Health and Education Chamber
First-tier Tribunal for Scotland

Additional Support Needs

DECISION OF THE TRIBUNAL

FTS/HEC/AR/23/0005

Witness List:

Witnesses for Appellant:

Speech & Language Therapy Team Lead (witness A)

Chief Executive Officer at school A (witness B)

Witnesses for Respondent:

Head of Centre, Family Learning Centre (witness C)

Educational Psychologist (witness D)

Continuous Improvement Officer for Inclusion (witness E)

Reference

1. This is a reference in relation to a placing request lodged in February 2023. It is made under Section 18(3)(d)(a)(ii) of The Education (Additional Support for Learning) (Scotland) Act 2004 (**The 2004 Act**).

2. The appellant made a placing request for the child to attend school A, an independent school. A formal letter refusing the placing request was issued by the respondent in November 2022.

3. The respondent relied upon the grounds in Section 3(1)(f) of Schedule 2 of the 2004 Act in refusing the placing request.

Decision

4. We are not satisfied that the ground for refusal exists, and we overturn the decision.

5. We require the respondent to place the child in school A with immediate effect or by such other date as the parties agree.

Process

6. Case management calls took place in April, June, July and August 2023. The hearing took place in person over 2 days in October 2023.

7. Written submissions were provided by both parties in advance and supplemented with additional written submissions following the hearing.

8. Two joint minutes of agreed facts were lodged at T041 – T045 and T046 – T048.

9. Witnesses gave oral evidence to supplement their written statements as follows:

   Statement of appellant at A031 – A042
   Statement of Witness A at A043 – A052
   Statement of Witness B at A053 – A071
   Statement of Witness C at R108 – R116
   Statement of Witness D at R122 – R138
   Statement of Witness E at R117 – R121

10. The Joint minute at T041-T045 confirms that the facts and opinions in Paediatric report at A026 to A028 dated October 2023 and Occupational Therapy report (undated) at R096 to R098 were agreed as true and accurate.

Findings in Fact

11. The appellant is the mother of the child aged 3 years old.

The child

12. The child is a three-year-old girl with a diagnosis of a rare genetic mutation which causes epilepsy, global development delay and learning disability. The condition affects the child's fine and gross motor skills including the ability to walk, and she uses mobility aids. The child is non-verbal. **[Part of this paragraph has been removed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

13. The child is currently enrolled at school C, a mainstream private nursery.

14. The child is not meeting her developmental milestones. She can sit unsupported but has very little movement. She needs cushions behind her when sitting up or there is a risk of her hurting herself. The child cannot get into the sitting position without assistance.

15. The child cannot stand unaided and she uses a standing aid for half an hour to an hour each day. She has no awareness of danger.

16. The child has significant mobility difficulties and uses both a standing/walking frame and a specialist wheelchair. The wheelchair is not self-propelling and requires third party manual operation. She uses a special chair both at home and at nursery. The child needs this specially designed support chair as she does not have the balance to sit up and support herself when sitting. She requires additional aids to promote support whilst both standing and seated. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

17. A monitor is used at night which sets off an alarm if the child's oxygen level drops too low. It also monitors her heartbeat, which alerts if her heartbeat drops low or goes too high, which may indicate that she is having a seizure.

18. The child needs help with all aspects of personal hygiene. She has no understanding of or interest in toilet training and wears nappies.

19. The child is non-verbal. She pushes things away and gestures to communicate her intentions.

20. The child consumes solid food but frequently has phases when she refuses to eat. The frequency of the child's eating difficulties varies but, on average, this occurs on a bi-weekly basis. She has gastric issues which are being reviewed by her Paediatrician. These issues have affected the child's weight gain, and she may require a feeding tube in the future.

21. The child was on a ketogenic diet from 6 months old, but she stopped this diet around January 2023. She is not currently on any seizure medication. She has seizures particularly when she is unwell, but they are not as regular as they once were. If she has more than 3 within a 12 hour period she requires rescue medication.

22. The child needs 1:1 support. If left for any length of time she becomes agitated and gets upset. She motions with her body, looks at her hands, puts her hands together, and makes moaning noises. The child needs constant supervision.

23. When emotionally dysregulated, the child makes loud noises, screams or cries, and throws her head and arms back. The child has recently started biting herself, pulling her hair and biting others when dysregulated.

