Health and Education Chamber
First-tier Tribunal for Scotland

Additional Support Needs

DECISION OF THE TRIBUNAL

FTS/HEC/AR/24/0203

List of witnesses

For the appellant:

The appellant

For the respondent:

Inclusion Manager (witness A)

Head Teacher of school B (witness B)

Educational Psychologist (witness C)

Head Teacher of school A (witness D)

Reference

1. This is a reference by the appellant challenging the respondent's decision to refuse to make a co-ordinated support plan (**CSP**).

Decision

2. We confirm the decision of the respondent that the child does not require a CSP in accordance with section 19(2)(a) of the Education (Additional Support for Learning)(Scotland) Act 2004 (**2004 Act**).

Process

3. The reference was made in August 2024. An online hearing took place over three days, including oral submissions. This was a conjoined hearing, with another reference, that other reference being about a placing request refusal. A separate decision is issued for each reference.

4. We considered all oral and written evidence. The written material is found in a combination of the placing request reference bundle, which consists of the following page numbering: T001-102; A001-084; and R001-144 (including supplementary written submissions from the respondent) and the CSP reference bundle, consisting of the following page numbering: T001-028; A001-005 and R001-008. Any bundle references in this decision are to the placing request reference bundle (the main one used at the hearing), unless otherwise stated.

5. The reference was managed to a hearing in two case management calls. The child was unable to provide her views to the Tribunal. Instead, a non-directed advocacy report was produced on the Tribunal's direction (T053-080). Given the nature of this reference, we have not drawn from the advocacy report.

Findings in Fact

General findings in fact

6. The appellant is the mother of the child. The child lives with her mother and her three older siblings. The child was born in 2019. The child is enrolled as a primary 1 pupil at school A, and has been attending there since August 2024. Prior to attending school A, the child attended the nursery since she was aged 3. The child attended First Steps Playschool for two days per week between August 2023 and summer 2024, as part of an enhanced transition to school A.

7. In May 2024, the appellant asked the respondent to make a CSP for the child. By letter of June 2024 (CSP bundle, T021-022), the respondent refused that request.

8. In January 2023, the child was diagnosed with global developmental delay. In around September or October 2023, the child was diagnosed with chromosome 1q21.2 microduplication syndrome, a lifelong genetic condition associated with severe developmental disability. The child does not currently meet the diagnostic criteria for intellectual disability, but this is expected to happen.

9. The child's verbal communication is limited. She is able to use some single words and some phrases. The child is sometimes self-directed and impulse driven. The child requires support with her personal care.

10. The child sometimes puts too much food in her mouth at once, giving rise to a risk of choking.

11. The child can find tasks that involve sharing with others difficult. She also struggles with group work sometimes. She sometimes finds it difficult to maintain concentration on a task.

12. The Schedule of Growing Skills Assessment (**SOGS**) is a developmental screening tool which measures how children are developing in line with their age. The child was tested using SOGS by witness C, educational psychologist, who observed the child and played with her and who also consulted the appellant and education professionals who had contact with the child. The test was completed by December 2023, and the results were reported in and Assessment of Wellbeing and Child's Transition Plan (R006-R021, at R012-013).

The child and school A

13. There are 178 pupils on the roll at school A. The child's class has a total of 22 pupils in it (including the child).

14. The child is in primary 1 at school A. The child is at the Early Level of the Curriculum for Excellence (**CfE**). This level is appropriate for her age and stage. There are some children at school A who are at Early Level of the CfE up to primary 3. The curriculum in primary 1 is largely play based.

15. In addition to her classroom, the child has access to a play room and a sensory room.

16. The play room is opposite the child's classroom. It is similar to the child's classroom, but with a few more play areas, such as a sand tray, home corner, block play area, a small library and tables for small group work. Pupils from primaries 1 and 2 access the play room. The play room can be used for 1:1 teaching support as well as for group work. The child now prefers to go with some of her classmates to the play room and interact there with them. The child no longer requires an adult to facilitate her play.

17. The sensory room was added to school A around five years ago. It has a large fish bubble tube, sensory cables with lights, a sofa, a small teaching table, a large dark tent with sensory toys, a small library stand with books.

18. The child has some time in her timetable four mornings per week in the sensory room.

19. The child requires differentiation of the curriculum due to her support needs. This includes the use of visual cards, object signifiers and singalong (a communication system to help children to learn vocabulary). In addition, specialist communication techniques are used with the child, as outlined in the report by the Speech and Language Therapist (R121-123).

