] testified that he is personally aware of one individual who is mentally retarded and who has the ability to memorize dates and can calculate the day of the week of any given date; this person is most definitely mentally retarded and cannot care for any of his needs, but he is brilliant in this one area of rote memory.

On Cross exam, Dr. [redacted] was questioned about his emphatically stated assertion of Mental Retardation, specifically that the Appellant's results are "typical" of a person with Mental Retardation and was asked if it is his experience that people with Mental Retardation typically have such a wide discrepancy in sub test scores. Dr. [redacted] answered yes, that people with brain damage who have Mental Retardation do typically have a wide discrepancy in sub test scores. Dr. [redacted] was asked if he was speaking of people with brain damage or people with both brain damage and Mental Retardation. Dr. [redacted] testified that that where brain damage produces Mental Retardation, a great deal of scatter is present and we see splinter skills with some areas of strength and areas of significant weakness. Dr. [redacted] further elaborated on his use of the word "typical" testifying that he meant to convey that the Appellant exhibits much like all who are mentally retarded when you look past his strengths and tendency to con-fabricate; he is someone who cannot make use of information, who has poor scores with a global disability, who is unable to care for himself and is in need of services.

- Patricia Shook Ph. D.

Dr. Shook testified that she is a Ph.D. Licensed Clinical Psychologist with over twenty years of experience in the field of Mental Retardation who has been employed by DDS's [redacted] Region for approximately four and one-half years as the [redacted] Region Eligibility Psychologist. As the [redacted] Region's Eligibility Psychologist, Dr. Shook is responsible for making all determinations regarding eligibility for children and adults applying for Department services through the [redacted] Region. (DDS Exhibit #1)

As the eligibility psychologist, Dr. Shook reviews all the information that is collected during the application process and makes a decision as to an individual's eligibility for Department services based on the information that has been submitted and the criteria set out in the Department's eligibility regulations. To be eligible for Department services, the individual must be domiciled in Massachusetts and must be a person with Mental Retardation as defined in 115 CMR 2.01 which states that an individual must have "significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning" and that the "Mental Retardation manifest before age 18". (DDS

Exhibits# 2 & #3)

Dr. Shook testified that the Department has defined "significantly sub-average intellectual functioning" as an intelligence test score that is indicated by a score of 70 or below as determined from the findings of assessment using valid and comprehensive, individual measures of intelligence that are administered in standardized formats and interpreted by qualified practitioners. Dr. Shook testified that the regulations have both a cognitive and an adaptive functioning component; to meet the adaptive functioning component of the regulations a person must have "significant limitations in adaptive functioning" existing concurrently and related to the sub-average intellectual functioning. The regulations require that both components must be present to be eligible for Department services.

Dr. Shook testified regarding the difference in her role as the Department's Eligibility Psychologist and the role of a Psychologist in the community who is a diagnostician, explaining that in making a determination of Mental Retardation as the Eligibility Psychologist, she must use the Department's regulations as opposed to the guidelines of DSM IV or other professional agencies such as the American Association of Intellectual Disabilities. A Psychologist working in the community does not have to adhere to the Department's definitions for eligibility; they may use other professionally accepted guidelines in making a diagnosis regarding Mental Retardation.

Dr. Shook testified that the primary factor in her decision that the Appellant was not eligible was based on cognitive scores. Dr. Shook testified that after reviewing the information submitted by the Appellant, she determined that he did not meet the Department's eligibility criteria. Dr. Shook acknowledged that the Appellant's situation is rather unusual in that there is no Full Scale IQ score to consider. Dr. Shook testified that she did review the Appellant's adaptive functioning as there is an adaptive functioning component administered as part of the application process. However, the adaptive functioning results did not play a role in making her decision; if the cognitive component is not met, then the adaptive piece is not part of the decision process.

Dr. Shook testified that there was a good amount of cognitive testing of the Appellant available for analysis and that she found a consistent pattern of enormous variability in all his cognitive testing with results that fell in the range from extremely low to above average; all tests showed significant deficits in comprehension and significant strength in memory. Dr. Shook discussed the concept of "intelligence" stating that definition of intelligence is not always an agreed upon concept in psychology and it has been argued since cognitive testing was first developed in the yearly part of the 20th century. However, the cognitive testing that is currently available is what we have to work with and, at this point in time, the Wechsler and Stanford Binet are considered the best intelligence testing instruments. Dr. Shook stated that the Wechsler Scales are the most frequently used assessment instrument but explained that the Performance section of these cognitive testing instruments cannot be used for individuals who are blind and therefore cannot result in a Full Scale IQ. Dr. Shook acknowledged that it is difficult to find tests that work well for people who are not typical, people who have additional disabilities that interfere with their ability to take the test. However, the concern is usually that people will under perform not over perform due to their additional disabilities.

Dr. Shook testified that there are different theories of intelligence and there are many factors and many issues associated with these theories. Dr. Shook testified that one such theory of intelligence is the concept of G which is a general intelligence factor for the Wechsler tests.

In the concept of G, the results of vocabulary tests are seen as having a large correlation to general intelligence for the general public. With the Appellant, it is necessary to use somewhat different approaches to determine cognition given that a Full Scale IQ is not possible, and given that his Composite IQ scores also show extreme variability in the subtest that make up these scores, his Composite IQ scores are also not valid indicators of cognition. In the Appellant's case, we have to look at the different individual subtests and decide what they represent. The WISC-III conducted at the Appellant age of eight years (Department Exhibit #8) resulted in a Vocabulary subtest score of 6, where 10 is considered average, scores of 8 to 12 fall within the average range, and scores below 5 are significantly below average. Thus a score of 6 is considered to be in the lower range of low-average. Dr. Shook acknowledged that some would argue that the Appellant has the ability to memorize all the words and can give them back due to his memory; however, Dr. Shook opined that such a memory would have to be extraordinary. She also stated that the Vocabulary subtest in addition to measuring word recall also involves some ability to understand word meaning.

Dr. Shook pointed out that the WISC-III conducted at the Appellant's age of eight years (DDS Exhibit #8) while reporting great discrepancy in test results from significantly below average to average for his age, did offer an estimate of Borderline range as an overall score. Dr. Shook testified that she gave somewhat less weight to this test as it represents testing early in the Appellant's development and in general earlier tests are not given the same weight as children can change as they develop.

Dr. Shook reviewed the Cognitive Test for the Blind (CTB) and WISC-IV conducted in [redacted] 2007 at the Appellant's age of fifteen years [redacted] (Appellant Exhibit #4) stating that the same pattern of variation from extremely low scores in Comprehension subtests, to high scores in areas requiring memory. The Appellant's performance in the Vocabulary subtest of the CTB where the Appellant was required to define words resulted in a score that fell in the Low Average Range. This test was described as requiring "word knowledge, long-term memory and expressive language functions". (Appellant Exhibit #4)

Dr. Shook reviewed the Neuropsychological Assessment conducted by Dr. [redacted], Ph.D., in [redacted] 2007 at the Appellant's age of fifteen years [redacted] where a Reynolds Intellectual Assessment System (RIAS) was administered. (Appellant Exhibit #5) Dr. Shook opined that a RIAS was used for this assessment because a WISC had been administered only two months prior and if used again would not produce a valid result. This test resulted in Verbal Scale in the Low Average Range based on his ability to define words and complete verbal analogies. Dr. Shook pointed to Dr. [redacted]'s statement in the Impression section of the report where it states as follows:

> "from a diagnostic perspective, [redacted] demonstrates behaviors similar to children diagnosed with Autism Spectrum Disorder. In some ways, his presentation is atypical; in particular, his acceptance and giving of affection is unusual for most children with autism. However, by and large, [redacted] meets the criteria for this disorder including significantly limited social interaction skills, highly restricted area of interest, repetitive behaviors, early social and language developmental delay is also consistent with Autism Spectrum Disorder. [redacted] does not demonstrate mental retardation as is the case with many individuals with Autism. [redacted]'s cognitive skills are highly variable and many clearly do not fall in the impaired range while others do. In contrast to [redacted]'s cognitive variability with marked strengths and weaknesses, his

independent living skills are quite uniformly impaired."

The Hearing Officer asked Dr. Shook to elaborate on the difference between what is cognitively tested in the administration of Vocabulary subtests and what is cognitively tested in the administration of Verbal Comprehension subtests. Dr. Shook stated that Vocabulary subtests measure word knowledge and word meanings which is different than Verbal Comprehension which has, among other things, a strong social component. Dr. Shook stated that it is her experience that many people with Autism Spectrum Disorder score low on the Verbal Comprehension subtest due to the social aspect of that particular test. However, some people can score high but it does not mean that they would know how to apply that knowledge in terms of adaptive behavior. Dr. Shook testified that one of the problems with cognitive testing is that it does not necessarily test whether or not you can apply the knowledge that you have. Dr. Shook stated that a person may score well on a test like comprehension, but it does not follow that the person will apply that knowledge. In these cases, the person's adaptive test results will not demonstrate that the person has that knowledge.

When asked whether a person could be Mentally Retarded and also exhibit savant abilities, Dr. Shook stated that it was possible but that it is not typical of a person with Mental Retardation.

Dr. Shook elaborated on the Wechsler IQ manual's stated requirements regarding supplemental tests and the manner in which supplemental tests may be used or "substituted" for the core tests when calculating a composite score. Dr. Shook stated that although substitution is allowed, it is expressly disallowed if the sole purpose is to change the original score results. Dr. Shook acknowledged that the substitutions made by Mr. [redacted] with the WAIS IV he administered to the Appellant (Appellant Exhibit #3) were reported to have been made for the purpose of further analysis and understanding of the Appellant's abilities. Dr. Shook stated that while the reason that Mr. [redacted] made substitutions were understandable, they were not acceptable as far as the manual is concerned because, in her opinion, they were made in order to change the original score results.