24. When the child becomes dysregulated, she needs adults to help her become calm. If she reaches a heightened state of dysregulation, it can be difficult to calm her. This can last up to an hour. Close adult support means staff familiar with her behaviour can intervene and redirect her prior to her becoming distressed.

25. The child has epilepsy and continues to have seizures at times. The child is under the care of a Consultant Neurologist and is reviewed regularly.

26. The child takes regular medication. **[Part of this paragraph has been removed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

27. The team around the child (**TAC**) includes paediatricians, a speech and language therapist (**SALT**), occupational therapist **(OT**) and educational psychologist (**EP**).

28. The child requires regular input from physiotherapy to keep her joints moving. She has low muscle tone and cannot bear weight. The child benefits from repetition of targeted actions and movement of the joints carried out regularly by staff at the nursery, which are essential for progress to be achieved.

29. The child's gastric and bowel issues cause discomfort, which is relieved by rebound therapy and hydrotherapy. Discomfort causes distress and leads to dysregulation. When the child is uncomfortable, she cannot engage in learning.

30. The child's potential for learning is unknown. Close monitoring, supervision and support is necessary to understand the child, her genetic condition, her responses to interventions and her potential.

31. The child would benefit most from a responsive approach by nursery staff, OT and SALT.

32. The communication approach currently recommended by SALT is on-body signing but has not been discussed with her parents, and the family have not seen SALT for several months.

The child's condition

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

33. The child has an extremely rare genetic disorder. The child has a diagnosis of developmental and epileptic encephalopathy caused by her genetic disorder. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**
The child's genetic disorder is not generally progressive but the abnormal production of the protein is a constant lifelong anomaly. The effect of the disorder through impaired neuronal activity reduces the capability to learn at the expected rate; reduces the ability to remember learned information; impedes communication often including an inability to develop speech; and affects balance and control of body movement. Visual impairment is frequently reported. There is often an impact on the digestive system resulting in gastric reflux and constipation. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

34. The child would benefit from being in a pool at least once a week for a creative learning session and/or relaxation session. Hydrotherapy can help alleviate the child's constipation thus enabling her system to function more effectively. Regular swimming would also allow the child to maintain good respiratory health as

recurring respiratory infections are common in individuals with her genetic disorder. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

35. Children like the child with altered muscle tone are at risk of secondary musculoskeletal complications and monitoring is vital. This allows collaborative and comprehensive assessment of physical needs to influence equipment provision, postural care, and consistency through the school day and at home.

36. Brains of individuals with the child's genetic disorder tend to grow to a normal size, but the development of neural synapses is impaired. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

Placing request

37. The appellant made a placing request for school A in October 2022.

38. The respondent refused the placing request by letter dated November 2022.

39. School A is not a public school.

40. The respondent is responsible for the child's education.

41. The respondent proposes to meet the child's needs at school B, an additional support needs classroom within a mainstream nursery. This place was offered in July 2023.

School A

42. School A provides preschool and school services for children with profound learning disabilities where their barriers to learning include severe and/or complex health needs.

43. The current combined preschool and school role at school A is 18 pupils. Most children have very rare or unknown conditions for which the prognosis is uncertain. Health and learning services are delivered in a responsive, collaborative and flexible way to minimise the impact of barriers to learning while exploiting emerging learning, abilities and learning styles and capabilities to maximise development and the opportunity for the child to reach their full potential.

44. The child attended school A's early intervention programme (**EIP**) from January 2022 until October 2023. The purpose of the EIP is to integrate therapeutic activity in day-to-day family life to improve outcomes for children with neurological impairments in all areas of development. It is a holistic programme delivered by a multi-professional team (A058 – A059).

45. The child would join a small nursery class of 3 pupils if attending school A. She would share activities with primary school pupils to promote learning and social development. Primary school classes usually comprise 6 pupils.

46. School A has prepared a draft risk assessment and treatment plan in anticipation of the child's attendance. Due to the complexity of the child's disorder and the effect on both verbal and physical communication abilities, school A requires an extended period of observation and assessment to explore the barriers to her learning, capabilities and learning styles, but this would not delay her admission.

47. There is an extensive range of specialist equipment to support the child's learning, physical, functional and communication requirements at school A. The child would have her own indoor wheelchair, standing frame and outdoor cycle. If required, she would have specialist walking or mobility aids and supportive seating.

