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ALJ \*\*Redacted\*\*  
Office of Hearings and Appeals  
300 Pearl Street, 4<sup>th</sup> Floor  
Buffalo, New York, 14202

**RE: Jane Doe, a Child  
SSN: \*\*Redacted\*\***

Your Honor:

The above-named claimant asserts disability at listing level severity, at a severity equivalent to several listings in Appendix 1, and as a result of marked functioning deficits in at least two domains per the “functional equivalence” analysis required at § 416.926a. Specifically, **the claimant’s impairments likely meet or equal the severity listed at §§ 112.05A, 112.05D, 112.05E, 112.05F (for mental retardation); § 112.11 (for Attention Deficit Hyperactivity Disorder); and also at §100.02B (for growth impairment).** This letter brief is intended to clarify several issues within the claimant’s record.

**Mental Retardation:**

The record is clear that the claimant (hereafter, “Jane” or “the child”) suffers from an IQ score between 60 and 70, which is always evidence of “marked” limitation in cognition. SSR 98-1p. Exhibit 23E, p. 2 documents a School Psychologist’s report showing a full scale IQ of 65 as understood from the most recent, validated testing between 6/17/05 and 6/21/05. Previous testing over a span of time has also shown downward trending scores consistent with an IQ deficit becoming more obvious as the child ages, and all testing results in the

child's file show scores within a standard error of measurement ("SEm") which allow a finding of IQ within the above-designated range. See, e.g., POMS DI 24515.055C (discussing the standard error of measurement) and POMS 24515.056D.1.c (permitting marginal or borderline IQ scores within the 70 - 75 range to suffice for "equivalence" analysis, as within the discretion of the finder of fact). Specifically, Exhibit 9F, p. 1 shows a full scale IQ of 69 as determined by the state agency in 2003; and Exhibit 12F, p. 22 shows a full scale (marginal) IQ of 72 in 2001. Thus, all IQ evidence indicates that Jane suffers, and has suffered, cognitive function deficits at approximately 2 or more standard deviations below the mean. The deficit is also becoming more clear through time.

Next, there is likely no serious question as to whether mild mental "retardation" is an appropriate label for Jane. Neither does it likely matter under equivalence analysis. § 416.926(a)(1)(A). But to be clear on the evidence, School Psychologist Elizabeth Johnson suggests in Exhibit 23 that "retardation" may not be an appropriate classification for this child as the mother did not report on a specific questionnaire such significant deficits in adaptation as might warrant this classification. However, the record was not then as well developed for School Psychologist Johnson as it is now for the Commissioner. Substantial evidence does show Jane's difficulty adapting, and this is true even if she is generally well-behaved when with her own mother. As well, it would be improper for the adjudicator to rely only on the way Jane functions when with her mother only. See, e.g., § 416.924a(b)(6), stating, "*We will not draw inferences about your functioning in other situations based only on how you function in a one-to-one, new, or unusual situation.*"

Here, substantial evidence shows maladaptive behavior throughout the period of Jane's claimed disability. The child's mother reported on 5/7/03 that "Jane is Hyper & reckless, has no concern about dangers around her & has very poor attention span & she listens very poorly." (Exhibit 11E, p. 3). Jane's mother also reported on 6/9/03 that the child does not ask a lot of what, why, and where questions, does not ask what words mean, does not know her phone number, cannot define common words, cannot read capital letters of the alphabet, cannot understand a joke, cannot print at least some letters, cannot copy her first name, does not play board games like checkers or Candyland, cannot walk or bathe without help, cannot brush her teeth without help, cannot put her toys away, cannot maintain concentration, and is very impulsive, all things this child should have been able to do at five years old (Exhibit 10E, pp. 4-8). Dr. Paul Masters recorded in his note of 5/20/03 that the child was biting herself due to problems dealing with her own father and grandmother, even though the child was fine with