Dr. Shook testified regarding her opinion of Mr. [redacted]'s assessment that the WAIS IV was problematic for individuals who are blind as indicated by Mr. [redacted] on page three of DDS Exhibit #9; Dr. Shook stated that the WAIS instructional manual accounts for this discrepancy by allowing substitution of other tests and therefore would not be a problem for the Appellant.

Dr. Shook reviewed the results of the WAIS-IV subtests administered in [redacted] 2009 (Appellant Exhibit #6) stating that in her opinion the results indicate an impressive working memory with a Working Memory Index score in the average range which is beyond what is typically found with individuals who have Mental Retardation. She acknowledged significant variability or scatter in the subtest but holds that some of the Verbal subtest indicate an impressive ability. Dr. Shook explained that the Information subtest assesses memory for general information and the Digit Span subtest measures ability to repeat a sequence of numbers. Some people get a good score because they are good at repeating numbers, but, in general, people with mental retardation have difficulty with repeating numbers backwards. Dr. Shook testified that the Appellant's test results indicate an incredible working memory not typical of people with Mental Retardation.

Dr. Shook discussed the Slosson Intelligence Test-R3 (SIT-R3) reported in the Psycho-education Evaluation Addendum conducted by Mr. [redacted] in [redacted] 2009. (DDS Exhibit #9) Dr. Shook testified that there is a problem with finding IQ testing instruments that are applicable to cognitive assessment of blind people. Dr. Shook acknowledged that the Slosson Intelligence Test is used as an intelligence test for people who are blind because it is more easily used with blind individuals but cautioned that it does not hold the same standing as a Wechsler IQ. Dr. Shook acknowledged that the Appellant scored extremely low with a score of 59 which is considered to be in the extremely low range of intelligence. However, Dr. Shook testified that the use of sixty questions to complete this assessment appeared to be an extraordinary large number of questions and, in her opinion, the use of sixty questions suggests a lot of variability in the Appellant's responses.

Dr. Shook stated that all test results should not be negated just because a Full Scale IQ cannot be reliably calculated; in situations like this qualified Psychologists must look at how the tests are constructed and interpret the results. Dr. Shook acknowledged the limitations that exist stating that there certainly are problems with interpreting test results in this case, but we must interpret what we have. Dr. Shook acknowledged that it is especially complex in that Composite scores are not possible and therefore cognitive level is especially difficult to ascertain. In making her determination, Dr. Shook has looked at the results of the Appellant's subtests associated with the G factor and compared these results to what is listed in the WAIS-IV interpretive & technical manual as the level expected of a typical person with mental retardation. The WAIS-IV manual identifies a mean Subtest and Composite Score performance for individuals who have Mild Mental Retardation. Dr. Shook testified that the manual lists the mean subtest score of the Digit Span memory test for a typical person with Mild Mental Retardation to be at 2.8 and the Appellant scored a 9 in this subtest which is atypical of a person with Mental Retardation. The manual lists the mean subtest score of the Letter Number Sequencing test for a typical person with Mild Mental Retardation to be at 3.1 and the Appellant scored a 10 in this subtest which is atypical of a person with Mental Retardation. The manual lists the mean subtest score of the Information subtest for a typical person with Mild Mental Retardation to be at 4.3 and the Appellant scored a 12 in this subtest which is atypical of a person with Mental Retardation. Dr. Shook acknowledged that the Appellant did test within the mean of a mentally retarded person in some of the other subtest areas but stated that when looked at, as a rule, the WAIS manual mean scores are lower than the Appellant's scores.

Attorney Barbara Whitbeck moved to enter two documents into evidence: table 5.21 of the WAIS-VI technical manual which contains the mean statistical data referenced by Dr. Shook, and page 34 of the manual which explains a technical point previously discussed by Dr. Shook. Attorney [redacted] objected to allowing table 5.21 of the manual stating relevance as the basis for her objection. Attorney [redacted] argued that it has already been established that the Appellant is not typical of a person with Mental Retardation because his diagnostic record is unique. Attorney [redacted] argued that this manual is listing statistics for someone who does not fit the Appellant's profile and therefore will not offer any relevant information. Attorney [redacted] argued that there have been three expert witnesses who have testified as to how they have administered the manual and how they have interpreted the testing; this table will not provide relevant information for the hearing officer.

The Hearing Officer ruled that table 5.21 would be accepted into evidence as it is relevant to Dr. Shook's testimony regarding the manner in which Dr. Shook has assessed the Appellant's level of cognition; Attorney [redacted] objection was overruled. Table 5.21 of the WAIS-VI technical manual was marked as DDS Exhibit #12 and page 34 of the manual was

marked as DDS Exhibit #13.

Dr. Shook testified that after hearing all the testimony, her opinion has not changed. Dr. Shook stated that in listening to the expert witnesses who have testified for the Appellant, it seems that they have assessed the Appellant by looking at adaptive functioning along with cognitive test results and have relied strongly on the Appellant's level of adaptive functioning in making their determination of the presence of Mental Retardation. The Department regulations do not allow a determination to be made using that process; Department protocol requires that a determination of the applicant's level of cognition is made first, prior to considering the applicant's level of functioning. This is the case because a deficit in adaptive functioning can be the result of factors other than a cognitive deficit, for example due to a visual impairment. Dr. Shook testified that the Appellant tested strong in some areas and not in others which is not typically seen with a person who has Mental Retardation. Dr. Shook testified that she has not changed her opinion; she continues to hold that the Appellant is not Mentally Retarded as defined by the Departments eligibility regulations.

On cross exam Dr. Shook testified that cognitive test results do not really determine how the person will be able to use their knowledge, stating for example, that a person may be able to test well in comprehension but may not be able to translate that knowledge into action.

Dr. Shook testified that many but not all who have Autism Spectrum Disorder also have Mental Retardation explaining that Autism Spectrum Disorder includes a spectrum of disorders. Dr. Shook testified that spikes in subtest results may or may not be present with Autistic Disorder.

Dr. Shook acknowledged that when the testing instruments are norm for the "typical" person with mental retardation, the norming sample is not broken down into subsections for people like the Appellant who have multiple disabilities; there is no subsection for blind individuals.

Dr. Shook acknowledged that when referring to a "typical" person with Mental Retardation, the reference is not to a person who has both Mental Retardation and Autism Spectrum Disorder. Dr. Shook pointed out that the presence of an additional disability generally does not help a person do better on test; additional disabilities generally do not help overestimate the level of intelligence. When asked if the ability to memorize the dictionary would help a person score better on tests, Dr. Shook stated that she does not see the ability to memorize the dictionary as a disability and that she was referring to the typical person with mental retardation and brain injury.

Dr. Shook was questioned about the rigidity in which she is applying the standards of the WSIA-VI manual. She acknowledged that substitutions made by Mr. [redacted] on the WAIS-IV (described on page six of Appellant Exhibit 6) included substitutions that actually increased the Appellant's score in some areas, and that this fact would appear to indicate that the reasoning behind the substitutions made by Mr. [redacted] was to obtain a better indication of where the Appellant was functioning and not to lower the scores. Dr. Shook also acknowledged that one could not always administer the WAIS-IV in accordance with the manual in every case and that adjustments are necessary in some instances, for example one cannot start at the first questions of the Vocabulary or Arithmetic questions of the WAIS-IV as instructed.

Dr. Shook testified that she has administered approximately 50 to 100 IQ tests over the course of her career but acknowledged that none have been administered to blind individuals. Dr. Shook could not give an estimate as to the number of individuals tested who were also diagnosed with a brain injury but opined that some individuals within the group tested would have also had brain damage.

Dr. Shook was asked to read the from DDS Exhibit #9 page four where it states:

"The Slosson Intelligence Test provides a measure of general verbal cognitive ability that does not rely heavily on visually loaded test items that must be seen to be used. A study in the journal "Exceptional Children" (March of 1970) reported the Slosson's usefulness and noted that the original Slosson could be easily adapted for use with visually impaired children."

Dr. Shook acknowledged that the Slosson Intelligence Test was a test that is better adapted to the visually impaired and a test that is accepted as applicable to testing individuals who are blind. Dr. Shook read from DDS Exhibit #9 where the result of the Appellant's Slosson Intelligence Test is reported as a score of 59 which correlates to a Wechsler IQ equivalent of 62.

Dr. Shook read the definition of Mental Retardation as stated in the Department's regulations and discussed the Department's procedure of determining a level of cognition prior to consideration of the individual's adaptive functioning. Dr. Shook explained that her determination regarding eligibility is approached in this manner because according to the Department's regulations, significant sub average intelligence must exist concurrently and be related to significant limitations in adaptive functioning; people could have significant limitations in adaptive functioning that are totally unrelated to sub average intelligence.

Dr. Shook acknowledged that her decision was made based only on the record, that she had not personally interviewed the Appellant, had not interviewed the Appellant's parents or his teachers, had not observed the Appellant at his home or his school, and had not personally conducted any IQ testing on the Appellant. Dr. Shook testified that although one always would like more information, she felt comfortable in making her determination based on the information she has before her because she was able to see a consistent pattern in the verbal subtest scores that led her to determine that the Appellant's cognition was not at the level required by the Department for eligibility.

On re-direct, Dr. Shook testified that Dr. [redacted] (Appellant Exhibit #5) had not made a diagnosis of Mental Retardation but did make a diagnosis of Autism Spectrum Disorder. Autism Spectrum Disorder includes several disorders including Autistic Disorder however a specific diagnosis of Autistic Disorder was not made by Dr. [redacted].

