DISABILITY LAW CENTER INVESTIGATION REPORT
Crowell Kindergarten Center, Haverhill, Massachusetts
February 1, 2018

I. Introduction

The Disability Law Center (“DLC”) is a private, non-profit organization mandated by Congress and designated by the Governor of Massachusetts as the protection and advocacy (“P&A”) system of Massachusetts. The federal P&A statutes specifically authorize P&A agencies, such as DLC, to investigate incidents of abuse or neglect of individuals with disabilities when the agency receives a complaint or determines that there is probable cause – that is, reasonable grounds to believe that individuals have been, or may be subject to abuse or neglect.¹

From January 26, 2017 to February 17, 2017, DLC received three complaints to the system² regarding the treatment of children with disabilities enrolled in Crowell Kindergarten Center (“Crowell”) in Haverhill, Massachusetts. Crowell is located within Haverhill Public Schools (“Haverhill”) and served 150 students with and without disabilities during the 2016-2017 school year.³ According to records provided by Haverhill, 29 of the 150 students were students with disabilities.⁴

DLC interviewed the three complainants and reviewed the records of two students. On April 26, 2017, DLC determined there was probable cause that students with disabilities have been, or may be, subject to abuse and neglect at Crowell.⁵ As a result of both the complaints and the probable cause finding, DLC exercised its P&A authority to fully investigate abuse and neglect at Crowell.⁶ On May 18, 2017, DLC sent Haverhill Attorney Catherine Lyons and Superintendent James F. Scully notice of our intent to investigate. After a comprehensive investigation with the cooperation of Haverhill, DLC found students with disabilities at Crowell were subjected to abuse, neglect and improper practices. Corrective measures are necessary to prevent further harm to students with disabilities.

II. Background

DLC begin its investigation with a Crowell site visit on June 8, 2017. This included an interview with Crowell’s principal in the presence of Haverhill’s counsel. During the visit, DLC also conducted an extensive tour of the building, including all classrooms and “safe rooms.” DLC staff returned to Crowell on June 20, 2017, informally observed the school day and interviewed two staff members (a general education teacher and Crowell’s speech therapist). The school’s only special education teacher declined our request for an interview.

As part of this investigation, DLC also requested extensive records from the District. Specifically: (1) training materials utilized to train any Crowell staff member on restraints and seclusion during the 2016-2017 school year; (2) the names, state-issued educator licenses and restraint certification documentation⁷ for each of the Crowell staff members trained and certified
during the 2016-2017 school year; and, (3) any and all incident and/or injury reports filed with regard to Crowell staff member student-inflicted injury during the 2016-2017 school year.

Haverhill provided a Safety Care™ training manual to DLC, but failed to provide the remainder of the requested documents, despite repeated follow-up.

DLC also interviewed 20 parents of students with disabilities enrolled in Crowell during the 2016-2017 school year. Additionally, DLC reviewed student records for 7 students with disabilities (with parental consent). For these 7 students, DLC requested special education records as well as attendance records, nursing records, report cards, conduct records and correspondence between Crowell staff and parents. Crowell provided all of the requested student records, except for correspondence between Crowell staff and parents. No correspondence (e.g. e-mails) between parents and Crowell staff were provided despite multiple requests.

DLC must reasonably infer that Haverhill’s failure to provide certain records was because those records contained negative information. Nonetheless, even without these records, DLC substantiated abuse and neglect at Crowell.

III. Legal Authority

DLC, as the designated Protection and Advocacy System for Massachusetts, is authorized under the PAIDD statute “to investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported . . . or if there is probable cause to believe that the incidents occurred.” 42 USC § 15043(a)(2)(b). Similarly, DLC is equivalently authorized under the PAIMI statute for individuals with mental illness. 42 U.S.C. § 10805(a)(1)(A). As noted above, this investigation was commenced based upon multiple “complaints to the system” and a probable cause finding. Although a complaint to the system and a finding of probable cause constitute independent alternative bases for commencement of an investigation, in order to seek and secure various records in the P&A investigation, DLC made a finding of probable cause. P&A systems are the “final arbitrators” of a probable cause determination and P&A access cannot be denied because the subject of the investigation disagrees with the finding.


The PADD and PAMII regulations define the terms “neglect” and “abuse” in almost the identical language. The PADD regulations define “abuse” as:

any act or failure to act which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with developmental disabilities, and includes but is not limited to such acts as: Verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations, or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.
45 C.F.R. § 1326.19. (The equivalent definition of “abuse” in the PAIMI regulations is found at 42 C.F.R. § 51.2).