her mother (Exhibit 16F, p. 10). Self-injurious behavior continues today per Jane's mother. The record is also replete with references to the maladaptive behavior of being impulsive or overactive, or suffering other behaviors related to ADHD, or to epilepsy-related absence seizures (See, e.g., Exhibit 16F, p. 46; see *also*, September 2005 Report of Special Education Teacher, Julie Grant, reporting Jane's inability to recognize the concept of "stranger danger"). Finally, at Exhibit 13F, p. 23, it was reported in 2001 that "consistent with her cognitive abilities, Jane's social skills are judged to be delayed by 25% or more." Presently, Jane's cognitive deficits are becoming all the more evident to those around her, as evidenced by her declining IQ scores over time, and this cannot help but hinder her social adaptation today "consistent with her cognitive abilities." This can be inferred true today just as it was stated in the past. As another example, School Teacher Barb Simms reported on 10/21/05 that "Jane needs 1 on 1 support and small group instruction to be successful in all areas of our school day." Other teachers of present concur unanimously. Thus, for all the above reasons, Jane does show maladaptive behaviors which require significant additional structure and attention from the adults around her. For the above reasons, the adjudicator should likely find that Jane's condition is at least equal to the mild mental retardation severity listings.

For the above reasons, a reasonable mind may conclude that this child suffers both an IQ within the range of 60 - 70 and a reality of maladaptive behavior. Certainly, Jane suffers the equivalent.

### **Mental Retardation Combined with Speech Impairment:**

Here, the "Children's Speech Impairment Severity Questionnaire" completed on 10/21/05 by Gretchen Jameson, CCC-SLP, provides substantial evidence upon which to make a finding of "disabled" in this claim. This is because the combination of mental retardation together with an independent speech impairment of more than minimal significance is considered equal in severity to the listings in Appendix 1:

"A speech impairment may satisfy the criterion for a physical or other mental impairment imposing 'additional and significant limitation of function' under Listings 112.05D and 112.05F when it causes more than minimal limitation of function. To satisfy this criterion, a child's problems in speech must be *separate* from his/her mild mental retardation." SSR 98-1p.

Furthermore, even if the adjudicator is unconvinced that the child here suffers from mental retardation; even if there is only a “marked” deficit in cognitive functioning which does not technically result in “retardation,” and this impairment is then combined with the “marked” speech impairment reported by Gretchen Jameson, CCC-SLP on 10/21/05, this combination of marked impairments is still sufficient to support a finding of “disabled” :

“A child whose impairment does not meet the capsule definition of mental retardation in Listing 112.05 may nevertheless have a marked limitation in cognitive functioning. When such a child also has an impairment that causes a ‘marked’ limitation in speech (see Table 1 and Section VI), the combination of limitations in cognition and speech will be found medically equivalent to Listing 2.09 in part A of the listings. [In general, part A of the listings contains medical criteria that apply to persons age 18 and over; part B contains medical criteria that apply to persons under age 18. However, the medical criteria in part A may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons, as in Listing 2.09. See 20 CFR 416.925(b).]” SSR 98-1p.

Thus, here substantial evidence and legal authority supports a finding of “disabled” based only on this child’s combined cognitive deficits and speech impairment (though the child does suffer additional impairments as well, including severe ADHD, absence seizures, and growth impairment).

### **Growth Impairment:**

Jonathan Michaels, M.D., of the Strong Memorial Hospital, Department of Neurology noted Jane’s height on 11/19/04 (Exhibit 16F, p. 46). Jane was born on 5/6/98 and was, therefore, 6 years and 6+ months old on the date of this examination. At that age, Jane’s height was measured at just 107.6 cm as reported in the “Physical examination” section of Dr. Michaels’ treatment note. Utilizing a chart correlated to both age and sex, and based on the most recent medical census data available to the National Center for Health Statistics (a department of the Centers for Disease Control, or “CDC”), this height places Jane below the third percentile, likely as a natural consequence of her severely premature birth.

Certainly Dr. Michaels notes Jane’s obvious growth impairment, but Dr. Michaels also seems to rely on Dr. Masters’ reporting and charting at Exhibit 14F,

p. 3, and elsewhere in the record, to assume without further inquiry that Jane is at approximately the 10<sup>th</sup> percentile for height correlated to age. This resulted in error.

Specifically, Dr. Micheals was simply reporting the same error as was originally made by Dr. Masters. This error occurred due to two methodological flaws. First, Dr. Masters was using a growth chart produced in 1982 when insufficient data was available to the National Center for Health Statistics and when the standard growth chart was no different as between boys and girls. Second, Dr. Masters' office made several of the record measurements with the child's shoes still on (this is confirmed by Jane's mother). Using the modern, more accurate and reliable chart, and using the proper data as was supplied by Dr. Michaels while measuring the child's height with her shoes off, this child's height is clearly recorded below the 3<sup>rd</sup> percentile for her age. At additional doctors' visits, and whenever the child's height is measured with her shoes off, the child's growth impairment places her near or even below the 3<sup>rd</sup> percentile. This data has been graphed for the adjudicator on an attached exhibit. Thus, the child's growth impairment here must likely be found at least equal to the severity at listing § 100.02B (this impaired growth in combination with mild mental retardation, speech impairment, ADHD, and absence seizures likely meets the listing severity, though that determination is, of course, reserved to the Commissioner).

