Health and Education Chamber
First-tier Tribunal for Scotland

Additional Support Needs

DECISION OF THE TRIBUNAL

Reference

1. By application dated 12 June 2019 the appellant lodged a reference under section 18(1) and 18(3)(b)(i) of the Education (Additional Support for Learning) (Scotland) Act 2004 ("the 2004 Act") against a decision of the respondent.

2. The reference is in respect of the decision dated 18 April 2019 whereby the respondent refused a request made by the appellant for a Coordinated Support Plan ("CSP") for her daughter ("the child").

Decision

3. The tribunal overturns the decision of the authority and requires the authority to prepare a CSP for the child within 10 weeks of the date of this decision in terms of section 19(2)(b) of the 2004 Act.

Process

4. The bundle consists of pages T1-T44, A1-A208 and pages R1-R148. I took all the papers into account in reaching the decision.

5. Following a series of case management conference calls the parties agreed that the reference should be decided by legal member alone without a hearing under Rule 37 of The First-tier Tribunal for Scotland Health and Education Chamber (Procedure) Regulations 2017 ("the rules").

6. The material facts were not in dispute between the parties. The dispute centered on whether the statutory test for a CSP in terms of s.2 of the 2004 Act had been met. The appellant's position was that the test had been met and the respondent's position was that it had not.

7. The views of the child were sought and a report from an Independent Advocate is in the bundle.

8. The appellant's and respondent's representatives lodged written submissions.

9. No oral evidence was led and I made the following material finding in facts from the documentary evidence.

Findings in fact

10. The appellant is the mother of the child.

11. The child was 13 years of age at the date of this decision. She is polite, hard-working and cooperative.

12. She lives with her parents and two siblings. She attends a mainstream high school managed by the respondent ("the school"). The child has a differentiated curriculum and mainly attends mainstream classes with some PSA support and also has access to the school's Enhanced Provision, known as the Community Resource Hub ("CRH"). After the summer break she is due to start second year ("S2").

13. The child has diagnoses of gene mutation, significant memory and learning difficulties, sensory issues, dysphagia, dyslexia, dyscalculia and significant academic delay. She has developmental coordination disorder ("DCD"), hypermobility and bowel problems. She has underdeveloped eye movements and poor eye control which causes difficulties with tracking and reading.

14. As a result of the child’s conditions she has a range of additional support and input, from the respondent as education authority and also from the NHS. She regularly misses school time due to attending medical appointments. Between starting high school in August 2019 and the end of January 2020 the child attended in excess of 30 external appointments and had two inpatient admissions to hospital. Her conditions and the difficulties they present can overlap but can be broadly categorised based on the nature of her difficulty and the input received.

Genetics

15. The child’s gene mutation is rare and not fully understood but it is suspected this may be the cause of her cognitive and physical difficulties. It is a lifelong condition.

Input

(a) Geneticist

16. The child has been attending a geneticist with the NHS board for approximately 4 years. The service is a diagnostic and assessment service. She will attend as required and the input is one to one appointments, every few years.

Learning/cognitive/sensory difficulties

17. The child’s learning, cognitive and sensory difficulties are lifelong. She has strengths in verbal reasoning, vocabulary and oral expressive language. She is able to state her views.

18. The child has marked difficulty with immediate working memory and processing speed. She can be easily distracted and display inattention to details. She has difficulty with task organisation and completion.

19. The child is severely dyslexic in reading and spelling and has a co-occuring moderate

specific maths learning difficulty. She is working on first and towards the second level of Curriculum for Excellence ("CFE") and is significantly behind S1 level in reading and numeracy. She displays some symptoms of anxiety associated with her learning difficulties and uncertain coping ability in school.

20. The child's sensory profile indicates difficulties with eye-hand coordination, difficulty distinguishing shapes and difficulties with visual tracking. The child can also be easily distracted and bothered by background noise. She dislikes new foods and has limited preferences. She has difficulty with fine motor skills and is fearful of escalators, elevators and all heights. She avoids swings and slides. She dislikes personal care/ grooming tasks and labels on clothing. She can overreact to minor injuries.

Input

(a) Educational Psychology

21. The child has had educational psychology input throughout her school education. The respondent's Educational Psychologists ("EPs") have conducted assessments and provide ongoing support to school staff in relation to curriculum planning and in relation to transition planning when the child moved to high school.