The PADD regulations define “neglect” as:

a negligent act or omission by an individual responsible for providing services, supports or other assistance which caused or may have caused injury or death to an individual with a developmental disability(ies) or which placed an individual with developmental disability(ies) at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with developmental disabilities; or provide a safe environment which also includes failure to maintain adequate numbers of trained staff or failure to take appropriate steps to prevent self–abuse, harassment, or assault by a peer.

45 C.F.R. § 1326.19. (The equivalent definition of “neglect” under PAIMI is found at 42 C.F.R. § 51.2).

IV. Factual Findings

A. Abuse Findings

1. The failure of Crowell staff to comply with state regulations regarding the use of bodily restraints with kindergarteners with disabilities constituted abuse.

Haverhill staff over-utilized restraint with at least one five-year old student and failed to report restraints with several other students. Under Massachusetts regulations, a restraint is defined as when a school staff member physically uses force with a student to prevent or restrict a student’s freedom of movement. See 603 C.M.R. § 46.02. Restraints may only be utilized as a matter of last resort to prevent imminent, serious physical harm after less intrusive behavioral interventions have failed (or are deemed inappropriate under the circumstances). 603 C.M.R. § 46.03(1)(c). Restraints must be “administered in such a way so as to prevent or minimize physical harm.” 603 C.M.R. § 46.05(5)(b). After a restraint, schools must notify parents orally within 24 hours and in writing within three days. 603 C.M.R. § 46.06(3). School staff must also review each restraint and patterns of restraints in order to develop appropriate, less intrusive interventions. See 603 C.M.R. § 46.06(4)-(6).

Of the seven student files reviewed, only one student’s contained any formal restraint or behavioral incident reports. This young student was restrained 22 times in a three month period during the 2016–2017 school year. Crowell staff restrained the student when she was engaging in common, but physically threatening behaviors towards peers and staff (e.g. kicking, hitting, or biting) related to her disability. While this may be considered imminent, serious harm, Crowell did not always attempt less intrusive behavioral interventions prior to utilizing restraints. For example, one day the five-year old student with a trauma history and a mental health disability
was agitated and hid under a table. Staff attempted to remove her, which caused the escalation in behaviors (attempting to bite/kick staff trying to remove her). Crowell did not attempt to leave her under the table or disengage with her. The staff’s engagement caused the escalation in behaviors. Simply disengaging would likely have stopped the physical altercation. Instead of attempting disengagement, staff removed the small girl forcibly and placed her in a restraint. While under the table, she was not an imminent, serious physical risk to herself or others. Staff failed to adequately attempt interventions short of restraint. In fact, often, staff intervention led to the unsafe behaviors. Throughout the 22 restraint reports, it is apparent that Crowell staff often failed to attempt, as mandated, all reasonable de-escalation techniques prior to engaging with restraint.

Moreover, the restrained child’s parent reported that she came home with adult size handprints (red marks and bruising) on her small body from these restraints, calling into question whether they were administered in a way to prevent harm. The parent also reported she was not always notified of the restraint within 24 hours and often did not receive a written report until more than a week later. Crowell did not establish any formal review process for each restraint, nor conduct a review of the child’s pattern of restraints in order to ensure safety procedures were followed and less restrictive interventions were tried in the future. Instead, the student was repeatedly restrained for the similar behavioral patterns month after month.

Reports from parents and student records reveal that other students were restrained at Crowell, but these restraints went unreported. Three parents (not including the parent of the child described above) reported students returning home with adult handprints (red marks or bruises). One parent reported that school officials notified her that her child was physically removed from the bus by school staff. Another parent reported that the bus driver informed her that two Crowell staff members physically carried her child onto the bus at dismissal. In nurse records for the same student, the nurse reported that an “adult needed to carry her up the stairs” after the child was playing on the stairs unsafely. None of these incidents were formally reported as restraints, despite the use of force by school staff to restrict student movement.

2. The Crowell staff’s frequent use of illegal time-out as a disciplinary tool, a practice which is likely to cause immediate physical or psychological harm, constituted abuse.

In Massachusetts “time-out” is legally defined as temporarily separating a student from the learning activity or classroom for the purposes of calming. In order for time-out to be compliant with state regulations: (1) it must be used for calming, not punishment (2) the student must be continuously observed by a staff member, (3) the space must be appropriate for calming, and, (4) the time-out must end when the student is calm. 603 C.M.R. § 46.02.

Crowell has converted two cubby closets (one on the first floor and one on the second floor) into time-out areas (called “safe rooms” in student records and “quiet rooms” by the Principal). During DLC’s site visit in June 2017, DLC observed that the time-out rooms had no doors and were partially covered on three walls by mats. The rooms were filled with bean bags and sensory
toys. A large (three fold) mat rested on the second floor near the time-out room. The rooms seemed appropriate for the purposes of calming; however, reports of how these rooms were used raised concern.