Dr. Shook testified that although she had not personally administered IQ testing to individuals who are blind, she does understand all the assessment that were administered to the Appellant.

Dr. Shook testified that the DDS Eligibility Psychologists do not conduct interviews of applicants or the applicant's family as part of the DDS eligibility process and that in accordance with this protocol, she did not interview the Appellant or his family prior to making her determination regarding eligibility. All her decisions are made by reviewing the

material submitted and the information that is obtained as part of the eligibility process.

FINDING OF FACTS:

The following facts, which are the basis for conclusions made in this case, emerged from a review of the documents entered into evidence and the testimony presented by witnesses.

- The following assessments are in evidence:

Exhibit	Age	Date	Assessments Administered
DDS #8	8 years, [redacted]	[redacted] 2000	WISC-III Verbal Scale WPPSI-R Verbal Scale McCarthy Verbal Subtest Reynell-Zinkin Scales Oregon Project Skill Inventory Blind Learning Aptitude
APP. #4	15 years, [redacted]	[redacted] 2007	WISC-IV- Comprehension subtests CTB- Cognitive Test for the Blind Vineland II- Subtests
APP. #5	15years, [redacted]	[redacted] 2007	RIAS TLC CELF-4 CMS CVLT-C D-KEFS
APP. #6	17years, [redacted]	[redacted] 2009	WAIS-IV- Subtests Vineland-II - Subtests
DDS #9	18years, [redacted]	[redacted] 2009	Slosson Intell Test-R3 Vineland-II- Subtests
APP. # 8	18 years, [redacted]	[redacted] 2010	Vineland-II Adaptive Behavioral Scales
APP. #9	18 years, [redacted]	[redacted] 2010	Vineland-II Adaptive Behavioral Scales

- The Appellant was born in [redacted], moved to Massachusetts when he was approximately two years old, and continues to be domiciled in Massachusetts. (Testimony, Ms. [redacted])

- The Appellant was born totally blind due to Septo-Optic Dysplasia (SOD). This rare condition involves congenital malformations within the brain including underdevelopment of the optic nerves, and absence of the Septum Pellucidum, a structure of the mid-brain. (Appellant Exhibit #7)

- The Appellant has attended [redacted] as a day student since age two, beginning in their pre-school program. He continued his education at [redacted] and is currently enrolled in their secondary program. (Testimony, Ms. [redacted])

- [redacted], founded in [redacted], has an international reputation with a stated mission of providing education and services that build productive, meaningful lives for children and adults who are blind, deafblind, or visually impaired with or without other disabilities. [2]

- The Appellant has a seizure disorder. His first grand mal seizure occurred at approximately age 14. Different trials of anti-seizure medications were administered until one was found that reduced the severity and frequency of the Appellant's seizures but also allow him to adequately function at home and at school. (Testimony, Ms. [redacted])

- An MRI of the Appellant brain revealed further brain malformation. The Appellant was found to have Polymicrogyria (PMG), Transmantle Heterotopias, the presence of mild to moderate enlargement of cerebral ventricles, and mild to moderate diminished white matter. As a result of this new information, the Appellant's diagnosis was revised from SOD to SOD, Polymicrogyria, and Transmantle Heterotopias, and was classified as an SOD Plus Syndrome; SOD Plus is a very rare syndrome. (Appellant Exhibit #7)

- The condition of Heterotopias is the result of a "groups of brain cells that, during development, migrated to the wrong area of the brain", and the condition of Polymicrogyria (PMG) is the presence of "numerous small, or too few, brain folds". [3]

- The Appellant's PMG was identified in the left hemisphere area of his brain; the area responsible for speech processing. (DDS Exhibit #9)

- The Appellant's Transmantle Heterotopia was indentified at two locations where gray matter connects to the ventricles and where there is supposed to be white matter in between. These anomalies have occurred in the areas of the Appellant's brain that involve abstract thinking and emotions. (DDS Exhibit #9)

- The Appellant learned both English and [redacted] simultaneously; he reportedly has conversational ability in both English and [redacted]. (Appellant Exhibit #4 and Testimony, Ms. [redacted])

- It is not possible to obtain a Full Scale IQ on Wechsler Intelligence Assessment tools or a General Ability Index score for individuals who are totally blind; blind individuals cannot attempt the visual performance subtests that are needed to determine these scores. (Appellant Exhibit #6)

- Although it is not possible to obtain a Full Scale IQ on Wechsler Intelligence Assessment tests for individuals who are blind, it is possible to administer some subtests and to determine a Verbal Comprehension Index (VCI) and a Working Memory Index

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[2] [redacted] website

[3] The Information page of the National Institute of Neurological Disorders and Stroke (NINDS), National Institutes of Health, US Department of Health and Human Services, re: Disorders.

(WMI) on individuals who are blind. A VCI score is meant to indicate an individual's level of general ability to comprehend and reason with auditorilly presented verbal material; the WMI is meant to indicate an individual's ability to hold and manipulate auditorilly presented verbal information in working memory.

- The presence of significant variability (scatter) in subtest scores does not allow a reliable determination of WMI or VCI Index Scores. The Appellant has consistently exhibited a pattern of significant variability in subtest scores, testing significantly below average in areas requiring reasoning and average to above average in areas requiring rote memory. (Testimony, Dr. [redacted], Dr. [redacted], & Dr. Shook, Mr. [redacted])

- At age six, an assessment conducted by Dr. [redacted], Licensed Psychologist, indicated that the Appellant's cognitive and developmental skills were found to cluster in the 3-4 year level, with a range from below 2 ½ years to above 4-5 years. Some isolated skills in auditory memory were at the 5 ½ year level. (DDS Exhibit #8)

- A WISC-III conducted by [redacted], Ph.D., Licensed Psychologist, at the Appellant's age of 8 years, [redacted] showed wide scatter on subtest from significantly below average to above average on one sub-test of auditory memory. (DDS Exhibit #8)

- Both the results of a WISC-III and a WPPSI-R conducted by [redacted], Ph.D., Licensed Psychologist, at the Appellant's age of 8 years, [redacted], indicated significant weakness on the comprehension subtests which assess practical knowledge, social judgment and verbal comprehension. The Appellant reportedly had particular difficulty in answering "why" questions and his overall cognitive developmental skill level was determined to be three years behind his peers. (DDS Exhibit #8)

- At age fourteen, the Appellant reportedly exhibited good fine motor skills but difficulty with higher level motor planning that required attention and organization. His overall language skills were described as "significantly reduced"; although he demonstrated a strong auditory memory, he had problems synthesizing information and had problems with tasks that involved abstract reasoning. The Appellant also reportedly was functioning only at the 3rd grade equivalent level in Listening Comprehension even though his Braille spelling and word recognition skills were excellent. Similarly the Appellant's arithmetic grade equivalent was within the 3rd grade level. (Appellant Exhibit #4)

- At age fifteen, the Appellant's Braille teacher reported that the Appellant could frequently repeat the definition of a word but then did not show good understanding of the meaning of the word or how to use it appropriately. The Appellant's math teacher reported that the Appellant had basic math concept deficits and that several [redacted] staff noted that the Appellant had difficulty learning tactual activities and needed to practice steps in context. (Appellant Exhibit #4)

- All Psychologists testifying as experts in the area of Mental Retardation have stated that Index Scores are invalid when extreme variation in subtest results are present because the Index scores do not represent a valid indicator of the individual's abilities. (Appellant Exhibit #4, Testimony Dr. Shook, Dr. [redacted], Dr. [redacted]t, & Mr. [redacted])

- The results of subsections of a Verbal Comprehension Index (VCI) and a Working Memory Index (WMI) from a WISC-IV reportedly administered by Ms. [redacted] in [redacted] 2006, at the Appellant's approximate age of fifteen years, are reported to have shown extreme subtest differences. Nonetheless, Ms. [redacted] reported Index scores, listing the VCI as falling in the Borderline to Low Average range and the WMI as falling in the Low Average to Average range. (Appellant Exhibit #4)

- The Appellant has been described as having savant attributes with an excellent memory for some limited types of information and a gifted musical talent [redacted] (Appellant Exhibit #4 and Testimony, Ms. [redacted])

- The Purpose of Dr. [redacted]'s neuropsychological assessment conducted on the Appellant at the [redacted] Hospital in [redacted] and [redacted] 2007 was to assist in planning interventions for control of the Appellant recent onset of seizures. (Appellant Exhibit #5)

- Dr. [redacted]'s assessment was comprised of several testing instruments; the Reynolds Intellectual Assessment System (RIAS) was used as the cognitive evaluation instrument in Dr. [redacted]'s Neuropsychological Assessment. (Appellant Exhibit #5)

- Dr. [redacted] stated that the psychological assessment tools used in her assessment were not specific for individuals with blindness and indicated that the evaluation may provide a minimum estimate of his functional capacity. (Appellant Exhibit #5)

- Dr. [redacted] could not use a WISC because a WISC had been administered only two months prior and if used again would not produce a valid result. (Testimony Dr. Shook)

- A Reynolds Intellectual Assessment System (RIAS) is a professionally acceptable instrument to gain information about neuropsychological functioning. (Appellant Exhibit #5 and DDS Exhibit #9)

- Dr. [redacted] notes variable performance throughout her report and states that the results should be interpreted with caution. (Appellant Exhibit #5)

