Health and Education Chamber
First-tier Tribunal for Scotland

Additional Support Needs

1. **The Reference**:

The appellant made a reference to the Tribunal in terms of Section 18(3)(b) of the Education (Additional Support for Learning) (Scotland) Act 2004 as amended ("the 2004 Act"). This is in respect that the respondent determined on 15 May 2018 that the child does not require a Co-ordinated Support Plan (CSP). The appellant appeals against this decision.

2. Decision of the Tribunal:

The tribunal overturns the decision of the respondent and dated 15 May 2018 and requires the respondent to open a CSP within 4 weeks.

3. Management of the Reference:

The reference was received by the Tribunal on 26 July 2018. Following both parties' case statements being received a judicial case management telephone conference call was conducted by the legal member on 2 November 2018. At that time an oral hearing was allowed subject to the identification of dates. Both parties were directed to lodge a list of witnesses and any productions within 6 weeks of the date of the conference call namely 14 December 2018.

Both parties lodged witness statements and agreed the terms of a Joint Minute of Admissions.

4. Summary of Evidence:

The tribunal had full regard to the bundle of papers lodged (T1-T27, A1-A93 and R1-R35).

Witness statements were provided by the appellant (A83-A87), Witness C, Clinical Support Worker with the Learning Disability Child and Adolescent Mental Health

Service (A88-A91) and Witness B, Social Worker, Children with Disabilities Unit, the respondent, School B, (A92-A93).

For the respondent a witness statement was provided by Witness A, Head Teacher, School A, (R31-R35).

The Tribunal then heard oral evidence from:-

1. Witness A
2. Witness B
3. Witness C
4. The appellant

Both parties thereafter provided written submissions and both parties gave further oral submissions. The tribunal thereafter reserved their decision.

5. Findings in Fact:

1. The appellant is the foster carer of the child.
2. The child is a six year old boy, with a diagnosis of Foetal Alcohol Spectrum Disorder, Cerebral Palsy, Attention Deficit Hyperactivity Disorder (ADHD) and is a Looked After Child under the Children (Scotland) Act 1995.
3. The child has Cerebral Palsy which results in muscle tone and movement difficulties.
4. The child suffers from high anxiety.
5. The child is prescribed Melatonin to assist with his sleeping difficulties.
6. The child is prescribed Methylphenidate to help him concentrate.
7. The child is currently in Primary 2 at School A. He has attended School A since Primary 1.
8. The child has additional support needs in terms of the Education (Additional Support for Learning) (Scotland) Act 2004.
9. In the classroom the child receives one to one support from either a teacher or Pupil Support Assistant.
10. The child has an individualised timetable.
11. The child accesses the full curriculum with support.

12. The appellant made a formal request for a CSP to the respondent in his capacity as the child's foster parent. A meeting was held to discuss this request on 5 February 2018. The appellant received a response on 15 May 2018 declaring that a CSP was not required. The grounds for refusal were stated as
13. The child's school education is the responsibility of the respondent .
14. The child has additional support needs arising from (i) one or more complex factors, or (ii) multiple factors.
15. The child's needs are likely to continue for more than a year.
16. The child attended nursery A prior to School A.
17. The child has a Child's Plan.
18. A range of strategies are necessary to keep the child engaged for longer periods of time.
19. The child has input from Social Work, CAMHS, Cerebral Palsy clinicians, Educational Psychology and other agencies.
20. The nature of the child's conditions means that the level of support will change through the years as the child matures both physically and cognitively.
21. The child is a Looked After Child so subject to LAC Reviews.
22. The child receives one to one support from either a teacher or a Pupil Support Assistant.
23. The child accesses his mainstream classroom at least twice a day but will continue to require one to one support.
24. The child can verbally communicate but he may not understand the words that he is using.
25. The child's writing is in scribbles and is not at the same level as those of his peers.
26. The child displays sexualised behaviour in particular at the home of the appellant. His sexualised behaviour is linked to the Foetal Alcohol Syndrome Disorder. There has been one incident of this at school. Witness C, a Clinical Support Worker with the Learning Disability Child and Adolescent Mental Health Service (LDCAMHS) from hospital A worked with the child from July 2017 for a period of a year on a weekly basis concentrating on issues of understanding appropriate behaviour in public.