22. In January 2019 the child's parents had the child assessed by an Independent Educational Psychologist. The Independent Educational Psychologist recommended that the child have maximum additional support for learning across the curriculum to compensate for her marked literacy and mathematical learning difficulties.

23. In March 2019 the respondent's EPs carried out a cognitive abilities profile ("CAP") on the child. It was found that the child had strengths in reasoning and attention but difficulties with memory, strategic thinking, written language and in particular extended writing involving paper and pencil.

24. Strategies suggested by the respondent's EPs to support the child included extra time, help to prioritise/break down tasks, reducing memory load, providing visual aids,

repetition of learning, bridging, planning and support in organising.

25. In June 2019 a sensory profile of the child was carried out by the respondent and some additional strategies were suggested such as providing the child with a quiet safe space, providing the child with movement breaks, carrying out threading activities to develop fine motor skills/control and warning the child of fire drills if possible.

26. In November 2019 the respondent's EPs confirmed that the child benefits from support strategies to aid working memory and sensory issues, mainly with the use of visual resources. It was also confirmed that the child accesses the majority of her timetable in mainstream classes with Pupil Support Assistant ("PSA") support available when necessary. In addition it was stated that the child accesses the Additional Support for Learning ("ASL") team through supported study periods to allow the child to revisit and consolidate learning concepts as well as receive targeted input in accordance with IEP targets.

27. In November 2019 the respondent's EPs stated that their role was to provide ongoing advice and consultation to school staff regarding curriculum support. In addition they would attend on an ongoing basis Multi Agency Action Planning Meetings ("MAAPM") and engage in a collaborative process of assessment and intervention.

(b) IT support ("ASPECTS")

28. The respondents as education authority provide a service called Specialist Technology Service. The service is to provide pupils with additional support needs access to specialist technology required in order for the pupil to access the curriculum. The child has had input from the Specialist Technology Service since primary school. They provide IT support, equipment and training for staff members. In her previous school the child used a laptop with "Clicker 6" a software package designed to assist with literacy. This was later replaced with an iPad with various apps including Clicker 6 and speech to text. Effective use of the "Read and Write Gold" ("RWG") software package was identified as a short-term target to support her writing in the child's IEP dated November 2019. It was stated the child should have support in class to access and use ICT resources effectively.

The child's parents have requested that Specialist Technology Service provide "Dragon Naturally Speaking" voice recognition software but this had not been actioned by the date of submissions in this case.

(c) Occupational therapy ("OT")

29. Paediatric OT is provided. The child and her family have been known to OT over a number of years. OT have provided support to the family and school staff with strategies for independence and motor skill development. In primary school she was provided with various aids including a C Pen to help with reading, a seat wedge, a writing slope and putty for her desk to help with fine motor skills.
30. The child was assessed by OT in December 2018 prior to her transition to high school and a detailed report was produced with a number of recommendations. It was recommended that the child be provided with interactive smart board notes, given access to a lift pass and attend a pre-secondary group in the summer holidays. The child attended all 3 sessions on offer and OT also attended a meeting in school in September 2019. Following on from this it was recommended that the child be provided with an angled writing slope, adapted kitchen utensil for use in Home Economics and stools with backrests in Science and home economics. The child's mother contacted OT again in November 2019 to advise that the child's angled writing slope had gone missing and a new one was sent out to the school. As of 29/11/2019 OT considered the child's case closed but stated she could be re-referred at any time if further issues arise.

DCD/Hypermobility

31. The child's developmental DCD and joint hypermobility cause difficulties with mobility and fine and gross motor skills. It also makes her very prone to injury. She has a particular problem with her knees due to also having genu valgum (known as knock knees) and a shallow patellar groove.

32. The child dislocated her knee on 03/09/2018, 05/03/2019 and 13/052019. She had a partial dislocation (or subluxation) on 24 August 2019. She had surgery on 16 September 2019 which involved the insertion of 8 metal plates. She was in hospital for 7 days.

Input

(a) Orthopaedics

33. The child attends the paedatric orthopaedic department, part of the NHS board. Following her surgery in September 2019 she was reviewed in the orthopadedic clinic on 16/10/19, 23/10/19, 7/11/19 and 20/11/19. As at the last appointment it was recommended that the child return for xrays/scans in 6 months' time but earlier review would be accommodated if the child had a significant growth spurt resulting in a change in the alignment of her legs. The child will require further surgery in the future to remove the metal work and remains under review with the orthopaedic department.