- Dr. [redacted] reports a substantial variability of cognitive skills, cautions the reader regarding interpretation of the results and refers the reader to the Appellant's previous recent and "very thorough" cognitive evaluation conducted by Mr. [redacted] at [redacted] for an additional understanding of the Appellant's cognitive ability. (Appellant Exhibit #5)

- Dr. [redacted] opines that the Appellant does not demonstrate Mental Retardation due to the high variability in cognitive skills but that his presentation is consistent with symptoms associated with Autism Spectrum Disorder. (Appellant Exhibit #5)

- Dr. [redacted] ends her report with a recommendation for a referral to the Massachusetts Department of Mental Retardation stating that the Appellant is likely to qualify for services based on his limited activities of daily living as well as his diagnosis with Autism Spectrum Disorder. (Appellant Exhibit #5)

- Mr. [redacted] conducted a Psychoeducational Evaluation in [redacted] 2009 at the Appellant's age of 17 years, [redacted] using two sections of the WAIS-IV and two sections of the Vineland-II Adaptive Behavior Scales. The evaluation was conducted as part of the school's ongoing assessment of the Appellant's abilities and progress. (Appellant Exhibit #6)

- Mr. [redacted] reported significant scatter in subtest scores, reporting that the variance between the WMI and VCI represents a significant difference at the .05 level of significance. Nonetheless Mr. [redacted] did calculate a Verbal Comprehension Index (VCI) and Working Memory Index (WMI). Using the national age norms, the Appellant's Verbal Comprehension Index score (VCI) was extremely low but the Working Memory Index score (WMI) was average . (Appellant Exhibit #6)

- The test results of the Psychoeducational Evaluation of [redacted] 2009 were lower by 13 points in the VCI and by 16 points for the WMI when compared to the 2006 results. Mr. [redacted] opined that these scaled-score decreases suggest that the Appellant's cognitive abilities are not progressing at the same rate as those of other students his age and may have "plateaued". (Appellant Exhibit #6)

- A Vineland-II was conducted by Mr. [redacted] as part of the Appellant's Psychoeducational Evaluation in [redacted] 2009. The Appellant's adaptive functioning results from the Vineland-II domains tested were very low, reported to be within the 1st percentile and almost three standard deviations below the mean. Mr. [redacted] reported that this score is much lower than is expected for a visually impaired student; the Appellant's scores reflect the presence of severe impairment. (Appellant Exhibit #6)

- The Vineland II manual indicates that the mean Adaptive Behavior Composite for visually impaired individuals is almost one standard deviation below the national norms. The difference in test results represents expected functional deficits a blind individual will experience due to the difficulty in learning and handling personal care and domestic chores. Thus a score of almost one standard deviation below the national norm represents the expected difference in Adaptive Behavior Composite test results due to the inherent functional deficits associated with the typical blind person. (Appellant Exhibit #6)

- A Slosson Intelligence Test-R3 (SIT-R3) was conducted in [redacted] 2009, at the Appellant's age of 18 years, [redacted] as an Addendum to the Psychoeducational Evaluation conducted in 2009. (DDS Exhibit #9)

- The Slosson Intelligence Test for Children and Adults-third revision (SIT-R3) provides a measure of general verbal cognitive ability that does not rely heavily on visually loaded test items or test items that must be seen to be used. (DDS Exhibit #9 & Testimony Mr. [redacted])

- The SIT-R3 has been cited in a study reported in the [redacted] 1970 journal "Exceptional Children" for its value as a measure of general verbal cognitive ability that does not rely heavily on visually loaded test items that must be seen to be used. The SIT-R3 was noted for its usefulness and because the Slosson could be easily adapted for use with visually

impaired children. (Testimony Mr. [redacted] & DDS Exhibit #9)

- Mr. [redacted] has been using the Slosson Intelligence Test with children and adults at the [redacted] School [redacted] since 1976, and uses this test because the SIT-R3 Total Standard Score (TSS) correlates well with the Wechsler IQ. (Testimony Mr. [redacted] & DDS Exhibit #9)

- It is Mr. [redacted]'s stated opinion that the Slosson Intelligence Test provides useful information when used with the Vineland-II and when compared to a Wechsler score. (Testimony Mr. [redacted] & DDS Exhibit #9)

- The SIT-R3 conducted on the Appellant by Mr. [redacted] in [redacted] 2009 resulted in a Total Standard Score (TSS) of 59 with a 95% confidence interval of the TSS falling between 52 and 66; a TSS of 59 is equivalent to a Wechsler IQ of 62. (Testimony Mr. [redacted] & DDS Exhibit #9)

- A SIT-R3 of 59 and its Wechsler IQ equivalent of 62, fall at the 1 Percentile, within the Mild range of Mental Retardation, and with a Mean Age Equivalent of 11.0 years. (Testimony Mr. [redacted] & DDS Exhibit #9)

- A Vineland-II Adaptive Behavior Scales was also conducted as part of the [redacted] 2009 Addendum. The Vineland-II results fell in the Low Level of overall adaptive behavior with an Adaptive Behavior Composite score of 58; an Adaptive Behavior Composite score of 58 is within the 1st percentile, more exactly, within the first three-tenths of the first percentile, and represents adaptive functioning over 2.5 standard deviations below the mean. This Composite Score is significantly lower than expected for a visually impaired student. (DDS Exhibit #9)

- The Appellant was evaluated by Dr. [redacted], MD. PhD for the Comprehensive Brain Malformation Program in [redacted] 2009. The Neurology Clinic Note written as a result of that evaluation confirms the diagnosis SOD, Polymicrogyria, and Transmantle Heterotopias, which is classified as a SOD plus syndrome. (Appellant Exhibit #7)

- A Vineland-II Adaptive Behavioral Scales assessment was conducted in [redacted] 2010 by Dr. [redacted] using the Appellant's mother, Ms. [redacted], as the respondent. This testing resulted in an Adaptive Behavior Composite Score of 57, a range that falls within the 1st percentile, in the Low level of adaptive functioning. (Appellant Exhibit #8)

- A Vineland-II Adaptive Behavioral Scales assessment was conducted in [redacted] 2010 by Dr. [redacted] using Staff from [redacted] who worked closely with the Appellant as the respondents. This testing also resulted in an Adaptive Behavior Composite Score of 57, a range that falls within the 1st percentile, in the Low level of adaptive functioning. (Appellant Exhibit #9)

- The Appellant's 2009 IEP documented that the Appellant has difficulty with abstract language comprehension, integration and generalizations of information, and spatial skills, and that these difficulties affect the Appellant's progress across all curriculum

areas. (DDS Exhibit #10)

- The Appellant's 2009 IEP documents that: the Appellant is a Braille reader and uses a Braille'n Speak note-taker and a computer with JAWS access software; he is reading at the 4th to 6th grade level; he is completing vocabulary comprehension questions at the 5th to 6th grade level; and he appropriately uses complete sentences with basic capitalization and punctuation. (DDS Exhibit #10)

- The Appellant's 2009 IEP also documents that the Appellant is progressing in his musical ability, and that he is steadily progressing in his computer and history classes. (DDS Exhibit #10)

- The Appellant testified at his Fair Hearing. He did not appear to understand the question asked of him when sworn in to testify under oath; he had to be prompted to answer "I do". (Appellant's Testimony)

- The Appellant was able to list some items that must be placed in the refrigerator. However, he did not know why they need to be placed in the refrigerator. (Appellant's Testimony)

- The Appellant was not able to answer the question "Where does food come from?" (Appellant's Testimony)

- The Appellant was able to list out the medications that he took daily. (Appellant's Testimony)

- The Appellant began playing the piano at age four, [redacted]. (Appellant's Testimony)

- The Appellant reads Braille and reads music using Braille. (Appellant's Testimony)

- The Appellant was asked to leave a [redacted] due to his cognitive limitations; he was not able to follow the directions that other blind children could and as a result required one to one attention that was beyond what was typically necessary for a blind child. (Ms. [redacted]'s Testimony)

- The Appellant's parent's moved from [redacted] so that their son could receive the expert instruction available at [redacted] in an attempt to help him develop to his fullest potential. (Ms. [redacted]'s Testimony)

- The Appellant exceptional ability with rote memory and with music became apparent at an early age. (Ms. [redacted]'s Testimony)

- The following four expert witnesses testified at the Fair Hearing: [redacted], Certified School Psychologist (Appellant Exhibit #1); Dr. [redacted], Licensed Clinical Psychologist (Appellant Exhibit #2); Dr. [redacted], Licensed Forensic Psychologist (Appellant Exhibit #3); and Dr. Patricia Shook, DDS's Licensed Psychologist (DDS Exhibit #1). Both the Department and the Appellant stipulated as to the credentials of all four witness to testify as experts in the field of Mental Retardation.