Two parents reported witnessing Crowell staff holding a large mat over the entrance to the closet (about the size of a door) to contain a hysterical child. One parent was called to the school at dismissal because her daughter refused to get on the bus. When the parent arrived, her approximately forty pound daughter with disabilities was being held in the downstairs cubby closet by a Crowell staff member with a giant mat. The parent noted her daughter was screaming, crying and trying desperately to escape the small room. The parent noted there was no way the child could remove herself from the room (mat covering door and being physically held against door by adult) and the intervention in no way was calming her daughter down. In fact, the holding of the mat over the door appeared to be escalating her daughter’s behavior.

Another parent reported that she picked her son up every day at dismissal. One day, she arrived to pick up her son and the Principal was holding a large mat over the first floor time-out room door. The parent noted a small child was screaming hysterically for the Principal to let him out and kicking and punching the mat. The Principal held the mat, so the child could not remove himself from the room at all. The parent noted she was in the school for about ten minutes and the scene continued the entire time. The child was not calmed by the behavioral intervention, yet it continued.

Both the Principal and a Crowell teacher do not deny that mats were used in the time-out rooms. However, they both indicated the mat was held up in order to protect the adult’s body from the child and never to contain a child in a room. Both the Principal and the teacher described this technique as “blocking,” and insisted a child could get around the mat to leave the room. That assertion is odds with the parent observations and the size of the mat in the hall. If Crowell staff needed a mat to block the student’s tiny hits and kicks from landing on the much larger adult’s body, one panel of the three panel mat would suffice. Instead, the mat was large enough to cover the entire door opening. Based on parent reports, the mats were used to both block the adult’s body and keep the child contained.

Four other parents reported that their children were regularly sent or “taken” by a paraprofessional to the “safe room” or “quiet room” for disruptive, but common disability-related classroom behavior (e.g. crying, running around, hitting, kicking, spitting other students/staff). Two parents reported school officials on more than one occasion told them their respective children had spent the “majority of the day” or a “half day” in these time-out rooms. All four parents reported that their respective children were frequently removed from the classroom and sent to these time-out rooms. The Principal and a teacher stated that students are sent to the time-out areas to calm down and generally are not there for more than 15 minutes. The Principal acknowledged that sometimes, even when students were calm in the time-out rooms, they were not immediately returned to class. At times, she noted the paraprofessional
would work with the student one-on-one in the time-out room, or the child would be allowed to nap in the room before going back to class.

The parent account and student records indicate that Crowell staff (usually a paraprofessional) observed and remained available to a student in the time-out area at all times. However, holding a mat against a door frame to contain a hysterical five-year-old child in a small room, seems objectively counter to the purpose of calming. Moreover, removing a child to a time-out area for disciplinary purposes is strictly prohibited. Yet, from parent reports and student records, the time-out areas were often used to separate students for misbehavior from the classroom – sometimes for an extended period of the school day. Additionally, time-out where a student is physically prevented from leaving is a practice that is likely to cause trauma and psychological harm. Finally, once students were calm, Crowell staff admitted children were not always returned to class immediately, in violation of state law.

3. The Crowell staff’s use of informal illegal disciplinary removals, a practice which is likely to cause both immediate and long-term psychological harm, constituted abuse.

The Massachusetts Department of Elementary and Secondary Education has made clear that a school cannot exclude a student from school for misconduct without complying with 603 CMR § 53.00. Instead, a school only has two options for disciplinary removal under the state law: (1) emergency removal, or (2) suspension. See 603 C.M.R § 53.00. There is no legal option to “agree” to pick up a child early as a result of student misbehavior.

Seven parents interviewed indicated that on more than one occasion a Crowell staff member called home and requested a child be picked up early for behavioral issues. These calls sometimes came from the office and other times came through the nurse’s office. One student was sent to the nurse and sent home for behavioral issues four times in a three month span. Another student was sent home through the nurse for behavioral issues three days in a row. These were coded as voluntary dismissals in nurse and attendance records. However, the parents disputed the voluntariness of the dismissals. One parent aptly described: “[my child] would act up in class [e.g. excessive crying, aggression towards other students] and get sent to the nurse. The nurse would call and say she’s not acting like herself today and immediately ask if I wanted to come pick her up…there was no attempt to try and resolve the issue, just phone calls from the nurse’s office and pressure to pick her up.” A different parent reported she was called several times a week by the main office to pick up her child. She noted sometimes she was called just fifteen minutes into the school day. When she was unable to pick up the child due to other obligations, the school threatened to call crisis intervention. All seven parents expressed frustration that the school appeared to just want to send their children home for maladaptive behavior instead of trying to address/improve the disability-related behavior in school.

Research indicates that repeated school exclusions are likely to cause psychological harm and to have a detrimental impact on school performance and outcomes. Crowell’s inappropriate and
illegal use of informal school exclusions fails to address students with disabilities’ underlying behavioral issues and likely has a negative psychological impact.