(b) Physiotherapy

34. The child has been attending physiotherapy, run by the NHS board, since September 2018 following an initial right knee patellar dislocation. In January 2019 a report from physiotherapy stated that she was having monthly appointments for rehabilitation and was expected to be discharged within 2 months. Advice was provided to the school regarding PE and what physical exercise the child should avoid. The appellant had several email exchanges with the school and physiotherapy to pass on information regarding the child's progress and ongoing activities.

35. The child continued with physiotherapy until March 2019 when she had a second knee dislocation. The child continued to attend physiotherapy appointments, every 2 – 4 weeks. The appellant passed information to the school regarding the child's rehabilitation and ability to participate in PE as the school expressed some difficulty in getting the information from physiotherapy.

36. On 8 May 2019 the head teacher of the primary school emailed the appellant to advise he had spoken to the child's physiotherapist regarding the child's participation in PE. PE was said to be encouraged but the child was to avoid contact sports and high impact activities such as jumping. On 13 May 2019 the child returned to PE and dislocated her knee while doing a triple long jump.

37. Following on from this injury the child continued with physiotherapy fortnightly and the appellant would contact the primary school to provide updates and pass on advice. The appellant raised concerns regarding the level of communication between physiotherapy and the primary school. On 25/06/2019 the child's physiotherapist sent an email to the primary school headteacher and stated that she had tried to call him to discuss the child. She went on to state that the appellant continues to be very concerned about communication between health care and education, and is concerned regarding transition to high school. The physiotherapist stated that she did not *"feel a CSP would be appropriate however I would be willing to contribute to a child's planning meeting if you would feel this would be of any help?".*

38. Shortly after starting high school the child had a partial dislocation or subluxation of her knee on 24/08/2019. She attended physiotherapy on 10/09/2019 and the physiotherapist asked the appellant for formal permission to share information with the school. The appellant considered such permission had already been given but prepared a formal letter the same day.

39. Following the child's inpatient stay of 7 days after the surgery to her knees she continued to attend physiotherapy. A report by physiotherapy dated 03/10/2019 was sent to the school, but not copied to the parents until a few weeks later. The letter outlined the ongoing treatment, estimating that rehabilitation would take a further 8 weeks. It was suggested that the child continue exercises at school in place of PE and exercise sheets would be passed on. It was suggested the exercises should be easy to follow but for the school to contact physiotherapy if there were any difficulties. It was hoped that PE could be reintegrated within 8-12 weeks, and that once the child had returned to PE and normal activities she would be discharged from physiotherapy. It was also stated, however, that the child may well have intermittent problems throughout her life and physiotherapy input would be given as required.

40. Around 17/10/2019 the appellant was provided with exercise sheets and was asked to pass these to the school. The appellant emailed the physiotherapist to express her

concern that it appeared the child was being given responsibility for ensuring they were being done correctly at school and also requested a copy of the report dated 03/10/2019 which had not been seen by the family.

41. A report dated 06/11/2019 from physiotherapy was sent to the school to confirm a telephone discussion between the physiotherapist and the principal support for learning ("SFL") teacher on 05/11/2019. The letter confirmed it had been agreed that the main form of communication between the school and physio would be by telephone followed by a written summary report which would be sent to the school and the child's parents. It was also stated that no physiotherapy exercise were to be done at school as the physiotherapy department were unable to provide a health carer to do this with the child at school. It was recommended that during PE sessions the child would go for short walks, increasing time as she was able.

42. The appellant had not received the report or heard from the school by 11/11/19 when she contacted them by email to request an update. The SFL teacher responded to say she had spoken to the physio and that the appellant should get a letter at home. She also confirmed that the suggestion was it was most appropriate to build up stamina with increasing walking time in PE, starting with 5 minutes and increasing. It was also stated that the SFL teacher would need to check staff availability and once she had a plan she would contact again with times and targets.

43. Following a further physiotherapy appointment on 20/11/2019 a report was copied to the school advising the child had made some progress and that during PE she should be moved to more dynamic exercises and it was stated that another physiotherapist would be able to go out to the school to review the child and help to introduce the exercises into the child's timetable. On 28/11/2019 the new physiotherapist visited the school and the principal SFL teacher and two PSAs were given training on the exercises to be done with the child during PE sessions.