- Mr. [redacted] is a master's level Licensed Educational Psychologist, Nationally Certified as a School Psychologist for all levels. He has been at [redacted] as a School Psychologist for approximately thirty-four years, has worked with the Appellant for several years, and has tested the Appellant on multiple occasions over that period of time. (Mr. [redacted]'s Testimony & Appellant Exhibit #1)

- Mr. [redacted]'s has worked with blind individuals who do not have other disabilities and with blind individuals who do have multiple disabilities. (Mr. [redacted] Testimony)

- The Appellant is very different from the national and clinical standardization groups used for IQ tests; and the test results may be misleading if used as a screening instrument. (Testimony Mr. [redacted] & DDS Exhibit #9)

- The development of "concepts" is one of the most critical learning concerns for blind students; the development of concepts is defined as mental representations, images or ideas of tangible and concrete objects and intangible ideas and feelings. (Testimony Mr. [redacted])

- It is Mr. [redacted]'s stated opinion that the verbal subtests in the older version of the Stanford-Binet-IV (SB-IV), were very helpful with blind students to identify discrepancies when compared to the Wechsler scores but that the newer version, the Stanford-Binet-V is not useful for assessing the intellectual potential of blind students. (Testimony Mr. [redacted] & DDS Exhibit #9)

- Mr. [redacted] has known and evaluated many blind students who had wonderful verbal memory strengths but they did not have a well-developed understanding of concepts. It has been his experience that these blind students were not assessed well by the Verbal IQ's calculated from past versions of the Wechsler Intelligence Scale for Children; these past versions tended to emphasize crystallized knowledge and because tactual performance abilities were also not assessed with the Wechsler scales, future adaptive success and level of independence were not well predicted by the Wechsler scales. (Testimony Mr. [redacted] & DDS Exhibit #9)

- It is Mr. [redacted] reported observation that, in his experience, problems can arise when the Wechsler Verbal subtests are used with blind and multi-handicapped individuals. The past versions of Wechsler tests tended to emphasize crystallized knowledge and because tactual performance abilities were also not assessed with the Wechsler scales, future adaptive success and level of independence were not well predicted by the Wechsler scales. (Testimony Mr. [redacted] & DDS Exhibit #9)

- It is Mr. [redacted]'s stated opinion that one must be cautious when using the WISC-IV and the WAIS-IV Index scores for placement and eligibility decisions concerning blind individuals; he recommends the use of multiple sources of information. The Index scores for Verbal Comprehension and for Working Memory are based on a small number of subtests (three for Verbal Comprehension and two for Working Memory). It is Mr. [redacted]'s opinion that the Wechsler tends to provide inaccurate verbal scores for the subgroup of students, like the Appellant, who have extraordinary verbal memory strengths. (Testimony Mr. [redacted] & DDS Exhibit #9)

- Mr. [redacted] raised an additional concern about the use of the WAIS-IV testing instrument for blind students stating that it not possible to use the test as instructed in the WAIS-IV manual for individuals who are blind. Mr. [redacted] explained that the usual practice for individuals who are not suspected to have a general intellectual deficiency is to begin at the typical starting point, and if one of the first two Vocabulary or Arithmetic questions is answered incorrectly, the examiner reverses direction and presents the preceding test item. This practice is not possible for blind individuals because the preceding test items uses pictures and no substitute materials or questions are provided. Additionally, the manual states that "examinees suspected of an intellectual disability or general intellectual deficiency should start with item 1"; it is not possible for a blind person who is suspected of an intellectual disability to begin at the first question (item 1) because pictures are used in all the questions preceding the typical start point . (Testimony Mr. [redacted] & DDS Exhibit #9)

- Dr. Shook testified that WAIS-IV technical and instructional manual explains how to accommodate and properly adjust for a situation where a cognitively impaired blind person cannot begin at the first question because pictures are used in all the questions preceding the typical start point. (Testimony Dr. Shook & DDS Exhibit #13)

- Mr. [redacted] raised concern about a possible inflated score for individuals who are blind when the WAIS-IV testing instrument is used stating that one of the three verbal cognitive subtests, the Information subtest, can be fully presented to blind students, but this subtest is designed to be primarily a measure of crystallized knowledge. Therefore the use of the Information subtest when calculating the VCI can be expected to inflate the scores of the subgroup for blind students who have extraordinary verbal memory strengths. (Testimony Mr. [redacted] & DDS Exhibit #9)

- It is Mr. [redacted]'s experience that a blind student's memory strengths do not correlate well with a blind student's problem solving ability or their ability to transfer learned skills to new situations. (Testimony Mr. [redacted] & DDS Exhibit #9)

- Mr. [redacted] opined that the usefulness and accuracy of the Appellant's WAIS-IV scores is reduced due to the Appellant's unique combinations of disabilities and argues that the Appellant's WISC-IV and WAIS-IV scores should be compared to other tests of cognition and to his functioning as assessed on an adaptive behaviors scale when making a determination regarding the presence of Mental Retardation. (Testimony Mr. [redacted] & DDS Exhibit #9)

- It is Mr. [redacted]'s professional opinion that the Appellant is Mentally Retarded but because of the Appellant's widely scattered abilities and impairments, most aggregate IQ index and factor scores are not reliable or useful as indicators of the Appellant's potential

and ability. It is Mr. [redacted]'s opinion that multiple testing results must be assessed to make a determination as to a blind student's cognitive capacity especially for an individual such as the Appellant who also has a congenital brain syndrome, a seizure disorder, and Autism Spectrum Disorder with savant like abilities in rote memory and in music. It is Mr. [redacted]'s opinion that no test should be the sole source of information for placement and eligibility decisions for the Appellant. (DDS Exhibit #9, Appellant Exhibit #4 & Testimony Mr. [redacted])

- Mr. [redacted] used cognitive score results along with adaptive functioning score results and his direct professional knowledge of the Appellant to determine his opinion that the Appellant was a person with Mental Retardation. (Testimony Mr. [redacted])

- Dr. [redacted] is a Ph.D. Licensed Clinical Psychologist with extensive experience evaluating and testing mentally retarded individuals who are dually diagnosed with autism disorders or mental health disabilities. He is licensed to practice in the states of [redacted] and Massachusetts. (Testimony Dr[redacted] & Appellant Exhibit #2)

- Dr. [redacted] has over fifteen years of experience as a Clinical Psychologist and has been on the faculty at [redacted] and [redacted] University. He is currently working at [redacted] in [redacted], Massachusetts. (Testimony Dr. [redacted] & Appellant Exhibit #2)

- Dr. [redacted] researched the neurological disorder that the Appellant has been diagnosed with and also reviewed the Appellant's clinical record. The research indicates that the Appellant is absent some parts of the brain that are needed to process information. (Testimony Dr. [redacted])

- Dr. [redacted] assessed the Appellant's current level of functioning both at home and at school using the Vineland II Behavior Assessment. The Vineland II assessments indicated deficits in every area of functioning and that the Appellant is functioning extremely low, almost three standard deviations below the mean, in all areas. (Dr. [redacted] Testimony & Appellant Exhibits #8 & #9).

- It is Dr. [redacted]'s opinion that a Full Scale IQ is difficult if not impossible to obtain for someone like the Appellant. Dr. [redacted] stated that the definition of intelligence basically is how a person can process information and problem solve in a variety of different areas. The definition requires that different areas must be assessed and compiled or combined into an overall IQ score. The problem with assessing the Appellant is that only a portion of his abilities can be assessed and that he has splinter skills which makes it difficult to determine an IQ score. Dr. [redacted] stated that in the absence of a Full Scale IQ score the mechanism to look at the Appellant's problem solving ability is through adaptive behavior. Looking at adaptive functioning allows the clinician to make inferences about intelligence. (Dr. [redacted] Testimony)

- It is Dr. [redacted]'s opinion that the Appellant's incredible gifts in music and recall are due to the way that his brain is uniquely wired and speaks to how hard his mother and father worked to develop those few areas of his brain. (Dr. [redacted] Testimony)

- It is Dr. [redacted]'s stated opinion that the presence of the Appellant's gifts in music and rote memory do not alter his cognitive profile so as to exclude a diagnosis of Mental

Retardation; individuals with savant abilities could meet the Full Scale IQ required for a definition of Mental Retardation. There are some individuals who have these gifts and are Mentally Retarded. (Dr. [redacted] Testimony)

- All psychologists testifying at the hearing stated that Autism Spectrum Disorder and Mental Retardation can and do exist together; they are not mutually exclusive; it is not an either or situation. (Testimony Dr. Shook, Dr. [redacted], Dr. [redacted] & Mr. [redacted])

- Many autistic individuals have splinter skill gifts. (Testimony Dr. [redacted] & Dr. [redacted])

- Dr. [redacted] testified that he is familiar with DDS's definition of Mental Retardation, and as a diagnostician it is his opinion that the Appellant meets DDS's criteria for a diagnosis of Mental Retardation. (Dr. Long Testimony)

- Dr. [redacted] used cognitive score results along with adaptive functioning score results to determine his opinion that the Appellant was a person with Mental Retardation. (Dr. [redacted] Testimony)

- It is Dr. [redacted]'s stated opinion that that he could not assess the Appellant's overall cognitive intelligence functioning by just looking at some of the cognitive subtest results. Dr. [redacted] testified that intelligence has to do with a very broad combination of skills across a broad area of many types of skills. Dr. [redacted] stated that one cannot consider individual subtest scores to determine the Appellant's overall cognitive functioning; one can use individual subtest scores to make an assessment on certain aspects of the Appellant's cognitive functioning but cannot use a subtest score to generalize to overall cognitive intelligence functioning. (Dr. [redacted] Testimony)

- Dr. [redacted] is a Ph.D. Licensed Clinical Psychologist with over forty years experience in the field of Mental Retardation including the development of programs and systems of community services for individuals with Mental Retardation. Dr. [redacted] is primarily a forensic psychologist but also a clinical diagnostician evaluating individuals with special needs. Dr. [redacted] has a professional affiliation with [redacted] School and [redacted] Hospital and currently has a private practice based at [redacted], in [redacted], Massachusetts. (Dr. [redacted] Testimony & Appellant Exhibit #3)

- Dr. [redacted] researched the Appellant's very rare neurological disorder, reviewed all of the Appellant's clinical reports, reviewed all cognitive and adaptive functioning testing that have been conducted on the Appellant, read a statement written by the Appellant's mother regarding her son's development and history, interviewed the Appellant's mother, the Appellant's father and the Appellant, and spoke directly with [redacted] staff who work with the Appellant including the following prior to making an opinion regarding the Appellant's level of intelligence. (Testimony Dr. [redacted])

- The Appellant has a very atypical disorder and presents with a very unusual profile as an individual who appears much more competent than he actually is. (Testimony Dr. [redacted])

- The Appellant con-fabricates and does not do many of the things that he said he does. The Appellant has very significant global deficits that require constant teaching and guidance and monitoring. The Appellant can memorize but cannot generalize; he cannot take information and use it. The Appellant can "parrot back" information but does not know the "why" answers. (Testimony Dr. [redacted])

- It is Dr. [redacted]'s opinion that the Appellant has received the best possible instruction both at [redacted] and at home by his parents. Nonetheless, the Appellant is extremely far behind at school; he is passed along from year to year but is not at all performing near the level of his peers. (Testimony Dr. [redacted])

- It is Dr. [redacted]'s clinical opinion, that the Appellant is a person with Mental Retardation; he is unable to process the instructions that he receives and is unable to make use of information, even information that he is able to "parrot back". It is Dr. [redacted]'s opinion that the Appellant can play the piano well because it is a rote learning experience. (Testimony Dr. [redacted])

- It is Dr. [redacted]'s opinion that the Appellant's MRI explains why the Appellant can function in some areas and not at all in other areas; the MRI shows significant damage to areas of the Appellant's brain.