4. **The exclusion of some students with disabilities from special school activities and field trips, a practice which is likely to cause both immediate and long-term psychological harm, constitutes abuse.**

School districts must provide extracurricular services and activities, including field trips, in such a manner as is necessary to afford students with disabilities an equal opportunity to participate. 34 C.F.R. § 104.37(a)(1). Two parents reported that their children were excluded from field trips and special school activities (e.g. school concert) due to the manifestations of their children’s disabilities. One parent provided e-mails between the teacher and the parent which demonstrated the child was prevented from going on a field trip due to behavioral manifestations of his disability (i.e. running around and spitting); and, prevented from participating in a school concert due to similar issues. The teacher’s e-mail to the child’s parent indicates: “I know you had mentioned to let you know if all the students will be doing an event and you do not want [the student] to miss out…but I think it will be safer and easier for him if you wanted to keep him home…I do not have staff besides [paraprofessional], and we both need to be at concert to help others.” The e-mail seems to imply that with an accommodation (i.e. one-to-one paraprofessional), the student would have had an equal opportunity to participate, but was denied this option.

Another parent reported that her daughter was excluded from field trips and special activities at school due to behavioral manifestations of her disability. The child’s school record was reviewed and the student does not have a conduct record; thus, the exclusions were not for disciplinary reasons, but rather likely as mom reported because “the teachers told me they could not handle her on a field trip or in a big event at school.” Mom was told on these occasions to keep her daughter home from school.

Denying students with disabilities an equal opportunity to participate in field trips and schoolwide activities is disability discrimination. Moreover, research demonstrates that social exclusion causes psychological harm. Thus, Crowell’s practice of excluding students with behavioral disability manifestations, instead of providing accommodations, is both discriminatory and potentially psychologically harmful.

B. **Neglect**

1. **Crowell neglected students with disabilities by placing them at risk of injury by failing to develop legally mandated written restraint prevention and behavior support policy.**

One of the reasons Massachusetts regulates the use of restraint and time-out in schools is to minimize the risk of student injury. See 603 CMR § 46.01(3). Part of the regulations require school districts to develop “written restraint prevention and behavior support policy and procedures.” 603 C.M.R. § 46.04. The purpose of a written policy is to ensure all school district
staff are aware of the regulations, as well as develop alternative, less intrusive means for behavioral de-escalation. Crowell failed to develop written policies in compliance with the regulations, which likely placed students at risk of injury. Specifically, Crowell’s written policies and procedures fail to include the following required elements:

- “Methods for preventing student violence, self-injurious behavior, and suicide, including individual crisis planning and de-escalation of potentially dangerous behavior occurring among groups of students or with an individual student”;  
- “Methods for engaging parents in discussions about restraint prevention and the use of restraint solely as an emergency procedure”;  
- “A description and explanation of the program’s alternatives to physical restraint and method of physical restraint in emergency situations”;  
- A statement prohibiting seclusion;  
- “A procedure for conducting periodic review of data and documentation on the use of physical restraints as described in 603 CMR 46.06(5) and (6)”;
- “[A] procedure for the use of time-out that includes a process for obtaining principal approval of time-out for more than 30 minutes based on the individual student's continuing agitation.”

Haverhill’s School Committee approved a policy titled “Physical Restraint of Students” on January 14, 2016. This policy directs the Superintendent to develop many of the detailed restraint procedures outlined in 603 C.M.R. § 46.04. Crowell’s Principal indicated that these polices were covered within the 2016-2017 Haverhill Student Handbook (Pre-K-8) (“Student Handbook”). However, the Student Handbook does not comply with 603 C.M.R. § 46.04 (as outlined above). Crowell’s Principal indicated no other policies or procedures related to restraints existed. In addition to the above mentioned list, Haverhill also failed to establish a procedure for receiving and investigating complaints regarding restraint practices. 603 C.M.R. § 46.04(f). The Student Handbook indicates it “expects students to refer problems, requests, or grievances directly to a classroom teacher, guidance counselor, conflict mediator, principal/designee, or to a student council representative depending on the issue.” Moreover, it notes “[t]he principal shall provide the student and the parent an opportunity to comment orally and in writing on the use of the restraint and on information in the report.” Neither of these procedures includes any information about how Haverhill staff will investigate complaints.

Moreover, Haverhill’s policies fail to include a written procedure dictating required restraint report contents. See 603 C.M.R. § 46.04(1)(h) (requiring a written procedure for implementing reporting requirements of 603 C.M.R. § 46.06) and 603 C.M.R. § 46.06(4) (requiring all restraint reports to include name of student, description of incident, name of administrator, etc.). Ultimately, Haverhill placed students at risk of injury by failing to develop a legally mandated restraint prevention and behavior support policy.