48. The child would have access to an onsite swimming pool and a large trampoline (rebound therapy) at school A, which has established benefits for children with the child's genetic disorder CAMk2B to promote joint movement, good respiratory health and bowel movement, thereby reducing discomfort and promoting wellbeing to enable learning. Staff at school A will undertake a detailed assessment to identify the most appropriate equipment to address the child's needs in collaboration with the child, her parents and those providing the equipment. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

49. Staff at school A are highly trained in working with children with profound and multiple learning disabilities, with life threatening and life-limiting conditions. School A has frequent visits from relevant specialists from across the UK and sharing of learning from external visits, training and education. Therapists have their own expert areas of interest such as augmentative and alternative communication (**AAC**), assisted technology, cerebral visual impairment, early powered mobility, aquatic therapy, swim school, rebound therapy, sensory processing, speciality equipment and 24-hour postural care.

50. At school A, the child would have ready access to the hydrotherapy pool and flexibility as to how it is incorporated into her weekly timetable. Recently, one of the onsite physiotherapists who is a trained swimming teacher for children with disabilities, took the child for a short swimming session in the pool along with her father as her parents were concerned that the pool would be overstimulating and cause her upset. The child managed this session well.

51. At school A, the child can have trampoline based rebound therapy which she enjoys, and which motivates her to work in a variety of positions, for example sitting and high kneeling rather than attempting these positions on a mat.

52. Uniquely, School A has five specialist paediatric physiotherapists, three OTs, two SALTs (with a third being recruited), and a nurse onsite daily working alongside the specialist teaching and learning team. This provides a highly responsive service, meaning experts are available immediately if required, short focused multi-disciplinary assessments can be scheduled and adaptations to equipment

or access to therapeutic interventions such as rebound or hydrotherapy can be made quickly. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

53. School A also has visiting specialists for subjects such as yoga, art and music therapy. They have links to bring in relevant specialists from a range of external providers.

54. School A supports and encourages local community access, hosts family days and promotes inclusivity.

55. Therapy is integrated into routine learning activities with targeted individualised sessions at school A as necessary. Therapists work with children during timetabled activities, literacy and numeracy, art, topic work, PE, free play sessions and holistic sessions as well as more specialist sessions such as rebound and hydrotherapy. This allows a combined approach to gross and fine motor activities, communication and learning.

56. School A has experience of children with another condition, which has a similar presentation to the child's genetic disorder. The child can become upset suddenly and pushes herself backwards and has started to pull at her hair, for which she was referred to a psychologist. As these traits are similar to this other condition, school A staff have experience to promote safety and positive behaviours to address these challenges. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

57. School A uses international and national assessments and outcome measures, which would monitor the child's progress in relation to gross motor function, postural assessments and upper limb assessments. These assessments are completed at regular intervals appropriate to the child's age and needs profile. School A also uses video analysis and multi professional notes to track progress.

58. At school A, all staff have attended extended pragmatic organisation dynamic display (**PODD**) training. PODD is used consistently throughout the school and across the centre by the full team. This is a robust communication tool whereby the vocabulary is organised in such a way that it supports communication at any time. PODD has been developed to be used alongside aided language stimulation (**ALS**), an evidence based AAC method.

59. The long term aim of PODD or any robust AAC system is to support the development of communication autonomy to enable the individual to say what they want to say, to whoever they want to say it to, whenever and however they chose to say it. There are no prerequisite skills for introducing AAC.

60. AAC is a dynamic process which evolves based on the child's needs and responses to strategies. Presentations of PODD are tailored to meet each child's diverse needs. Learning across school A is delivered through PODD allowing children to be active participants in their learning rather than passive observers.

61. Speech and language therapists are employed by school A and closely monitor children's communication and make necessary adjustments as part of a dynamic assessment process to ensure maximum progress. Additional communication strategies and approaches are embedded across the school and used as appropriate. SALT and OT teams would collaborate to ensure a good understanding of the child's sensory needs so that her ability to communicate and access learning is maximised.

62. At school A, the child would be grouped with peers in a variety of ways taking into account her learning style, sensory needs, physical ability, cognitive ability and interests as well as her chronological age.

63. The child finds noisy environments overstimulating and becomes anxious. She would be placed in a nursery class with a maximum of 3 to 4 children at school A. These children have similar learning, developmental and communication difficulties to the child.

64. In each class, there is at least one member of staff with each child as well as a qualified specialist additional support needs (**ASN**) teacher. The non-teaching staff in the class are all registered with the Scottish Social Services Council (**SSSC**) and are trained learning, care and therapy practitioners. Additional therapy staff support activities when required.