- The literature regarding the Appellant's disorder reports a high incidence of Autism, Mental Retardation and seizures associated with this disorder and the Appellant has all three. (Testimony Dr. [redacted])

- Dr. [redacted] stated that he is familiar with DDS's definition of Mental Retardation, and in his clinical opinion the Appellant meets the Department's definition of Mental Retardation. He stated that his opinion is based on the testing material he has reviewed including the adaptive functioning test results, the Appellant's MRI results, and the interviews of the Appellant, the Appellant's parents, and his teachers. Dr. [redacted] stated that the absence of an ability to determine a Full Scale IQ does not change his opinion. (Testimony Dr. [redacted])

- It is Dr [redacted]'s clinical opinion that, in spite of the fact that the Appellant has areas of brilliance in rote memory and music, he is a person with Mental Retardation. Dr. [redacted] stated that although not common, there are a number of individuals who are Mentally Retarded and who have extraordinary abilities and he is personally familiar with once such case. (Testimony Dr. [redacted])

- The Appellant's profile as a person with a wide discrepancy in sub test scores is typically found with individuals with brain damage who have Mental Retardation. Where brain damage produces Mental Retardation, a great deal of scatter is present and splinter skills are seen with some areas of strength and areas of significant weakness. (Testimony Dr. [redacted])

- Dr. Shook is a Ph.D. Licensed Clinical Psychologist with over twenty years of experience in the field of Mental Retardation who has been employed by DDS's [redacted] Region for approximately four and one-half years as the [redacted] Region Eligibility Psychologist. As the [redacted] Region's Eligibility Psychologist, Dr. Shook is

responsible for making all determinations regarding eligibility for children and adults applying for Department services through the [redacted] Region. (Dr. Shook Testimony & DDS Exhibit #1)

- As the eligibility psychologist, Dr. Shook reviews all the information that is collected during the application process and makes a decision as to an individual's eligibility for Department services based on the information that has been submitted and the criteria set out in the Department's eligibility regulations. (Dr. Shook Testimony)

- DDS eligibility regulations have both a cognitive and an adaptive functioning component; to meet the adaptive functioning component of the regulations a person must have "significant limitations in adaptive functioning" existing concurrently and related to the sub-average intellectual functioning. The regulations require that both components must be present to be eligible for Department services. (DDS Exhibit #2 & #3)

- Dr. Shook's responsibility in making a determination about Mental Retardation as the Department's Eligibility Psychologist differs from the role of a Psychologist in the community who is making a determination about Mental Retardation. In making a determination of Mental Retardation as the Eligibility Psychologist, Dr. Shook must use the Department's regulations as opposed to the guidelines of DSM IV or other professional agencies such as the American Association of Intellectual Disabilities. A Psychologist working in the community as a diagnostician does not have to adhere to the Department's definitions for eligibility; they may use other professionally accepted guidelines in making a diagnosis regarding Mental Retardation. (Testimony Dr. Shook)

- The primary factor in Dr. Shook's decision that the Appellant was not eligible was based on cognitive scores. Adaptive functioning results did not play a role in Dr. Shook's decision. (Testimony Dr. Shook)

- Department protocol requires that a determination of the applicant's level of cognition is made first, prior to considering the applicant's level of functioning. This is the case because a deficit in adaptive functioning can be the result of factors other than a cognitive deficit, for example due to a visual impairment. (Testimony Dr. Shook)

- Dr. Shook found a consistent pattern of enormous variability in all of the Appellant's cognitive test results with results that fell in the range from extremely low to above average; all tests showed significant deficits in comprehension and significant strength in memory. (Testimony Dr. Shook)

- The concept of "intelligence" is difficult to define; the definition of intelligence is not always an agreed upon concept in psychology and it has been argued since cognitive testing was first developed in the yearly part of the 20th century. (Testimony Dr. Shook)

- The Wechsler and Stanford Binet are considered the best intelligence testing instruments by the psychology profession. Although the Wechsler Scales are the most frequently used assessment instrument, the Performance section of these cognitive testing instruments cannot be used for individuals who are blind and therefore cannot result in a Full Scale IQ. (Testimony Dr. Shook)

- The Weschler IQ manual's stated requirements regarding supplemental tests expressly disallows "substitutions" if the sole purpose is to change the original score results. (Testimony Dr. Shook)

- The substitutions made by Mr. [redacted] with the WAIS IV he administered to the Appellant (Appellant Exhibit #3) while made for the purpose of further analysis and understanding of the Appellant's abilities, are not technically acceptable. (Testimony Dr. Shook)

- The WAIS instructional manual accounts for the problem that arises when a person with a visual disability cannot start at the first question in some tests where the question requires sight. (Testimony Dr. Shook)

- It is difficult to find tests that work well for people who are not typical, people who have additional disabilities that interfere with their ability to take the test. However, the concern is usually that people will under perform not over perform due to their additional disabilities. (Testimony Dr. Shook)

- When a Full Scale IQ is not possible, and when Composite IQ scores are invalid due to extreme variability in the subtest scores, it is necessary to look at the different individual subtests and decide what they represent. (Testimony Dr. Shook)

- Dr. Shook used a concept of intelligence utilized in evaluating Wechsler test results known as a "general intelligence factor" (G factor) in making a determination regarding the Appellant's level of intelligence. In the concept of G, the results of vocabulary tests are seen as having a large correlation to general intelligence for the general public. (Testimony Dr. Shook)

- Dr. Shook acknowledged that some would argue that the Appellant has the ability to memorize all the words and can give them back due to his memory. It is Dr. Shook's opinion that such a memory would have to be extraordinary. (Testimony Dr. Shook)

- The Cognitive Test for the Blind (CTB) and WISC-IV conducted in [redacted] 2007 (Appellant Exhibit #4) show a pattern of variation from extremely low scores in Comprehension subtests, to high scores in areas requiring memory. The Appellant's performance in the Vocabulary subtest of the CTB where the Appellant was required to define words resulted in a score that fell in the Low Average Range. This test was described as requiring "word knowledge, long-term memory and expressive language functions". (Appellant Exhibit #4, page #5)

- The results of the WAIS-IV subtests administered in [redacted] 2009 (Appellant Exhibit #6) indicate an impressive working memory with a Working Memory Index score in the average range which is beyond what is typically found with individuals who have Mental Retardation. (Testimony Dr. Shook)

- Information subtest assesses memory for general information and the Digit Span subtest measures ability to repeat a sequence of numbers. Some people get a good score because they are good at repeating numbers, but, in general, people with mental retardation have difficulty with repeating numbers backwards. The Appellant's test

results indicate an incredible working memory not typical of people with Mental Retardation. (Testimony Dr. Shook)

- Dr. Shook acknowledged that the Slosson Intelligence Test is used as an intelligence test for people who are blind because it is more easily used with blind individuals but cautioned that it does not hold the same standing as a Wechsler IQ. (Testimony Dr. Shook)

- Dr. Shook acknowledged that the Appellant scored extremely low with a score of 59 which is considered to be in the extremely low range of intelligence. However, Dr. Shook testified that the use of sixty questions to complete this assessment appeared to be an extraordinary large number of questions and, in her opinion, the use of sixty questions suggests a lot of variability in the Appellant's responses. (Testimony Dr. Shook)

- Many but not all who have Autism Spectrum Disorder also have Mental Retardation. Autism Spectrum Disorder includes a spectrum of disorders. Spikes in subtest results may or may not be present with Autistic Disorder. (Testimony Dr. Shook)

- When IQ testing instruments are norm for the "typical" person with mental retardation, the norming sample is not broken down into subsections for people like the Appellant who have multiple disabilities; there is no subsection for blind individuals. (Testimony Dr. Shook)

- Dr. Shook acknowledged that when referring to a "typical" person with Mental Retardation, the reference is not to a person who has both Mental Retardation and Autism Spectrum Disorder. (Testimony Dr. Shook)

- Dr. Shook formed her opinion regarding the Appellant's level of intelligence based in part on the statement made by Dr. [redacted] in Dr. [redacted]'s Neuropsychological Assessment, where Dr. [redacted] stated that the Appellant did not demonstrate Mental Retardation and that his cognitive skills are highly variable with many not falling in the impaired range while others do. (Testimony Dr. Shook & Appellant Exhibit #5)