2. Crowell neglected students with disabilities by placing them at risk of injury by failing to properly train Crowell staff members on restraint prevention and behavioral support.
Massachusetts regulations require two types of restraint prevention and behavioral support training: (1) an all-staff restraint training, and (2) an in-depth training for select staff. Crowell failed to train all staff members on the program’s restraint prevention and behavior support policies as required by 603 C.M.R. § 46.04(2). Thus, not all staff were trained in the following elements as required by 603 C.M.R. § 46.04(2):

- The role of the student, family, and staff in preventing restraint;
- The program’s restraint prevention and behavior support policy and procedures, including use of time-out as a behavior support strategy distinct from seclusion;
- When behavior presents an emergency that requires physical restraint, the types of permitted physical restraints and related safety considerations, including information regarding the increased risk of injury to a student when any restraint is used, in particular a restraint of extended duration;
- Administering physical restraint in accordance with medical or psychological limitations, known or suspected trauma history, and/or behavioral intervention plans applicable to an individual student.

Crowell’s Principal reported during her interview with DLC that several paraprofessionals completed an in-depth Safety Care™ training. The teacher interviewed also confirmed that several paraprofessionals, including the one assigned to her classroom, were Safety Care™ trained. Crowell provided DLC with a Safety Care™ training manual, but failed to identify which staff members received the training or how many hours of training the unidentified individuals completed. Thus, it is unclear if Crowell is compliant with 603 C.M.R. § 46.04(3) (requiring at least one designated staff member complete in-depth restraint training). Even if several individuals had completed the Safety Care™ training outlined in the manual, the content of the training was still deficient in several areas. Specifically, the training did not included the following, as mandated by 603 C.M.R. § 46.04(4)(d)-(f):

- “Instruction regarding documentation and reporting requirements and investigation of injuries and complaints”
  - The Safety Care™ manual includes a page on data collection and analysis generally, but does not provide instructions regarding the Massachusetts reporting and review requirements as outlined in 603 C.M.R. § 46.06.
- “Demonstration by participants of proficiency in administering physical restraint”
  - The Safety Care™ manual includes a page on role play procedure for practice administrating physical restraints, but does not include any way to measure demonstrated proficiency in restraints for participants.
- “Instruction regarding the impact of physical restraint on the student and family, recognizing the act of restraint has impact, including but not limited to psychological, physiological, and social-emotional effects”
  - The Safety Care™ manual is devoid of information on the psychological and social-emotional impact of restraints on students and families.
Thus, even if Crowell did train multiple paraprofessionals in the in-depth Safety Care™ training, the training failed to instruct these professionals on Massachusetts reporting/review requirements, ensure demonstrated proficiency and explain the psychological and social/emotional impact of restraints on children and families. Ultimately, Crowell placed students at risk of injury by failing to properly train staff in restraint prevention and behavior support.

3. Crowell neglected students with disabilities by failing to establish or carry out appropriate individualized education plans.

   i. Crowell failed to carry out student’s IEP service grids and issue mandated progress reports.

   Schools districts are required to “implement all accepted elements of the IEP without delay.” 603 C.M.R § 28.05(7)(b). If a student with an IEP transfers to a new school district, the new district must provide services comparable to those the student received in the old district until a new IEP is developed/adopted. 34 C.F.R. § 300.323(e)-(f). Crowell did not comply (or provide comparable services) for four of the six students’ IEPs reviewed. One student, who transferred from a Haverhill preschool, had an IEP which provided an integrated special education classroom with both a special education teacher and general education teacher support five days per week for the entirety of the school day (375 minutes, or 6.25 hours). The IEP also mandated that a behavioral specialist consult with the IEP Team once per month for 30 minutes. Instead, the student was placed in a general education “inclusion” classroom with a general education teacher and a paraprofessional. She did not receive any direct special education teacher services as mandated by her IEP. Moreover, there are no notes in the file or any indication that the IEP Team met with a behavioral specialist. One other students in this “inclusion” classroom had service grids that mandated “special ed/regular ed staff” provide the inclusion service. However, no special education teacher ever provided any direct services. Essentially, the student was in a general education classroom with a paraprofessional. No direct special education services were provided by special education staff at any time.

   Another student’s out-of-district developed IEP mandated a sub-separate program for the majority of the school day (3.75 hours/day) and general education inclusion for part of the day (2.5 hours/day). Instead, the student was placed in a sub-separate classroom for the entire day and denied any opportunity for general education inclusion. Conversely, another student, whose out-of-district IEP mandated a sub-separate program, was placed in the all-day “inclusion” classroom with a general education teacher and no direct special education teacher support. Ultimately, Crowell was not carrying out IEPs as written, neglecting student’s educational needs.