65. Onsite SALTs are involved in assessment and eating and drinking plans for children attending school A. There are concerns that the child may not be able to chew her food properly and further investigation is planned by the child's SALT. Both SALTs at school A are dysphagia trained and able to support the safety of the child's eating and drinking difficulties.

66. If the child were to attend school A, the child's additional support needs necessitate SO4 Early Learning Programme rate for an early years placement at £1,552.24 per week. A 43-week year equates to £66,746.32 per annum.

67. If the appellant elects to transport the child to and from nursery and claim expenses from the respondent, a mileage allowance is paid at 45p per mile.

68. The distance between the appellant's current home address and school A is 6.6 miles.

69. The costs for parental transport is calculated by number of miles x 0.45p per mile x 4 journeys per day x 5 days per week x the number of weeks in the school year.

70. Parental costs for the child to attend school A would be £59.60 per week and £2,554.20 per annum if the child's parents were to transport her to and from school each day.

71. The costs of the child travelling to school A each day by taxi and escort would be £900 per week and £38,700 per annum.

School B

72. School B is a mainstream provision with an additional support needs classroom. **[Part of this paragraph has been removed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

73. School B operates 48 weeks of the year. The age range at school B is 6 weeks old up to primary 1. The school currently has 64 pupils comprising 6 babies, 20 children aged 2-3 years and 38 children in the 3-5 age group.

74. There are 4 main rooms at school B in addition to a wellbeing room, a sensory room and a parent room. There is an outdoor space with a wellbeing room and an outdoor lunchroom.

75. If the child were to attend school B, she would be in the additional support needs classroom where there is 1 member of staff to 3 pupils. At present, 6 children attend supported by 3 members of staff, so the present ratio is 1:2. The maximum class size is 8. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

76. Staff in the additional support needs classroom comprise one SSSC registered staff member and additional support needs assistants (**ASNA**) who do not have any specific qualifications. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

77. Children attending the additional support needs classroom have a wide variety of additional support needs. They have been identified through the respondent's needs-based pathway review. One pupil currently uses a wheelchair like that used by the child but is not in the additional support needs classroom. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

78. At school B, 42% of the children with ASN are in the 0–3-year-old age range and 23% are 3-5 years of age. A child who previously attended had a standing frame, a floor frame and a wheelchair, but was not in the additional support needs classroom. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

79. The additional support needs classroom is a large room with direct access to both the garden area and the sensory room. There is a table in the middle where an adult can sit to support all children. There is a storeroom just off the additional support needs classroom where equipment can be stored. **[Part of this paragraph has been changed by the Chamber President for privacy under**

rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]

80. Staff at school B have experience of using a supportive buggy and a trike such as the child might use and the corridors are wide, enabling accessibility for this type of equipment.

81. If attending school B, the child would be able to use the sensory room. The room can be adapted to the needs of the child. If other adapted equipment was required for the child, school B would make a request to the OT.

82. School B has a wellbeing room which is a calming room. This is used if children become overwhelmed and they need to regulate with a member of staff. It is also used for children who have input from a physiotherapist, OT or SALT. It can be used as a sleep area.

83. School B is fully accessible for wheelchair users. The indoor space is on one level.

84. School B is an outdoor registered nursery. There is a large outdoor space around the nursery accessible for all children. The outdoor space has been tarmacked to enable wheelchair use. There is an area of grass which may be a barrier to the child's use of the outdoor space.

85. A number of different communication systems are used at school B. Staff are trained in Hanen and Picture Exchange Communication System (**PECS**). Staff have been provided with information on PODD through training videos. One child is using PODD in the additional support needs classroom. Other children use Makaton. Staff have been introduced to on-body signing as a method of multi-sensory communication support. Staff are trained in a wide range of communication tools. Staff receive training from SALT to support children's individualised communication needs. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

86. The SALT linked to school B attends one day approximately every 6 weeks (A032) and can drop in as required. A further SALT from the complex feeding team sometimes works with some of the younger children. There are no onsite SALT or OT staff members.

87. Staff in school B are trained by SALT how to work with a child and advise about appropriate strategies. The SALT uses video effective reflective practice by videoing staff communication and engagement with children and providing feedback to identify and evaluate the use of strategies.

88. If the child was to attend school B, the school would have a discussion with her parents to draw up a health care plan for her eating and gastric issues and provide appropriate support to encourage eating. A nutritionist can be consulted to provide advice at school B.