27. In addition the child has displayed self-harming behavious, impulsive behaviours and has sensory issues. The child's conditions will be life-long.
28. The child undertakes activities which include skiing (3 times a week), horseriding (once per week) and swimming (twice per week). These activities assist at a physical level in respect of assisting with co-ordination and as a form of exercise but in addition provide a valuable source of self-esteem for the child. There are positive effects of these activities at school.
29. In addition in 2017 the child was referred to Occupational Therapy and worked with an Occupational Therapist from May to July 2017 at school and has been given advice on fine motor skills and a weighted vest which he uses at school to ground him.
30. The child has been re-referred to Speech and Language Therapy.
31. Doctor A, Counsultant at the Learning Disabilities Team at the Child and Adolescent Mental Health Services sees the child 6 monthly and prescribes his medication. That medication assists the child in being able to concentrate at school.
32. The child's needs are likely to remain significant and may worsen over the years as the gap widens with the normal population and the demands on him increase. The child remains an open case with the Learning Disabilities Child and Adolescent Mental Health Service.
33. The child is seen by his allocated Social Worker at least every 6 weeks.
34. The child has had previous involvement with an Educational Psychologist.
35. The child attends the Cerebral Palsy Integrated Pathway Clinic every 6 months and has been given daily exercises which must be completed to help him maintain a stable core and a good range of movement.

6. Reasons for Decision

36. The tribunal considered all the documentary and oral evidence and was satisifed that there was sufficient evidence available to the Tribunal to reach a decision on the reference. The issue is whether or not the child satisfies the terms of Section 2 of the 2004 Act and requires a CSP is as follows:-

2. Co-ordinated Support Plans

(1) for the purposes of this Act, a child or a Young Person requires a plan (referred to in this act as a "Co-ordinated Support Plan") for the provision of additional support if –

(a) an Education Authority are responsible for the school education of the child or Young Person,

(b) the child or Young Person has additional support needs arising from –

(i) one or more complex factors, or

(ii) multiple factors,

(c) those needs are likely to continue for more than a year and

(d) those needs require significant additional support to be provided –

(i) by the Education Authority in the exercise of any of their other functions as well as in the exercise of their functions relating to education, or

(ii) by one or more appropriate agencies (within the meaning of section 23(2)) as well as by the education authority themselves.

37. It was accepted by the Respondents that sub-sections (a), (b) and (c) of section 2(1) of the Act are fulfilled. Accordingly the only matter of contention between the parties was whether or not sub-section (d) of section 2(1) of the 2004 Act is met.

38. Helpfully there were witness statements for all witnesses.

Witness A

36. Evidence for the respondent was given by Witness A, Head Teacher, School A. In her statement she confirmed that the child is currently in primary 2 at School A. Witness A is currently on secondment but visits the school on a weekly basis. The child has a diagnosis of foetal alcohol spectrum sydrome, cerebral palsy and ADHD. He is a looked after child. In the classroom he receives one-to-one support from either a teacher or pupil support assistant. He does access meanstream classrooms but is supported one-to-one by his pupil support assistant. He requires an individual timetable. He is in mainstream class for up to two hours a day. She indicated that the child is

not having any speech and language therapy at present. She confirmed that he has visits from social work every six weeks, that the educational psychologist does not have a huge role and that his concentration is improving, having now reached up to twenty minutes at a time. The involvement of Doctor A at CAMHS is for the purpose of medication and review. The previous involvement of Witness C from the CAMHS team was commonplace and his work has come to an end. The school continued to use strategies on a daily basis. In addition the child has not received any input from occupational therapy or any external agency in school whilst he was in primary 2.

37. The view of Witness A was that the child did not meet the statutory criteria for a co-ordinated support plan.

Witness B

38. Witness B is a social worker based at the Children with Disabilities Unit. He has been the child's allocated social worker since 3 November 2015. He has known the family since December 2014. In evidence he confirmed the child's diagnosis of foetal alcohol syndrome and cerebral palsy. He confirmed also that the child is a looked after child. As his allocated social worker he has involvement with the child at Looked After Child Reviews but also providing support to the appellant. He confirmed that the child needs constant supervision on a one to one basis at all times. The anticipation is that his needs will remain the same. The child's behaviour has changed with age but there remains sexualised behaviour with verbalised sexualised comments.