   Additionally, written IEP progress reports must be provided at least as often as regular report cards. See 603 C.M.R. § 28.07(3). The IEP progress reports are an important means of tracking student’s progress towards their individualized goals. Failure to properly provide these reports makes it difficult for IEP Teams to analyze whether a student is making meaningful progress towards his or her IEP goals. Crowell is on a trimester schedule, but no students
reviewed received progress reports in the second trimester. Two students also did not receive end of the year progress reports. Here, Crowell failed to carry out an important progress tracking component of student’s IEPs.

ii. Crowell failed to establish appropriate social/emotional and behavioral supports services for students with disabilities.

The IDEA specifically requires the IEP Team to consider the use of positive behavioral interventions and supports, and other strategies, to address behavior for any child with a disability whose behavior impedes his learning or that of others. 20 U.S.C. § 1414(d)(3)(B)(i). The United States Department of Education Office of Special Education and Rehabilitative Services (“OSERS”) clarified school districts’ responsibility surrounding behavioral supports for special education students in an August 1, 2016 “Dear Colleague” letter stating:

“Incidents of child misbehavior and classroom disruptions, as well as violations of a code of student conduct, may indicate that the child’s IEP needs to include appropriate behavioral supports…To the extent a child’s behavior including its impact and consequences…impeded the child’s learning or that of others, the IEP Team must consider when, whether and what aspects of the child’s IEP related to behavior need to be addressed or revised to ensure FAPE.”19 (emphasis added)

OSERS also made clear that use of positive behavioral interventions applies to all IEP Teams regardless of the student’s disability classification.20 Overall, Haverhill has failed to consider program modifications, supports for school personnel, teacher training/coaching, or other tools to appropriately address students with disabilities’ social/emotional needs. See OSERS August 1, 2016 “Dear Colleague Letter”, at 7. In five of the seven student records reviewed, students demonstrated repeated maladaptive behaviors, but Crowell failed to appropriately intervene. Crowell did not provide a Functional Behavioral Assessment (“FBA”) or a Behavior Intervention Plan (“BIP”) to any of the students engaging in repeated maladaptive behaviors. In fact, the only students Crowell appeared to evaluate, were those up for a triennial evaluation. Students who were engaging in daily disruptive behavior and being sent home or sent to the “safe room” on a regular basis were not provided any individualized behavioral interventions.

One student who entered Crowell from a Haverhill preschool “participat[ing] in [preschool] classroom activities 95% of the time” and left Crowell “refus[ing] to follow[] the rules 90% of the time by falling on the floor, crying out and/or trying to run away…he does not show a desire to interact with others.” No FBA or BIP was developed for this student; no IEP meeting was held; no behavioral strategies or interventions were attempted to curb the steep regression.

The student files reviewed are full of examples of repeated instances of extended crying, hitting, kicking, biting, scratching and elopement. Each instance was treated with the same ineffective strategies – send to the “safe room,” return to classroom, repeat; or, send to office/nurse, send home, repeat. No individualized assessment or interventions were attempted and as a result, students with behavioral manifestations of a variety of disabilities regressed throughout the year.
Even for two students whose files were reviewed that included triennial evaluations for the 2016-2017 school year, needed social/emotional intervention was extremely lacking. For instance, one student, whose teacher described her in an Educational Assessment as regularly “defiant” and “very physical with other students” including hitting, kicking and biting, did not have any social/emotional or behavioral assessments included in her triennial evaluation. Her mother reported she was regularly sent home early for misbehavior, but no behavioral assessments were conducted as a part of the triennial. While the IEP Team did develop social and classroom IEP goals for her, they did not develop a BIP.

3. Crowell neglected students with disabilities by failing to provide a safe environment by failing to maintain an adequate number of trained staff, which resulted in failure to take appropriate steps relative to harassment and peer assault.

Almost half of the parents DLC interviewed (9 out of 20) reported concern about the overall level of staffing and supervision at Crowell. Parents expressed shared concern in three main areas: (1) Students wandering halls unsupervised; (2) Children returning home with unexplained scratches/bruises; and, (3) Principal noticeably absent from building at times. One mother reports coming to school to pick up her daughter early for an appointment and finding her daughter jumping down the stairs alone with her shoe laces tied together. Another parent reported her daughter alleged inappropriate genital touching between students that she did not feel was fully investigated. Crowell’s records indicate staff spoke to some, but not all of the children involved. Additionally, Crowell did not reach out to any parents to see if the students reported similar allegations at home. Multiple parents reported instances of hitting, kicking, biting, punching between students (sometimes described as bullying) that went uninvestigated by school staff even after being brought to school’s attention by concerned parents. No formal bullying reports or investigations were found in the seven student files reviewed. Multiple injuries were reported to the nurse in these files, some involving altercations between students, but no follow-up incident reports or investigations accompanied the nurse records.