### **The Consultant Physician's Opinion is Improper and Wrong:**

Here, Paulette Harrison, MD. provided a consultant opinion on 9/3/03 in which she opined that Jane's impairments are not "functionally equivalent" to the listings under the 6-domain analysis mandated in § 416.926a. From the above discussion, and after analyzing Dr. Harrison's opinion more closely, clearly Dr. Harrison's methodology was improper and her conclusions were wrong. Her opinions should, therefore, be devalued in the final decision. Furthermore, the claimant urges a finding that the opinion of Dr. Harrison is so methodologically improper and wrong that it fails to constitute "substantial evidence" in this claim.

For instance, Dr. Harrison states on page 3 that the child suffers "less than marked" impairment in the domain of Acquiring and Using Information. The law rejects this conclusion because Jane suffers an IQ below 70. Such a low IQ automatically "*by definition*" provides for a finding of "marked" limitation in cognition, the core of what is being measured in the domain of Acquiring and

Using Information. SSR 98-1p. Thus, where a child has an IQ of less than 70, and certainly where the child, as here, also needs constant 1:1 and/or small group instruction in order to learn (which is to say the child's functioning confirms her IQ score's validity), any finding that the child does not suffer a "marked" limitation in Acquiring and Using Information would be improper and wrong. Dr. Harrison made this mistake, so her opinion is legally improper and wrong and must be rejected.

Dr. Harrison also opined that Jane suffers "less than marked" impairment in the domain of Attending and Completing Tasks. Dr. Harrison's opinion seems to rely at times on the February 2003 Annual Review Recommendations report provided through the Rochester School District, yet doesn't apparently credit such important statements in that report as "*Jane is extremely distractible and very inattentive to what she is doing.*" In the face of reports by school teachers that Jane needs 1:1 or small group only supports within her Special Education classroom to stay focused and attend to tasks, Dr. Harrison's opinion as a paid consultant for the Administration is either biased or just plain wrong. In the face of reports that Jane suffers staring spells and impulsiveness which cause her not only the inability to attend, but in fact, may even cause her to walk away from her small group discussions if she fixates on an object in her classroom, Dr. Harrison's opinion that she suffers no marked impairment in this domain should be rejected.

However, Dr. Harrison makes even more unforgivable mistakes. Dr. Harrison states that Jane suffers "no limitation" in the domain of Interacting and Relating with Others. This is utterly inconsistent with the report at Exhibit 16F, p. 10, that the child bites herself when around her father or grandmother. This opinion is also utterly inconsistent with the statement at Exhibit 13F, p. 23 that "consistent with her cognitive abilities, Jane's Social Skills are judged to be delayed by 25% or more." Jane's cognitive impairment has not diminished since this Exhibit 13F statement was made in 2001, so it can reasonably be inferred that at least some delay in Social Skills is still apparent today. The staring spells referred to above are a good example. Furthermore, Jane also suffers "marked" impairment in speech abilities according to her consultant speech teacher, Gretchen Jameson, CCC-SLP, and such severe impairment in communicative ability, by any reasonable consideration, must certainly impact Jane's ability to interact with and relate to others. Thus, Dr. Harrison's statement that Jane suffers "no limitation" in this domain is absurd. Then, as the proverb goes, *falsus in unum, falsus in omnibus*. Dr. Harrison's opinion should be disregarded as unsound. It does not rise to the level of "substantial evidence" because it is

insufficient to convince a reasonable mind. For these important reasons, and consistent with this child's Due Process rights, Dr. Harrison's report cannot form the basis of a judicial decision denying this child's claim.