- Dr. Shook formed her opinion regarding the Appellant's level of intelligence based on the concept of G and the presence of average to above average subtest scores in some cognitive tests results in evidence. (Testimony Dr. Shook)

- In making her determination, Dr. Shook has looked at the results of the Appellant's subtests associated with the G factor and compared these results to what is listed in the WAIS-IV interpretive & technical manual as the level expected of a typical person with mental retardation. The WAIS-IV manual identifies a mean Subtest and Composite Score performance for individuals who have Mild Mental Retardation. (Testimony Dr. Shook)

- Dr. Shook testified that the Appellant did test within the mean of a mentally retarded person in some of the other subtest areas but stated that when looked at, as a rule, the WAIS manual mean scores are lower than the Appellant's higher scores. The manual lists the mean subtest score of the Digit Span memory test for a typical person with Mild

Mental Retardation to be at 2.8 and the Appellant scored a 9 in this subtest which is atypical of a person with Mental Retardation. The manual lists the mean subtest score of the Letter Number Sequencing test for a typical person with Mild Mental Retardation to be at 3.1 and the Appellant scored a 10 in this subtest which is atypical of a person with Mental Retardation. The manual lists the mean subtest score of the Information subtest for a typical person with Mild Mental Retardation to be at 4.3 and the Appellant scored a 12 in this subtest which is atypical of a person with Mental Retardation. (Testimony Dr. Shook)

- Dr. Shook stated that in listening to the three expert witnesses who have testified for the Appellant, it seems that they have assessed the Appellant by looking at adaptive functioning along with cognitive test results and have relied strongly on the Appellant's level of adaptive functioning in making their determination of the presence of Mental Retardation. The Department regulations do not allow a determination to be made using that process. (Testimony Dr. Shook)

- The department regulations require that Mental Retardation exists concurrently and is related to significant limitation in adaptive functioning. Since a deficit in adaptive functioning can be the result of factors other than a cognitive deficit, for example due to a visual impairment, the Department requires that Mental Retardation is established prior to a consideration of the level of adaptive function. (Testimony Dr. Shook)

- Dr. Shook testified that after hearing all the testimony, her opinion has not changed; she continues to hold that the Appellant is not Mentally Retarded as defined by the Department's eligibility regulations. (Testimony Dr. Shook)

RECOMMENDED DECISION:

After a thorough review of all of the evidence, I find that the Appellant has shown by a preponderance of the evidence that he meets the DDS eligibility criteria. I find that the weight of the evidence shows that the Appellant does meet the Department's definition of Mental Retardation and therefore is mentally retarded as that term is used in statute and regulation for the determination of DDS supports as defined in 115 CMR 2.01. My reasons are as follows:

REGULATORY REQUIREMENTS:

Massachusetts General Law c. 123B, section 1, defines a mentally retarded person as "a person who, as a result of inadequately developed or impaired intelligence, as determined by clinical authorities as described in the regulations of the department, is substantially limited in his ability to learn or adapt, as judged by established standards available for the evaluation of a person's ability to function in the community." In accordance with statutory and regulatory authority, the Department has promulgated regulations both defining Mental Retardation (DDS Exhibit #3) and setting regulatory standards by which an individual may be determined eligible for DDS services (DDS Exhibit #2).

In order to be eligible for DDS supports, an individual who is 18 year of age or older must

meet the criteria for general eligibility requirements set forth at 115 CMR 6.04 & the definitions set forth at 115 CMR 2.01 as follows:

The General Eligibility requirements for services from the Department of Developmental Services (DDS) are found in 115 CMR 6.04 where it states the following:

> "persons who are 18 years of age or older are eligible for supports provided, purchased, or arranged by the Department if the person:
>
> a) Is domiciled in the Commonwealth; and
> b) Is a person with Mental Retardation as defined in 115 CMR 2.01"

The Department's definition of "Mental Retardation" found in 115 CMR 2.01 with its incorporated definition of "significantly sub-average intellectual functioning" and "significant limitations in adaptive functioning" is stated as follows:

> "Mental retardation means significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning. Mental retardation manifests before age 18."

The Department's definition of "significantly sub-average intellectual functioning" found in 115 CMR 2.01 is stated as follows:

> "...an intelligence test score that is indicated by a score of 70 or below as determined from the findings of assessment using valid and comprehensive, individual measures of intelligence that are administered in standardized formats and interpreted by qualified practitioners."

And, the Department's definition of "significant limitation in adaptive functioning" found in 115 CMR 2.01 requires a test score of 70 to meet the requirement of two standard deviations below the mean or a test score of 77 to meet the requirement 1.5 standard deviations below the mean, and is stated as follows:

> "...an overall composite adaptive functioning limitation that is two standard deviations below the mean or adaptive functioning limitations in two out of three domains at 1.5 standard deviations below the mean of the appropriate norming sample determined from the findings of assessment using a comprehensive, standardized measure of adaptive behavior, interpreted by a qualified practitioner. The domains of adaptive functioning that are assessed shall be
>
> a) areas of independent living/practical skills;
> b) cognitive, communication, and academic/conceptual skills; and
> c) social competence/social skills."

HEARING OFFICER CONCLUSIONS:

- The Appellant has met the domicile requirement for eligibility. The issue in question is whether the Appellant has met his burden of proving by a preponderance of the evidence that he is a person with Mental Retardation as that term us used and defined by the Department of Developmental Services.

- The Appellant's MRI results confirm brain anomalies with sections of the Appellant's brain reported to be insufficient as compared to what is present in a typically developed

brain. In addition, the instructors at [redacted] have reported that even with the expert specialized instruction offered to accommodate blind individuals at [redacted], the Appellant has not kept up with the level of achievement expected of other same aged peers who are also blind. Thus, the evidence and testimony support a finding that some level of cognitive impairment is present and that this impairment began during the Appellant's developmental period. The issue before us is the extent of the cognitive impairment and whether the Appellant's cognitive impairment is at the level that would be determined to be two standard deviations below the mean in accordance with the Department's definition of Mental Retardation.

- A diagnosis of Mental Retardation can only be determined by qualified psychologists using valid and comprehensive IQ tests that are administered properly in accordance with professional standards. The evidence shows that all IQ tests in evidence have been conducted by qualified psychologist using valid and comprehensive tests which were administered in accordance with professional standards.

- The Department's attorney and the Appellant's attorneys stipulated to the credentials of all four psychologists who testified at the Fair Hearing. Therefore all testimony given by Dr. Patricia Shook, Mr. [redacted], Dr. [redacted], and Dr. [redacted] was considered as testimony given by psychologists who meet the qualifications necessary to determine a diagnosis of Mental Retardation.

- The Appellant presents a very unique set of circumstances whereby although multiple IQ tests have been administered over the course of the Appellant's developing years, a valid Full Scale IQ score can not been established due in part to the limited cognitive testing instruments that are available for individuals who are blind, but in the Appellant's case, primarily due to the extreme variability in his test score results. The typically mentally retarded individual does not exhibit the extent of variability present in the Appellant's test results. However, the Appellant's status as having a very atypical combination of disabilities is undisputed. Appellant is totally blind and carries a diagnosis of Autism Spectrum Disorder and a congenital brain disorder, SOD Plus Syndrome with PMG and Transmantle Heterotopias. Dr. [redacted] testified that people with brain damage who have Mental Retardation do typically have a wide discrepancy in sub test scores. Therefore, given the Appellant's unique diagnostic record, no consideration has been given to the fact that the Appellant's test results are extremely variable and not typically seen with mentally retarded individuals.

- The Appellant has been diagnosed with Autism Spectrum Disorder with savant abilities in rote memory and music that are associated with his Autism Spectrum Disorder. It appears that the Appellant's savant ability in rote memory skews the test results in some sections of IQ tests because the results are meant to indicate an understanding of the subject matter and not simply a parroting back of facts. The evidence indicates that although the Appellant is able to repeat some facts through rote memory, he clearly is not able to understand what he is reporting. The Appellant's testimony at the Fair Hearing confirmed the fact that while the Appellant can repeat some facts, he could not answer the why questions regarding any of those facts. The question now to be considered is whether the Appellant's savant ability in rote memory and the resulting high score results in some subtests that require and measure memory are factors that are contrary to a definition of Mental Retardation and would be reasons, in and of themselves, to eliminate a possible diagnosis of Mental Retardation.

Dr. [redacted] testified that over the course of his professional career, he has personal knowledge of mentally retarded individuals who also have savant abilities and stated that the presence of savant abilities does not disqualify or exclude a diagnosis of Mental Retardation. Dr. [redacted] concurred with this position also stating that the presence of savant abilities does not disqualify or exclude a diagnosis of Mental Retardation. When Dr. Shook was asked if savant abilities could be present in a person who is mentally retarded, Dr. Shook did not rule out the possibility, stating only that "it was not typical" of a person with Mental Retardation. As a result, the fact that the Appellant has savant ability in rote memory and music and the fact that he scored higher in some subtest areas that are associated with his savant ability were not considered as factors that would exclude, in and of itself, a possible diagnosis of Mental Retardation.

- Dr. Shook's testimony with regard to the Department's eligibility regulations was given the most weight among all the psychologists who have testified in this matter as Dr. Shook's current duties at the [redacted] Region make her the most qualified expert in the area of the Department's eligibility requirements.