20. When she started primary 1 in school A, the child did not say many words and would mostly lead people to what she wanted. The child's speech and language has improved significantly during her time in primary 1. She is now able to say three or four word sentences, using her words consistently and in context.

21. The child can find it difficult to engage in a task for a prolonged period. The child's engagement time in class has increased since she started in primary 1: she can now engage in a task for up to 15 minutes alongside her peers. Where the child's engagement in a task reduces, she can easily be re-directed back to the task.

22. Witness C's involvement with the child consists of attendance with other professionals at regular planning meetings for the child.

Appropriate agency involvement for the child

23. The child's gross and fine motor skills are in line with her age and stage of development. The appellant has made a request for an assessment of the child by an occupational therapist (**OT**). An OT has not yet been allocated to carry out this assessment. There is currently no active input for the child from an OT.

24. The child receives input from a speech and language therapist (**SLT**). The SLT prepared a profile report relating to the child, dated March 2025 (R121-124). Part of that report identifies techniques for assisting the child with understanding, communication and

social interaction and play. With one exception, all of these techniques were already being used by school A staff by the time that report was prepared. There is currently no active input by the SLT for the child.

25. The child receives support from the local department of community paediatrics. The main most recent component of that support was an assessment of the child's intellectual functioning across a number of areas, using the Behaviour Assessment System Third Addition (**ABAS-3**). This is a clinical diagnostic assessment tool used by the National Health Service. It is not an educational assessment tool.

26. In December 2024, the child was assessed using ABAS-3 by a consultant paediatrician. At the point of this assessment, the child was 5 years and 23 days old. For education purposes, the child was found to be at an age of less than 2 years against the following factors: communication, functional pre-academic, health and safety, self-care, self-direction and social. For school living and leisure, she was assessed as being at 2 years and 2 months. For motor skills, the child was assessed as being at the 3 years to 3 years 2 months range.

27. The conclusion of this assessment (at A080-081) is that these results help to explain the child's issues with concentration, distractibility, impulsivity danger awareness and the need for supervision.

28. The next planned paediatric input for the child will take place in May 2026, when the child will be reviewed with a view to a possible confirmation of intellectual disability.

Reasons for the Decision

29. The parties agree that the child has additional support needs, as defined in section 1 of the 2004 Act. We agree, as supported by our findings in fact at paragraphs 8-12 above.

30. The appropriate point in time for consideration of the evidence is at the date of the hearing: the law is clear on this. The burden of establishing that the respondent's decision should be confirmed falls on the respondent.

31. The evidence given by all witnesses was credible and reliable. Witnesses A, B C and D are all experienced educational professionals, and we are in no doubt that they are skilled witnesses who are well qualified to state the opinions offered in their written and oral evidence. This case turns on the interpretation of the written and oral evidence.

The test for a CSP

32. This is found in section 2 of the 2004 Act. A child or young person requires a plan if four conditions are met. These are set out in paragraphs (a)-(d) of section 2(1). There is no dispute between the parties over the conditions in sections 2(1)(a)-(c): it is agreed that these conditions are satisfied here. We also agree that this is the case, given the findings in fact recorded at paragraphs 8-22 above.

33. This leaves the condition in section 2(1)(d). The appellant argues that this condition is met. The respondent asserts that it is not. The wording of this condition is as follows:

    (d) [the child or young person's additional support 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.

34. There was no suggestion that section 2(1)(d)(i) applies in this case. There is no evidence for the need for support from the respondent in the exercise of any of its non-education functions. Instead, the appellant argued that section 2(1)(d)(ii) applies.

35. Case law on section 2(1)(d) assists with its meaning, in particular the cases of *JT v Stirling Council* 2007 SC 783 (Inner House); *City of Edinburgh Council v Additional Support Needs Tribunal* 2012 CSIH 48 (Inner House) and *Aberdeenshire Council v CD* [2023] UT 28 (Upper Tribunal). All three cases are, of course, binding on us.