44. On 04/12/2019 physiotherapy completed a proforma issued by the respondents to gather information for the CSP request. The proforma confirmed the child had attended physiotherapy for the last 14 months and was progressing well with rehabilitation. It was

also confirmed that the child was using PE sessions to build strength and that a physiotherapist had attended at the school on a one-off basis to implement specific exercises to be supervised by SFL staff. The aim was stated to have the child return to PE and usual activities activities within about 6-8 weeks depending on progress. The overall educational objective was said to be to return the child fully to all physical activities in school. The support was to consist of the child attending physiotherapy appointments about once per month, that supervision from SFL was required to implement exercises in PE and that communication between SFL, physiotherapy and the child/her parents was required.

45. On 10/12/2019 the child attended a further physio appointment. A report was sent to the school to advise the child was progressing well and that they hoped they could start her return to PE classes after the Christmas holidays. The physiotherapist stated that she would wish to discuss this with the school to ensure the child is returned to a suitable activity and she would contact the SFL teacher by email to see if they could arrange a time for a telephone conversation.

46. On 17/12/2019 a further progress report was submitted to the SFL team. The report confirmed the intention to return the child to PE after Christmas and that discussions would be ongoing with the school. It was also noted that the child and her mother had been advised that there was no guarantee that she would not have further dislocations or subluxations in the future but the best way to maintain her activities and in the long term reduce dislocations is to keep her as active as possible.

47. The child attended a further physiotherapy appointment on 07/01/2020 and the appellant requested a meeting be set up with the school to discuss a staged return to PE. No meeting took place. The child returned to swimming lessons on 08/01/2020 but had to stop due to pain after 10 mins and advice was sought from physiotherapy who indicated the child may have had a further subluxation.

48. A further report dated 20/01/2020 was prepared by the physiotherapist which stated that the child had some complaints of knee aches but was still progressing well. The physiotherapist indicated that she had had a further telephone discussion with the

principal SFL teacher and it was stated that the intention was to formulate a plan of action for return to PE. It was noted that the school had been unable to complete as many of the activity sessions as had been hoped, but these had recommenced. It was also stated that the physiotherapy department hoped to be able to have the other physiotherapist return to the school to show the school some progressions that they could work on in the child's activity sessions, and also discuss a gradual return to PE with SFL and the school PE teachers. It was proposed that from 27/01/2020 the child should be completing 2 activity sessions per week and from 17/02/2020 the child should be re-introduced to 1 PE class per week starting with 10 minutes and increasing by a further 5 minutes every week until fully returned to PE. As at April 2020 the child had still not returned to PE.

(c) Orthotics

49. The child attends the orthotic department run by the NHS board. She is assessed and provided with orthotic intervention as required. She has been given insoles for her footwear to improve balance. The insoles would be of particular benefit if weight bearing in PE. The child would sometimes need to be reminded at school to transfer over the insoles if changing footwear for PE. The child attends for review whenever her feet grow and the insoles become too small. She would normally have two 30 minute appointments six weeks apart after a growth spurt.

Bowel problems

50. [This paragraph has been removed by the Chamber President to protect the privacy of the child under rule 55(3)(a)(b)(c) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]

Input

(a) Gastroenterology

51. The child attends paediatric gastroenterology, run by the NHS board. She attends a clinic at least every 6 months but it can be more often depending on her symptoms. The treatment will be required for many months and possibly years and the child will continue

to be reviewed by gastroenterology as required. [Part of this paragraph has been removed by the Chamber President to protect the privacy of the child under rule 55(3)(a)(b)(c) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]

Underdeveloped eye movement

52. The child has underdeveloped eye movements possibly as a result of her underlying poor muscle tone and hypermobility. Her tracking and saccadic eye movements are poor and this impedes her reading. She also wears tinted glasses which replaced coloured overlays she previously used to assist her while reading.

Input

(a) Orthoptics

53. The child attends a colorimetry clinic in the orthoptics department, run by the NHS board. They provided the child with her tinted glasses and also with exercises to assist with her poor movement control. The child was assessed at the clinic on 13/01/2020. The orthoptist prepared a report dated 20/01/2020 which was sent to the child's parents (but not copied to the school) confirming the child's eye movements were very poor and also stating that she had reviewed the exercises the child is doing, and along with mum's suggestion, it would be best for the child to try her eye movement exercises during her support for learning time in school. The orthoptist states that she "*would still be hopeful for some improvement in her eye movements which are undoubtedly impeding her progress in reading*". The report also states that the child would be reviewed again in 6 months' time.