Crowell shares its Principal with another school, Moody School (“Moody”). Moody serves about 200 preschoolers. Thus, the Principal is responsible for about 350 students in two separate buildings about a ten minute drive apart. Neither Crowell nor Moody have any other administrator assigned to the building (e.g. Assistant Principal). Thus, when the Principal is at Moody, there is no administrator at Crowell. The building is then staffed with one office clerk, a nurse, classroom teachers and paraprofessionals. Each classroom at Crowell is staffed with one teacher and one paraprofessional. Only one teacher at Crowell has a special education license. This teacher runs the substantially separate special education classroom. Crowell has an “inclusion” classroom, but the classroom is staffed with one general education teacher and one paraprofessional like all of the other classrooms. Although student’s IEPs in this “inclusion” classroom revealed at least some students require direct special education teacher support, none was available at Crowell, nor provided. Haverhill also indicated the district has one behaviorist that serves all 7,452 students district-wide. There was no evidence in any student record
reviewed that the behaviorist had worked with any of the seven students, despite serious, repeated maladaptive behaviors in at least five of the student’s files.

When the Principal is at Moody, there is no administrator at Crowell to deal with any classroom overflow. For instance, if there is a peer-to-peer physical or serious verbal altercation, there is no administrator to immediately investigate and attempt to resolve the situation. This explains why, at times, the nurse was calling parents after a peer altercation. Additionally, if a teacher or paraprofessional is having difficulty de-escalating a student, there is no administrator on site half of the time to assist. Moreover, if the teacher and paraprofessional are otherwise engaged in the classroom and a student needs to leave the room (bathroom, water, early dismissal), there is no adult in the hall to ensure very young students (mostly ages 5 and 6) are safely travelling to their destination.

Additionally, Crowell should have an additional special education teacher to provide direct teacher services to the inclusion students. An additional teacher with specific special education training would likely mitigate behavioral and peer-to-peer issues. Moreover, Crowell students with behavioral manifestations of their disabilities should have access to behaviorist services and consult. While Haverhill has one behaviorist on staff, it does not appear this behaviorist was utilized at Crowell. This is likely because one behaviorist for a 7,000+ student body is not sufficient. Teachers and families actively engaging with a behaviorist also likely could have mitigated many behavioral and safety issues.

V. Required Remedial Plan

In order to address the concerns identified above, Haverhill must create a detailed measurable remedial plan and submit this plan to DLC by Monday, March 19, 2018, which includes the following elements:

A. Modification of Restraint Policies and Procedures

1. Crowell will cease utilizing restraints as a behavioral management tool, and only utilize restraints as a matter of last resort to prevent imminent, serious physical harm after less intrusive behavioral interventions have failed.

2. Crowell will report and review all restraints in compliance with state regulations.

B. Modification of Time-Out Policies and Procedures

1. Crowell will eliminate the use of the “safe rooms” or time-out spaces as a disciplinary tool.

2. Crowell will eliminate the use of a large mat over the door of the “safe rooms” or time-out spaces to contain a child. If Crowell utilizes a mat as a blocking tool, it will be appropriately sized to an adult’s body, not a doorway.
3. Crowell will ensure the “safe rooms” are only utilized for the purpose of calming and once a child is calm, he or she will immediately be returned to his or her classroom.

4. If Crowell attempts an exclusionary time-out for the purposes of calming and the child escalates in the time-out area; Crowell will cease utilizing the ineffective behavior management tool for that particular child.

5. Crowell will create “safe room” logs. Here, Crowell will record student’s name, staff observer, reason removed from classroom, time entered room, and time left room and emotional state at the end of the time-out.

C. Modification of School Exclusion Policies and Procedures

1. Crowell will cease informal disciplinary removals and comply with state regulations regarding school exclusions.

2. The Crowell nurse will cease asking parents to pick children up early from school for maladaptive behavior.

3. Crowell will cease excluding students with disabilities from field trips and schoolwide activities and instead provide appropriate accommodations to these students.

D. Written Restraint Prevention and Behavior Support Policies & Procedures

1. Crowell will create written restraint prevention and behavior support policies and procedures that complies with state regulations.

2. Crowell will develop a working protocol to investigate physical altercations and peer harassment between students.

E. Modifications to Staff Training on Restraint Prevention and Behavior Support

1. Crowell will create an all-staff restraint prevention and behavior support training that complies with state regulations.

2. Crowell will update the in-depth staff restraint training to include: (a) documentation and reporting requirements; (b) a means to measure participants to demonstrate proficiency in administering restraints; and, (c) instruction regarding the psychological and physical impacts of restraint on students and families.
3. Crowell will ensure at least one staff member receives in-depth restraint training.