89. A Getting It Right for Me plan (**GIRFME**) would be created at school B to obtain information relevant for all parties working with the child. In addition, TAC meetings are held every 12 weeks when other agencies are invited along with the child's parents to facilitate effective communication. A number of agencies support the needs of children at school B including a family partnership nurse, social work, OT, physiotherapy, SALT and complex feeding team. These are all external services.

90. The child could access hydrotherapy and rebound therapy at other local authority schools. The respondent would provide transportation and the child's key person at school B would accompany the child with another member of staff. These therapies would be timetabled in the GIRFME plan. There would be no additional cost to the respondent for accessing these provisions. No other children at school B have ever accessed these facilities.

91. An additional ASNA would be required if the child attends school B. That member of staff would either be redeployed from existing staff within school B or allocated from newly recruited employees. The member of staff would be an additional resource for the class, not specifically allocated to the child.

92. Two ASNA would be available at school B for the child's dignity and safety to be maintained while being changed or assisting with personal care. Physiotherapists who attend weekly at school B would provide a plan for staff to implement for the child. Physiotherapists work with OTs to ensure that staff are implementing the child's plan.

93. OTs attend weekly at school B and work with staff to facilitate a child's plan. OT sessions normally in a clinic, can take place at school B.

94. In consultation with physiotherapists and OTs, a wide range of experiences are offered at school B to work on fine motor skills, hand-eye coordination, sensory and water play and can be tailored to meet the individual needs of the child. Movement is offered to all children on a daily basis as part of the curriculum and if there is a specific physiotherapy or OT plan, this is incorporated into the child's GIRFME plan.

95. At school B, there are 3 first aiders and paediatric fulltime first aiders. They would undergo seizure training facilitated by the health visitor to ensure up to date knowledge if the child was to attend.

96. The child would have an allocated key worker at school B but would build relationships with all staff members. Staff work with outside agencies to facilitate and develop knowledge and there is at least one training day per month throughout the year.

97. School B operates each week between 08:00 to 17:45 for 48 weeks in a year.

98. The appellant visited school B in April 2023.

99. The child resides 4.8 miles from school B.

100. Parental transport costs for the child to attend school B would be £43.20 per week and £2073.60 per annum.

101. The taxi and escort costs for the child to attend school B would £960 per week and £46,080 per annum.

Reasons for the Decision

102. It was a matter of agreement, and was established in evidence, that the child has additional support needs in terms of Section 1 of the Education (Additional Support for Learning) (Scotland) Act 2004 (the 2004 Act).

103. The respondent's refusal to grant the placing request is based on the ground of refusal in Schedule 2, 3(1)(f). For this ground to be established, the respondent must satisfy us that all 4 of the conditions in Section 3(1)(f)(i) to (iv) apply to the facts of this case.

104. It was a matter of agreement between the parties, and is established by agreed facts, that the conditions in paragraphs 3(1)(f)(i) and (iv) apply. We will therefore deal with only 3(1)f(ii) and 3(1)f(iii).

(ii) the authority are able to make provision for the additional support needs of the child in a school (whether or not a school under their management) other than the specified school.

105. We are not satisfied that this condition applies.

106. We have no doubt that school B, which has an excellent inspection report and is a good nursery provision would be able to meet the needs of many children with additional support needs. We do not think it is equipped to meet the needs of the child, whose needs are complex, rare and severe.

107. We heard unchallenged evidence from witness B that in addition to the direct neurodevelopmental impact of the disorder, it is frequently associated with seizures and epilepsy resulting in secondary epileptic encephalopathy. It is essential that the child's seizures are monitored as epileptic encephalopathy may cause permanent brain damage whereas the developmental encephalopathy caused by abnormal synaptic activity causes abnormal brain functioning. This is a fundamental point when considering the barriers to and opportunities for the child's learning. We accepted that this means that the focus is on mitigating the developmental encephalopathy/neurodevelopmental impact of the child's genetic disorder. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

108. As this disorder has only been discovered in the last 6 years, evidence about prognosis or what may reduce or mitigate the effect of the disorder on learning, development and health is still emerging.

109. We agree with witness B that the child's learning partner needs to be actively engaged in worldwide networks, have the capacity and capability to process emerging evidence, have the proficiency to consider how this may or may not

apply to the child's individual circumstances and have the expertise and agility to try and test new techniques as and when they emerge and appear to be beneficial to promote the child's learning development and health, in order to maximise her potential.