54. Following on from the appointment the appellant emailed the principal SFL teacher at the school on 13/01/2020 to enquire if the exercises could be done at school. The school replied on 20/01/2020 to say they could see if the exercises could be done in supported studies or some of the time the child is in the CRH rather than in PE. As at April 2020 the exercises had still not been carried out in school.

55. In compiling information for consideration of the appellants request for a CSP the respondent contacted the child's orthoptist. By email dated 05/02/2020 the same orthoptist who prepared the report dated 20/01/2020 responded to provide information.

56. The orthoptists confirmed that the child had initially been referred in 2012 and had been re-referred in 2016 when the school were considering dyslexia. She had a trial with coloured overlays which helped her reading and was given exercises for her undeveloped eye movements. The child was also seen in 2017 when she was prescribed the tinted glasses to use instead of the overlays. The orthoptist also stated that child had been reviewed in January 2020 and new glasses had been ordered.

57. The orthoptists goes on to state that the child is "*still carrying out exercises at home and at school, although these may not help much more due to her underlying poor muscle tone and hypermobility. We plan to review her in 6 months' time but she will likely be discharged from our service at that time (Actually, only still seeing her because of Mother's insistence)*". The orthoptist also confirms that the child's poor eye movements are likely to be long term.

The request for a CSP

58. In March 2018, when the child was still in primary 6 the question of opening a CSP for her was first discussed, in the context of planning for her transition to high school. On 05/06/2018 an initial transition meeting was held but staff from the high school did not attend. Another transition meeting was fixed for 14/11/2018 and again staff from the high school did not attend and the meeting did not go ahead. On 05/12/2018 the appellant handed in a letter dated 04/12/2018 to the primary school requesting that the child be assessed for a CSP.

59. A CSP meeting was held at the high school on 27/02/2019. None of the health professionals involved in the child's care attended the meeting, and neither did the Specialist Technology Service. Completed proformas or reports from various health professionals were discussed and the appellant felt some reports were inaccurate or

different to what she had been told.

60. The overall conclusion of the respondent’s staff who attended the meeting was that a CSP was not required and a Child’s Plan with frequent MAAPMs would be best to support the child’s needs. The Child’s plan was intended to link to her IEP. It was suggested that health could be requested to submit regular reports for a Child’s Plan. School staff did note that it would be beneficial for health to be coordinating things more effectively amongst themselves in terms of appointment times and sharing information so that the amount of time the child misses at school and disruption to home life could be minimised.

The Educational Psychologist at the meeting had concerns on how they could have MAAPMs with health not attending. The child’s parents express concerns that a Child’s Plan would not be concrete or legally binding.

61. Following the meeting a report was sent to the respondent’s CSP advisory board who decided that the child did not meet the criteria for a CSP and a letter of refusal was sent to the child’s parents on 18/04/2019.

62. No child’s plan was prepared. A review meeting took place on 29/05/2019 when transition plans were also discussed. Staff from both schools and educational psychology were present but nobody from health attended. Following the meeting a detailed single service assessment document was prepared outlining the child’s needs and support required, with reference to the wellbeing indicators (SHANNARI).

63. Under the Healthy indicator the issues with the child’s knees, her attendance at orthopeadics and physiotherapy and the involvement of many health professionals are noted as a concern. The desired outcome is stated to be minimization of disruption to school life. It is also stated OT and physiotherapy will be in regular communication with education services and will be included in future school meetings as part of the MAAPM process, along with any other agencies in the future. In the section which details who is going to take actions to achieve the desired outcome it states the appellant is to seek advice on best way to ensure communication and support from health services through the child development team.

64. There was a further transition meeting on 11/06/2019 and a meeting on 26/06/2019 to review IEP progress at the end of term. The IEP considered had a start date of March 2019 and review date of June 2019. The targets included literacy and numeracy targets as well as a target relating to transition preparation.

65. After the child started high school and following her surgery on her knees there was a further MAAPM meeting at the school on 03/10/2019. Health professionals, including physiotherapy did not attend. The appellant updated the school on the child's health and passed on information from physiotherapy regarding the gradual build-up of hours on return to school. The review of the child's IEP was discussed and it was suggested this would focus on life skills but the child's parents felt literacy and numeracy targets should also be included.