36. The following main points emerge from these cases:

   a. The word 'significant' is to be judged by reference to the need for co-ordination (*JT*, paragraph 24).

   b. In order that section 2(1)(d) applies, the significance requirement must attach to each element within whichever of section 2(1)(d)(i) or (ii) applies. For section 2(1)(d)(ii), this means that the additional support required from the appropriate agency(ies) must be significant <u>and</u> the additional support required from the education authority themselves must also be significant (*CD*, paragraphs 16-20).

   c. When considering whether the additional support required from the appropriate agencies is significant, the support from all of these agencies combined must be considered (so there is no need for the support from each appropriate agency to be significant) (*CD*, paragraph 27, following the relevant part of *Supporting Children's Learning: Statutory Guidance on the Education (Additional Support for Learning) Scotland Act 2004 (as amended)*, 2017, **Code of Practice**). Clearly, where a single appropriate agency (such as a health board) makes provision of more than one type, all provision types are considered together for the purposes of the significance assessment.

   d. The significance requirement applies to the extent of the provision and not its effect on the child (*JT*, paragraph 24).

   e. The significance of the support should be measured by its <u>frequency, nature, intensity and duration</u> (*JT*, paragraph 25, following the Code of Practice wording).

   f. Any health input must be relevant to the educational needs of the child before it may count for the purposes of the CSP test (*City of Edinburgh*, paragraph 13).

   g. What is relevant is not the additional support being <u>provided</u>, but what is <u>required</u> to meet the additional support needs of the child (the plain wording of section 2(1), confirmed in *CD*, paragraph 27).

Application of the CSP test

37. Turning to the evidence here, it is clear that significant additional support requires to be provided by the education authority: see our findings about that support in paragraphs 13-22 above.

38. On additional support from an appropriate agency (the local National Health Service board), there are three possible sources of health staff input: from the OT and SLT and from community paediatrics.

39. On input by an OT, in our findings in fact at paragraph 23 above, we reflect the evidence that there is no such input at this point, nor is there any evidence to suggest that it is required. Indeed, the evidence of witness D is that the child's gross and fine motor skills are in line with the child's age and stage. We accept that evidence, and it is not contradicted.

40. On input by an SLT, while this has taken place recently, that input is no longer happening, nor is it required. We refer to our findings in fact at paragraph 24 above. Witness D was very clear in her oral evidence that all of the techniques advised by the SLT in her recent report (R121-124) were already being practised in relation to the child, with one exception, namely the advice to work on short story sequences (R123, one of the recommendations). Even in relation to that single recommendation, there is no direct input from an SLT since the purpose of the report is to offer advice to those working with the child (for example staff in school A) to directly apply the techniques set out there (in other words so that teaching staff can provide the support). The appellant's representative conceded (properly in our view) that once advice such as is contained in this report is passed to school staff, the resulting input is by school staff, and is therefore educational, and not health input, for the purposes of its source under section 2(1)(d) of the 2004 Act.

41. We turn now to input from the community paediatric service. This input is set out in our findings in fact at paragraphs 25-28, above. The most recent such input was to complete and report on the child's functioning (from education and home perspectives) using the ABAS-3 test. However, we can place only very limited weight on the outcome of this assessment. No skilled witness was called to give oral evidence about the assessment outcome or about how it should (if at all) translate into the educational environment in any practical sense. Witness C made it clear that it is a health assessment, not an education one, and this must be the case as it was completed by a consultant paediatrician. This means that none of the witnesses who gave evidence are qualified to give an opinion on it. This leaves us with the written evidence on its own (the reports of the paediatrician at A080-084, the ABAS-3 assessment being at A080-081).

42. Taking the three input sources (from an OT, an SLT and community paediatrics) together (as parts of the provision by a single appropriate agency), we are in no doubt that the 'significance' test is not met. There is no evidence of a current need for input from any of these three sources relating to the educational provision for the child. The only evidence of frequency relates to paediatric input, which is planned to take place 18 months after the last input (and is therefore infrequent). In any event, there is no evidence to suggest that the educational input from the paediatric service would reach any level of intensity or last longer than the next review point. Future SLT and OT input may never be needed and so the stage of considering frequency, nature, intensity and duration for those services is not even reached.

43. Finally, we do not accept the appellants representative's argument that attendance by a health professional (such as the child's SLT) at child planning meetings constitutes significant support, without evidence to indicate the level of input that professional is likely to bring to such meetings. No such evidence is available here.

44. This means that the test in section 2(1)(d) of the 2004 Act is not currently met here, which means that the child does not require a CSP. In these circumstances, we must (under section 19(2)(a) of the 2004 Act) confirm the respondent's decision (under section 18(3)(b) of the 2004 Act) to refuse the appellant's request to make one.

Paragraph 6 in this decision have been edited by the Chamber President for reasons of privacy under rule 55(3)(b) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018.