39. One of the instances that social work provides is the opportunities for the child to focus on extracurricular activities. These directly assist the school situation as they create a positive effect in terms of allowing the child to "let off steam" but also providing the family with a period of respite.

40. Witness B confirmed that there remain issues with the child's use of words. He may not understand what he is saying and he needs assistance with this.

There will be changes with his medication as times goes on. None of what is being done could be viewed in isolation.

Witness C

41. Witness C is a clinical support worker with the Learning Disability Child and Adolescent Mental Health Service. The child was initially referred to him in April 2017. He was asked by Doctor A from the CAMHS team to work with the child regarding sexualised behaviours he displays.

42. Witness C worked with the child on a weekly basis from July 2017 to better understand appropriate behaviour in public spaces and what should be kept private. He observed the child displaying self harming behaviours, very impulsive behaviours and sensory issues. Witness C confirmed that the child requires medication which is under constant review by Doctor A. As well as working on the child's sexualised behaviour Witness C also identified sensory problems which were quite significant and an occupational therapist from the CAMHS team became involved. The sexualised behaviour primarily takes place at the child's home because he regards that as being a "safe home environment".

43. There was a plan to meet the child at school and at home after the Christmas break but this has not happened. Witness C said that the child is a "boomerang". He will have good periods but then will require further input. Significantly as the child gets older the learning gap between himself and his peers will broaden and this will have an impact upon him. He confirmed that the communication between all agencies for the child was absolutely imperative. He is a complex boy. The child's case remains open with CAMHS. Witness C pointed out that it is inconceivable that further help from the CAMHS team will not be required for the child.

The appellant

44. The appellant is the child's foster carer. He lives with his wife. They have fostered the child since he was discharged from hospital following upon birth. They plan to adopt the child but one of the concerns they have is that without

a CSP ,when the child is no longer a looked after child, there will no longer be the access to supports that they currently have.

45. The child has always required additional support. He has sexualised behaviours. Work has been done on this.

46. He also displays challenging behaviour. He is prone to “meltdowns”. His personality can change quickly. He behaves inpulsively. He has sensory issues. His concentration at school has improved since he has been placed on different medication. He can now concentrate for between 20 and 30 minutes. However he will never be fully incorporated into mainsteam school. There has been the involvement of social work, Doctor A, the CAMHS team, occupational therapy and the Cerebral Palsy Integrated Pathway. There has also apparently been a re-referral to speech and language therapy.

47. To assist sensory issues, but also to use his energies up, the child skis three times a week, horse rides once a week and swims twice a week. These are not only important insofar as physical aspects are concerned but provide him with significant self esteem which feeds into a positive influence at school. He has no ongoing occupational therapy but that is because his foster parents and the school are proactive in following recommendations. Educational Psychology are not involved at the present but the case is not closed and the child can be re-referred at any time.

48. The sexualised behaviour of the child has come into school on one occasion.

Communication between the various agencies is absolutely vital.

The submissions for the Respondent

49. Both parties helpfully provided written submissions prior to hearing on submissions. We do not intend to rehearse the whole of the submissions. The respondent’s position is that they provide significant additional support to the child. However the child’s additional support needs do not require significant additional support from one or more appropriate agencies or from

the respondent in exercising their other functions outwith education. All additional support being provided by appropriate agencies to enable the child to benefit from school education was considered to be either sporadic, minimal or of short duration.

50. Reference was made to the decision in *JT v Stirling Council (2007)* CSIH 52 and the definition of "significant".

51. In the Judgment comment was given to the definition by Lord Nimmo-Smith at paragraph 2.3 namely that "It can at least be said with some confidence that, by including this word, the Scottish Parliament intended to add an emphasis to the provision which it would lack if the word were omitted. In our view, this emphasis is better recognised by construing "significant" as importing more than "not significant." The next point of which we take note is that "significant" is an adjective which qualifies one or more other words. In its immediate context, the words which it qualifies are "additional support". Moreover the additional support is "to be provided". So the emphasis appears to us to be on the provision, rather than on the needs which require it.