66. On 16/12/2019 a draft IEP was sent to the appellant. The IEP states the child's health conditions affect her ability to take part in some curricular areas. The first target in the IEP is to improve motor skills/movement opportunities in collaboration with physiotherapy. Strategies for support were to include input from physiotherapy and liaison between physiotherapy, the appellant and the school. The second target was to ensure the child can use ICT effectively to support learning. Strategies to support included that the child would have access to suitable ICT equipment and support in class to ensure she is using it effectively. The final target was to improve life skills through taking part in hospitality in a small group.

67. A further MAAPM was held on 19/12/2019. Physiotherapy did not attend the meeting and neither did educational psychology. The respondent undertook a further review of the need for a CSP at the end of 2019. They gathered further information via proformas and reports. The education authority decided in February 2020 that the test for a CSP was not met.

The child's views

68. The child's views were obtained by an Independent Advocate from Partners in Advocacy. Due to the Covid-19 pandemic restrictions the Independent Advocate could not meet the child in person but had a Skype videocall with the child on 17/04/2020 and an initial draft report was sent to the child as an audio file. The child's additional comments were added on 27/04/2020. The child was asked a series of questions which had been agreed in advance by the representatives for both parties.

69. The child stated there are things that she likes about school, such as History and Geography but other things she does not like, such as Science and English. She does not like science because she does not get PSA support and the teachers' writing is hard to read, and all writing is done on the board.

70. The child also does not like the fact that she misses quite a lot of classes for medical appointments and does not get time to catch up on what she has missed. The child also feels that she needs a PSA in every class and does not get this. She has a PSA in some of her humanities classes, sometimes in English and not at all in Science. She needs to leave class early to avoid crowds and to use the lift. She feels she needs a PSA between classes but does not get one.

71. The child also feels she does not have the correct equipment to use in school. She has to use a school laptop but hardly ever gets one. When she does get a school laptop it is a different one each time and she finds they are slow and do not support the software she uses for her reading and writing. She also feels she needs text-to-speech and speech-to-text software of good quality which works "*without causing stress*". She also feels audiobooks would be helpful but these are not used and none of the teachers do reading with her which she thinks would be helpful.

72. The child also stated that her SFL teacher was meant to do eye tracking exercises with her from January but these had not been done. She also felt she should have a physiotherapist during school because her knees keep dislocating. She stated that she has a PSA present when she is doing the physiotherapy and they were meant to follow the plan from her physiotherapist but this is not followed by the school. She said that the plan was meant to get her back to PE but because it was not followed and the teachers

are not sure what she can do she has not been able to do PE for a year and a half.

73. The child stated that she felt it would be helpful if staff knew about changes to her health or treatment. . She also stated that she felt the school would say they would do things but they don't and "*everything is left to just be a mess*". [Part of this paragraph has been removed by the Chamber President to protect the privacy of the child under rule 55(3)(a)(b)(c) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]

Reasons for the Decision

74. I was satisfied that there was sufficient evidence available to reach a decision on the reference. The parties had agreed that there was no dispute about the material facts and a hearing was not required. Both parties had clearly gone to considerable effort in preparing the case statements and submissions and the documentary evidence was plentiful. The child's views were also clearly stated in the Independent Advocate's report. I have made the findings in fact from the material available to me.

75. Having found the facts that I did it was necessary to consider the sole issue in dispute between the parties, which briefly put was whether the child satisfied all the conditions for a CSP.

Conditions for a CSP

76. Section 2 of the 2004 Act sets out the conditions which must apply before a CSP is required. The parties agreed that the conditions set out in s.2(1) (a) –(c) are met in this case and I found as matter of law that the respondent is responsible for the child's education and that the child has additional support needs arising from complex and multiple factors that are likely to continue for more than a year.

77. The dispute between the parties was whether the condition in 2(1)(d) was met. That condition, in summary, is that the child's needs require significant additional support to be provided (i) by the respondent operating as education authority as well as operating

in some other capacity (for example social work) or (ii) by the respondent as education authority and by an appropriate agency (in this case the NHS). It was accepted that it was part (ii) that was relevant and the question was whether the child's needs required significant additional support from the respondent and the NHS. The appellant's position was that the child's needs did require significant additional support and the respondent's position was that they did not.

78. The respondent did concede in their case statement (paragraph 22, R134) that the support that the child receives from the education authority represents significant additional support. The remaining question therefore was whether the support the child received from the NHS board fell within the definition of significant additional support.

Significant additional support

79. In their written submissions both parties referred to the case of *JT v Stirling Council* [2007] CSIH 52 which is the leading authority considering the definition of significant additional support. The appellant also referred to the Code of Practice: Supporting Children's Learning: Statutory Guidance on the Education (Additional Support for Learning) Scotland Act 2004 (as amended). I considered both the code of practice and *JT* in reaching my decision.