  Dr. Shook has testified that in accordance with Department regulation the Appellant's adaptive functioning test results are not considered until it has been determined that the Appellant meets the Department's cognitive deficit requirement of two standard deviations below the mean. Department eligibility regulations require that Mental Retardation exists concurrently and is related to significant limitations in adaptive functioning. The Department has interpreted their regulation to mean that the first requirement for eligibility is a diagnosis of Mental Retardation and a second requirement is significant limitations in adaptive functioning related to the Mental Retardation. The regulations of administrative agencies are presumptively valid and entitled to deference. [4]

  The Department points out that a significant limitation in adaptive functioning cannot be related to Mental Retardation if Mental Retardation does not exist. Thus the second requirement of significant limitations in adaptive functioning is not looked at by the Department when making a determination of eligibility until it has been established that Mental Retardation is present. This is the Department's practice since significant limitations in adaptive functioning can be the result of conditions other than Mental Retardation. Significant limitations in adaptive functioning can be caused by mental illness, significant psychological problems, and, or, other medical problems such as blindness that impede upon an individuals ability to function. Thus a finding of significant limitation in adaptive functioning is not, in and of itself, justification for a diagnosis of Mental Retardation; it is considered only after an individual as been determined to meet the cognitive requirement within the definition of Mental Retardation.

  As a result, the evidence and testimony given by Mr. [redacted], Dr. [redacted] and Dr. [redacted] regarding the Appellant's adaptive functioning and, in particular, their professional opinion that that the Appellant is a person with Mental Retardation which is, to a large extent, based on the Appellant's level of adaptive functioning, could not be considered until, and if, it had been determined that the Appellant's cognitive abilities fell at or below two standard deviations below the mean.

[4] Molly A. v. commissioner of the Department of Mental Retardation, 69 Mass App Ct 267, 867 NE ed 350 (2007)

- The assertion that the concept of the General Intelligence Factor (G factor) is the most applicable to analyzing the Appellant's cognitive abilities was seen as less viable due to the particular circumstances of this case. In the concept of General Intelligence Factor, the results of vocabulary tests are seen as having a large correlation to general intelligence. Some vocabulary tests are very influenced by the individual's memory ability. Dr. Shook has indicated that she does not feel that the Appellant's ability to memorize would be at a level that would impact test results, but acknowledged that some would argue that point. Given that possibility, I find that the use of the General Intelligence Factor to be less persuasive in making a possible determination regarding cognitive ability in this particular case; therefore less weight was given to the conclusions drawn as a result of this type of analysis.

- Little weight was given to Neuropsychologist, Dr. [redacted]'s suggestion in the "Impressions" section of her 2007 report that presumes the Appellant does not demonstrate Mental Retardation due to the high variability in cognitive skills but rather that the Appellant's presentation is consistent with symptoms associate with Autism Spectrum Disorder. The reason for Dr. [redacted]'s 2007 Neuropsychological Assessment was the recent onset of the Appellant's seizures; a referral from the Division of Epilepsy was submitted to Dr. [redacted] to generate recommendations for clinical management of his seizures. In multiple sections throughout her report, Dr. [redacted] instructs the reader to refer to Mr. [redacted]s psycho-educational evaluation "for a more detailed assessment of the Appellant's intellectual functioning" which infers that Dr. [redacted]'s cognitive impressions are not reviewed as thoroughly as the most recent cognitive testing conducted by Mr. [redacted].

  Dr. [redacted] clearly states that the reason for her declaration that the Appellant "does not demonstrate Mental Retardation" is due to his "high variability in skills" which she presents as more consistent with a diagnosis of Autism Spectrum Disorder. We have heard expert testimony that individuals with Mental Retardation can also have Autism Spectrum Disorder; it is not an either or diagnosis. We have also heard expert testimony that variability in test results is typical of a mentally retarded person who has brain damage, as is the case with the Appellant.

  Additionally, Dr. [redacted]'s qualifies the results of her report advising that that the results should be interpreted with caution as the assessments she used are intended for individuals who are not blind. Given these facts, Dr. [redacted]s statement was interpreted as a presumption made without the level of research and analysis necessary to give it weight in making my recommended decision.

- Mr. [redacted]'s testimony with regard to the IQ testing instruments that can be effectively used for totally blind individuals was given the most weight among all the psychologists who have testified in this matter as Mr. [redacted]'s thirty-four years of experience as the psychologist at [redacted] makes him the most qualified expert in the area of IQ testing for blind individuals with multiple deficits. Mr. [redacted]'s testimony as well as the written document (DDS Exhibit #9) analyzing the effectiveness of the various cognitive testing instruments that have been used to assess the Appellant, offered insight into the limitations of these cognitive testing instruments when administered to individuals who are blind and specifically as to how the testing instrument results could be impacted by the Appellant's unique set of disabilities. Significant weight was given to Mr. [redacted]'s statements regarding the

need to proceed cautiously when making a determination about a blind person like the Appellant who is so very different from the national and clinical standardization groups.

- The unique combination of the Appellant's multiple disorders makes it very difficult to determine whether he possesses a level of cognition that is two standard deviations below the mean which is required to meet the Department's definition of "significantly sub-average intellectual functioning". The Appellant's atypical set of circumstances limits the reliability of most all aggregate scores, and subtest scores that involve rote memory can misrepresent the Appellant's cognitive abilities. There exists, however, one testing instrument, the Slosson Intelligence Test for Children and Adults, third Revision (SIT-R3), that is successfully used with Blind individuals and reportedly does correlate well with the highly regarded Wechsler IQ testing instruments.

  Mr. [redacted] testified that the SIT-R3 has been used at [redacted] for many years because it correlates well with the Wechsler IQ and because it provides a measure of general verbal cognitive ability that does not rely heavily on visually loaded test items or test items that must be seen to be used, which is an important aspect for visually impaired individuals. The Appellant was tested in [redacted] 2009 using the SIT-R3 (DDS Exhibit #9) and received a Total Standard Score (TSS) of 59 which is equivalent to a Wechsler IQ of 62. Given that this testing instrument has been used at [redacted] for many years and has been acknowledged for its usefulness by the psychology profession, it was considered as a reliable testing instrument for the blind individuals and one that can be correlated to a Full Scale IQ of the highly regarded Wechsler IQ tests. While it is not a typically used cognitive testing instrument to determine the presence of Mental Retardation for the general public, it has been accepted by the professional community and used at [redacted] as a valid tool for the above specified reasons and therefore was given weight in my decision as to its use in making a correlation to the highly regarded Wechsler IQ test assessments.

  Since the Appellant's TSS score of 59 is equivalent to a Wechsler IQ of 62, I find that the Appellant, more likely than not, is a person with a cognitive level of two standard deviations below the mean.

- The question now before us is whether the Appellant's level of adaptive functioning meets the Department's definition of significant limitation in adaptive functioning, and if so, whether the Appellant's significant limitation in adaptive functioning is a result of the Appellant's significantly sub-average intellectual functioning and <u>not</u> due to his vision impairment.

  The Appellant has been tested for adaptive functioning using the Vineland II. The Vineland II is a valid and comprehensive test recognized by the psychology profession as meeting the professional standards necessary to determine a level of adaptive functioning. The Appellant's Vineland II test results place the Appellant at the 1st percentile, almost three standard deviations below the mean, reflecting the presence of a severe impairment.

  The Vineland II manual speaks to the expected functional deficit that a blind person will experience due to the difficulty in learning and handling personal care and domestic chores, indicating that the mean Adaptive Behavior Composite for visually impaired

individuals is almost one standard deviation below the national norms. Thus a score of almost one standard deviation below the national norm represents the expected difference in Adaptive Behavior Composite test results due to the inherent functional deficits associated with a typical blind person. The Appellant's Adaptive Behavior Composite is significantly below the level expected of a typical blind person who is not mentally retarded.

In order to meet the Department's eligibility requirements, an individual must exhibit adaptive functioning limitations at a level of 2 standard deviations below the mean or adaptive functioning limitations in two out of three domains at 1.5 standard deviations below the mean. The evidence presented shows that the Appellant has more than met the Department's adaptive functioning requirements and that his adaptive deficits are well beyond what is reported for blind individuals who are not mentally retarded. The Appellant is therefore found to be a person with significant limitation in adaptive functioning as required by Department regulations.

- In summary, upon a comprehensive review of expert witness testimony and all documentary evidence submitted in this matter, I find that the preponderance of the evidence indicates that the Appellant, more likely than not, does meet the Departments definition of Mental Retardation. The Appellant's MRI confirms the presence of brain anomalies that cause significant cognitive deficits which have been demonstrated by the results of cognitive testing and further substantiated by the Appellant's responses to questions at the hearing. The psychologists, all of whom have been accepted as experts in the field of mental retardation, testified that Autism Spectrum Disorder and Mental Retardation are not mutually exclusive and, more specifically, that the presence of savant abilities associated with Autism Spectrum Disorder does not disqualify or prevent a possible diagnosis of Mental Retardation. Although the Appellant's visual impairment and his extreme variability in subtest results that are caused by his savant ability in rote memory have made it extremely difficult to determine a valid level of overall intelligence, the results of the SIT-R3 allow a correlation to the highly regarded Wechsler IQ tests. This correlation indicates a level of cognition that meets the Department's eligibility requirement of two standard deviations below the mean. An analysis of the Appellant's adaptive function shows significant deficits, well beyond the level that the experts have statistically attributed to be the result of blindness and well beyond the adaptive functioning deficit requirement set out in the Department's eligibility regulations. I find that the Appellant has met the burden of proof in this matter and that the evidence supports a finding that the Appellant's diagnostic profile indicates a diagnosis of Mental Retardation that meets the eligibility requirements set out in Department regulations. Therefore, the Department's determination of ineligibility is overturned.

APPEAL:

Any person aggrieved by a final decision of the Department may appeal to the Superior Court in accordance with M.G.L.c.30A [115CMR 6.34(5)]

Date:_____

Jeanne Adamo
Hearing Officer