52. The submission made by the respondent is that none of the supports, with the exception of the medication provided by Doctor A and the ongoing social work support to the child's foster carers, was of long duration. He is currently discharged from speech and language therapy and has no current input from CAMHS.

53. Further and in addition, the case of *WA'S Legal Rep v Highland Council* [2008] CSIH was also referred to. It was suggested as in that case there was not enough significant additional support by external agencies to meet the criteria for a CSP.

54. Further even if a CSP were put in place it would still be subject to reviews if circumstances changed e.g. funding was cut.

55. In response, the appellant submitted that the child has additional support needs arising from multiple and complex factors. Reference was made to the significant input of social work, the provision of CAMHS, and that this was not going to end shortly, the involvement of the occupational therapist, the support provided by speech and language therapy and the work of cerebral palsy clinicians. Reference was also made by the appellant to the decision of *JT v Stirling Council*. Emphasis was given that the definition of the word "significant" referring to the frequency, nature, intensity and duration of the support and the extent to which that support needs to be co-ordinated and is necessary for the achievement of the educational objectives of the child or young person's education plan.

56. The tribunal accepted the evidence of all parties here. There was not a great deal of dispute about the provision of supports in relation to the child. It was accepted that the child has a lifelong condition. He has foetal alcohol syndrome. He has cerebral palsy. He has attention deficit hyperactivity disorder and is a looked after child. He requires significant support at school. That support is on a one-to-one basis. He requires to be medicated in order to perform at school. His medication now allows him to concentrate for periods of around 20 minutes at a time. He is able to participate in mainstream school for a short period each day. He has had significant input from the Social Work Department. They continue to meet with him and the family regularly. They perform their statutory duties but also co-ordinate other functions. They have been involved in assisting to fund many of his extracurricular activities, Without these extracurricular activities he would not have the self esteem that he does at the moment. The activities include skiing, horseriding and swimming. These assist with his sensory issues, and also with his level of calmness at school.

57. He has sexualised behaviours. CAMHS required to work with him weekly for a period of a year in relation to this. In addition, he required occupational therapy who put strategies into place for him, which have assisted him at school (e.g. fine motor skills and weighted vest).

58. He has required speech and language therapy and there appears to be a current re-referral in relation to that.

59. He is under regular review by Doctor A at the CAMHS team for medication purposes. In addition, he attends the Cerebral Palsy Integrated Pathway Clinic every 6 months and has been given on daily exercises which must be completed to help him maintain a stable core and a good range of movement.

60. He suffers from impulsive behaviours and is prone to “meltdowns” at any time. All of this evidence appears to be accepted.

61. Although not all of these external agencies are actively involved at this time, all appear to remain to be open to involvement. It has been said that it is impossible to believe that the child will not require the involvement of many if not all of these agencies going forward. All of these agencies need co-ordination.

62. In the case of *JT v Stirling Council* [2007] CSIH 52 at paragraph 24 Lord Nimmo-Smith confirmed the following “In addition it seems plain, as was recognised by the Lord Ordinary, that in its context in section 2 the word “significant” is to be judged by reference to the need for co-ordination.” Reference in that case was also made to the Code of Practice, entitled Supporting Children’s Learning published in 2005. Lord Nimmo-Smith went on, in referring to the Code of Practice to confirm the following “………and obliged the Tribunal to take into account the frequency, nature, intensity and duration of the support, and the extent to which that support was necessary for achievement of the educational objectives which would be included in a CSP. If the duration of the support, on the information available to the Tribunal, was such that little or no useful purpose would be served by a CSP, once prepared, the Tribunal would be not only entitled but bound to conclude that a CSP was not required. There is no point in devoting resources to the preparation of a plan for the co-ordination of services which are unlikely to require co-ordination by the time that the plan is ready”.

63. It is the view of the tribunal that there is clearly a need for a plan here. The child's conditions are lifelong. He has benefited from signficant support. These supports have been necessary for achievement of his educational objectives. In addition, these supports will require to continue and to be co-ordinated.

64. Accordingly the reference is granted.