Similarly, Dr. Harrison states that in the domain of Caring for Oneself, Jane suffers "no limitation." This is baldly, internally and eternally inconsistent with Dr. Harrison's own statement that Jane's self help skills when measured at 5 years and 4 months old were at "the mid 4 year level." A delay of approximately one year in such a young child amounts to "no limitation"? Such logic cannot be affirmed. Furthermore, Dr. Harrison's opinion is clearly reliant on the statement in the February 2003 Annual Review Recommendations report provided through the Rochester School District where it is stated, "*Jane's self-help skills are at the mid four year level. These skills allow her to participate within her preschool setting and feel successful...One concern [however] is that Jane continues to act first and is unaware at times that she is unsafe. Even with talking to her she doesn't seem to understand the concepts. Jane's impulsive behavior gets in the way of her feeling successful.*" Clearly, this report does indicate both some ability and some impairment, yet it also states in objective terms that the overall impairment suffered is significant, an impairment amounting to approximately one year's developmental expectation at that age. Nevertheless, Dr. Harrison adopts only the "ability" aspect of this report and then improperly concludes for the Administration (which pays her consulting fee) that Jane suffers "no limitation" in the ability to care for herself.

Again, *falsus in unum, falsus in omnibus*. Dr. Harrison's opinion is biased and improper and incapable of convincing a reasonable mind due to several glaring errors and omissions. Dr. Harrison's impeached opinion should be rejected in the face of very strong evidence to the contrary throughout the child's record.

### **Second Circuit Law Likely Requires This Child Be Found "Disabled" When Performing "Functional Equivalence" Analysis:**

Here, the adjudicator likely need not even advance to "functional equivalence" analysis, because the child likely meets or actually equals specific listings argued above. As well, even if the adjudicator proceeds to "functional equivalence" analysis, a finding of "marked" and severe impairments in at least two domains would appear appropriate. Nevertheless, if the adjudicator finds otherwise, the adjudicator should be aware the Second Circuit has a special rule that must be applied in a child's disability

case. This rule holds that where a child's impairment in one domain is at least "marked", and where the child has both another domain impaired at nearly the "marked" level as well as additional impairments in any third or additional domains, the child should still likely still be found disabled under "functional equivalence" analysis.

Here, for instance, if the adjudicator finds that the child suffers "marked" impairment in Acquiring and Using Information due to the child's low IQ, and "nearly marked" impairment in Attending and Completing Tasks due to the child's ADHD and absence seizures, the adjudicator is free, and likely should, adjust upward the finding in the Attending and Completing Tasks domain to account for such additional impairments as the child's inability within the Caring for Oneself domain to be aware of "stranger danger" or the child's Growth Impairment within the Health and Physical Well-Being domain.

In support of this argument, please see the analysis of the Court in *Encarnacion Ex Rel. George v. Barnhart*, 331 F.3d 78, 88 (2nd Cir. 2003)(citing to 20 C.F.R. § 416.926a(a) (2002)): "The regulations indicate that, although SSA ultimately does not permit moderate limitations to give rise to a finding of eligibility, the existence of sub-marked limitations in other domains may influence the level of impairment SSA finds in any one given domain...[and] it appears that the regulations permit SSA to increase a non-marked limitation up to marked to reflect the impact that other non-marked impairments may have on the claimant's overall level of functioning." Thus, "ALJs retain the power to account for the existence of non-marked limitations in the disability determination process...[and] nothing would preclude SSA from adjusting an otherwise moderate, but nearly marked, limitation in domain A up to fully marked to account for the effect of a limitation in domain B." *Id.* at 89.

As for the Due Process basis for such a result, the *Encarnacion* Court stated at page 90 that, consistent with the reasoning of the Supreme Court's holding in *Sullivan v. Zebley*, 493 U.S. 521 (1990)(holding that a consideration of the combined effects of a claimant's severe impairments must be made at every step in the Sequential Evaluation Process), the Second Circuit "cannot accept an interpretation of 'consider the combined effect' where the impairment is assigned zero weight in the ultimate decision whether or not to award benefits. Nor can this approach be reconciled with the statutory requirement that the Commissioner consider 'the combined impact of [all of the claimant's] impairments throughout the disability determination process.' 42 U.S.C. § 1382c(a)(3)(G) (emphasis added)."

Thus, when deciding the ultimate question in a child's disability claim, the Second Circuit's decision in *Encarnacion* likely requires an ALJ either to adjust upward a second domain showing nearly marked limitation(s), or to utilize some other *meaningful* consideration of the "combined effect" of remaining limitation(s). Such meaningful consideration must also be evidenced in the adjudicator's written decision.

**Conclusion:**

For the above stated reasons, and for reasons evident within the record at large, the claimant should likely be found “disabled” consistent with the meaning of that term as it is used in the Social Security Act.

Respectfully Submitted,

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