F. Implementation of IEPs and Consideration of Social/Emotional Supports

1. Crowell will fully implement each student’s IEP in the least restrictive environment.

2. When a student with a disability’s behavior impedes his or her learning or that of others, Crowell will immediately consider program modifications, supports for school personnel, teacher training/coaching, or other tools to appropriately address students with disabilities’ social/emotional needs.

G. Increase Qualified Staffing

1. Crowell will ensure that at least one school administrator is on site at all times.

2. Crowell will ensure a special education teacher is contracted or hired to provide direct special education services to inclusion students.

3. Crowell will ensure a qualified behaviorist is available for staff consults as well as, when needed, evaluation and direct services for students with disabilities.

VI. Monitoring

DLC is also requesting that Haverhill cooperate and help facilitate DLC’s monitoring of this remedial plan for a period of 12 months. After 12 months, DLC will determine if any further action/monitoring is required. The monitoring will include the following:

A. Record Review

On a quarterly basis (April 1, 2018; July 1, 2018; October 1, 2018; January 1, 2019), Crowell will provide DLC with the following records:

1. All restraint and behavioral support policies and procedures
2. All restraint and behavioral support training (for all staff and in-depth trainings)
3. The working protocol for investigating physical altercations and peer harassment between students
4. All restraint reports
5. All incident reports
6. All staff injury reports
7. All safe room logs
8. All notes from restraint reviews
9. All nursing logs
10. All early dismissal logs
11. Any other internal record or document reflecting corrective action taken involving the violations in this report.

B. On Site Monitoring

Within 30 days of receiving the above quarterly reports, DLC will conduct an on-site visit. These visits will include staff interviews, building tours, and classroom observations.

Colleen Shea (s)
Colleen Shea
Attorney/Skadden Fellow

Stanley J. Eichner (s)
Stanley J. Eichner
Litigation Director

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1 See 45 C.F.R. § 1386.19 (defining probable cause under PADD as “a reasonable ground for belief that an individual with developmental disability(ies) has been or may be subject to abuse and neglect.” See also 42 C.F.R. § 51.2 (defining probable cause under PAMII in a substantially similar manner). See also 42 U.S.C. § 10801(a)(1)(A); 29 U.S.C. § 794e(f)(2); 42 U.S.C. § 300d-53(k) (defining authority to investigate abuse and neglect when P&A receives reports of incidents of abuse and neglect or determines there is probable cause).

2 See 45 C.F.R. § 1386.19 (defining “complaint” as “includes, but is not limited to, any report or communication, whether formal or informal, written or oral, received by the P&A system, including…electronic communications, telephone calls (including anonymous calls) from any source alleging abuse or neglect of an individual with a developmental disability.” See also 42 U.S.C. § 10805(a)(1)(A) (noting P&A authority to “investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system.”)).


4 The District provided DLC with a directory of all students with disabilities enrolled in Crowell

5 See 45 C.F.R. § 1386.19 (stating the P&A makes a determination of probable cause based on “reasonable inferences” drawn from experience involving similar incidents and problems surrounding abuse and neglect).


7 Crowell staff informed DLC that it uses Safety Care™ training materials.

8 The total number of parent interviews includes the three initial complaints to the system.

9 DLC has identical authority under the PAIR statute for individuals who do not fall within the PADD and PAMII statutes. See 29 U.S.C. § 794(e)(f)(2)(stating that P&A’s have the same investigation authority for people who meet the definition set forth in 29 U.S.C. § 794(a)(1)(b) as the P&A has for people with developmental disabilities).


12 It appears incident reports are missing from other student files as multiple nurse records refer to a formal “incident report,” but these incident reports were not provided with the student’s files.
13 See Council for Children with Behavioral Disorders, Position Summary on the Use of Seclusion in School Settings, 34 BEHAV. DISORDERS 235 (2009), available at: https://higherlogicedownload.s3.amazonaws.com/SPED/bc40048c-ef24-4380-a493-273ff305ca3c/UploadedImages/CCBD%20Position%20on%20Use%20of%20Seclusion%207-8-09.pdf (noting the harmful psychological effects of seclusion, which was defined to include physically preventing a child from leaving a given area).

14 Massachusetts Department of Elementary and Secondary Education, Student Discipline Laws and Regulations: Question and Answers G.L. e. 71, §37H ¾ and G.L. e. 76, §21 (Feb. 28, 2015), at Section I, Question 7, available at: http://www.doe.mass.edu/lawsregs/advisory/discipline/QA.html#7 (“It is not permissible for a principal to remove a student from school involuntarily for misconduct at any point in the school day without complying with 603 CMR 53.00.”)


17 See Student Handbook at 36.

18 Seven student records were reviewed in total, but one student with disabilities did not have an IEP.


20 Id.