80. The court in *JT* refers to the Code of Practice and states that in determining what amounts to significant additional support consideration must be given to the frequency, nature, intensity and duration of the support and the extent to which the support was necessary for the achievement of the educational objectives that would be included in the CSP. The court also states that the word significant in it's context in section 2 of the Act is to be judged by reference to the need for coordination.

81. The Code of Practice states that where a child has several professionals involved from the one appropriate agency, such as an NHS Board then the cumulative effects of those professionals involvement may amount to significant additional support from that agency, even although the input from each professional individually is not significant.

Frequency, Nature, Intensity and duration of support

82. I considered that these factors pointed towards a conclusion that the support from the

NHS board was significant. The child has had input from several professionals over a number of years and continues to have ongoing input. While some of the professionals are involved less frequently (eg Genetics) it is clear that the child has very frequent input from health professionals. She attends multiple appointments throughout the school year and misses a lot of time at school.

83. The nature and intensity of the support varies depending on the professional involved. One the one end of the scale she sees genetics for assessment and diagnosis and on the other end she has had invasive investigations and treatment from gastroenterology, surgery from orthopaedics and intensive one to one exercises and rehabilitation from physiotherapy.

84. The child's conditions are lifelong and she will continue to have input from health professionals throughout her entire school career. Although it may have been initially thought that for example physiotherapy would be for a short period of rehabilitation, due to the nature of the child's conditions physiotherapy input has been ongoing for more than 18 months and is most likely to continue for a considerable period longer. This is due to the ongoing risk of further dislocations/subluxations.

Educational objectives

85. In considering the extent to which the support provided was necessary to achieve the educational objectives in the CSP I considered it was helpful to consider the educational objectives in the Child's last 2 IEPs. In the IEP dated March 2019 one of the child's objectives was to make progress in reading and the support required to achieve this included IT support and also use of aids provided by OT (C Pen) and orthoptics (tinted glasses). I also considered that the eye exercises recommended by orthoptics to seek to improve the child's tracking and reading ability were also clearly relevant to the educational objective of improving the child's reading.

86. In relation to the more recent IEP dated November 2019 the first target in the IEP is to improve motor skills/movement opportunities in collaboration with physiotherapy. This clearly draws a specific link between the child's educational objectives and support from physiotherapy. Strategies for support were to include input from physiotherapy and liaison between physiotherapy, the appellant and the school. The second target was to

ensure the child can use ICT effectively to support learning and a link was clearly made between support from IT/OT in order to reach this educational objective.

Need for coordination

87. I consider that in this case there is clear evidence of a need for coordination of the support in order to meet the child's additional support needs. This is due not just to the wide range of professionals involved in supporting the child but also the extent of the support she needs to reach her educational objectives. It has been noted by a number of the professionals supporting the child that she has a significant amount of time away from school to attend appointments and the child's own view was that she did not have the opportunity to make up what she had missed. A level of coordination between the respondent and the NHS board around the timings of her appointments to minismise disruption would clearly be advantageous.

88. Furthermore it was clear that there had been attempts at coordination in the past but these had not always been fruitful. The respondent has proposed other methods of coordinating support such as a child's plan or a MAAPM but despite assurances that other agencies will be involved the NHS professionals have not attended the majority of the meetings. The appellant has argued that she has been left to coordinate between health and education and the evidence provides some justification for her view.

89. The evidence also supports the view that on occasion the information given to the family and the school has been conflicting (eg orthoptics) and this also points toward a need for coordination. Support from physiotherapy and communication between the school and physiotherapy has been variable in the past and the respondents have not always followed advice correctly which on one occasion contributed to the child's further injury. The child has not been supported to do the eye exercises she was recommended to do in school and despite plans for a re-introduction to PE this has still not happened.

Cumulative effect of professional involvement

90. Finally, although the input the child receives from some of the NHS professionals involved may not be significant in their own right when the cumulative effect of the input from all health professionals supporting the child is considered it is very clear that this

amounts to significant additional support.

Conclusion

91. Overall I consider that this is a child who requires significant additional support from the respondent acting as education authority and the NHS board and that support needs to be coordinated in order for her to reach her educational objectives. Given that this decision has been issued during the school holiday period I have allowed a period of 10 weeks for the CSP to be prepared.