110. We accept witness B's evidence that although the effect of the disorder is to reduce neural activity including neuroplasticity, the fundamental building block of learning, there is still the potential opportunity in early and mid-childhood, while the brain is growing, producing neural synapses and strengthening selected pathways, to take advantage of this unique time to intensively promote the child's learning and development.

111. The child's brain appears to be growing as expected and there is no evidence of significant brain damage from her epileptic encephalopathy. Accordingly, it can be assumed that she has the capacity to learn. A concern is that if the synapses in the brain are not developed in childhood, the brain may shrink in adolescence (cerebral atrophy A056).

112. We accept the evidence of witness B that one of the most important effects of the child's genetic disorder is on memory as the abnormal protein has a significant effect on memory consolidation and less so on memory acquisition or recall. Accordingly, the child is highly likely to have great difficulty in achieving learning but also retaining learning. Frequent assessment and review of the child's learning achievements is necessary, potentially with frequent relearning other than simply consolidation or refreshing of learning. The child currently demonstrates functional memory in relation to environments, people and objects. Exploration of this capacity is required as soon as possible as it may be a strength that will facilitate learning and development. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

113. We accept that the child's needs may unexpectedly change, providing challenges and opportunities requiring prompt reassessment and an adapted response to meet those needs and capitalise on breakthrough learning.

114. The respondent relied on evidence from witnesses C, D and E. We are satisfied that school B is a very positive learning environment but there are key areas where the child's needs would not be met in this placement. The level of complexity of the child's additional support needs is such that specialist and highly trained staff are required to be proactive in assessing the child's needs and promoting skills. The child is demonstrating learning new skills in several areas, motor progress, communication progress, awareness of the world around her and increasing interactions with others. It would be incorrect to make assumptions because her condition is so rare. Our view is that the staff at school B do not have sufficient expertise or knowledge to anticipate the child's developmental needs and act timeously to reinforce her learning. This is based on their experience of children with very complex needs, their qualifications, the lack of onsite specialist advice (from SALT and OT in particular) and their understanding of both the child's needs and condition.

115. Of concern to us is the fact that there is no adapted play equipment for children using wheelchairs in the outdoor space at school B. Although play equipment was described as being accessible, this is different to having adapted equipment specifically designed for children using wheelchairs. Witness C acknowledged that they do not have adapted play equipment but said that she would, in consultation with OT, identify equipment needed. It would take time both for the assessment and the acquisition, in our view, and in the meantime the child would not have equipment specific to her needs. This indicates a failure by the respondent to assess the equipment needed for the development of the child's motor skills and overall physical development.

116. The evidence shows that the child can and is learning and that no one knows her potential at this stage. It is difficult for the child to demonstrate or communicate this to others. It would be highly beneficial to the child, given her potential memory difficulties, to reinforce and develop her learning as it occurs and revisit her support and learning plan immediately, to stop new learning disappearing as a result of her likely memory difficulties. Witness C described school B's approach in a way which indicated that the staff would react to the child's needs rather than anticipate them, for example in relation to the acquisition of adapted equipment.

117. We are persuaded by the evidence provided by the appellant's witnesses who used comparators in the limited findings from medical research, that the issue for the child may be laying down new memories and neuroplasticity. Witness A referred to the least 'dangerous presumption' as an approach to be used as there is still a lot to learn about the child, her potential and the genetic condition. We agree that this approach is likely to develop the child's full potential.

118. We accept the appellant's evidence that the child needs full-time one-to-one support given the level of complexity of her multiple needs. It is also a matter of agreement that the child needs one-to-one support (T042). The evidence of witnesses C and E conflicted in relation to the level of support which would be provided should the child attend school B. Witness C was clear that the child would receive one-to-one support and that an additional ASNA would be placed in the additional support needs class for that purpose. Witness E stated that there was sufficient staff at school B at present if the child was to attend even without an additional member of staff. He indicated that if an additional ASNA was required, he had a mechanism to readily deploy someone for the benefit of the whole class. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

119. Witness B was of the view that the child would immediately have one-to-one support 'if that was required'. He stated that he was willing to place an additional ASNA in the additional support needs class 'to increase the ratio…to reassure the family'. He understood that there are 4 members of staff in the additional support needs class, which conflicted with the evidence of witness C that there are 3. Witness C referred to the child needing support most of the time, but the evidence clearly suggests the child cannot be left unsupported at any time. We are not confident that school B understands the complexity of the child's condition so that the child would receive the level one-to-one support that she needs at school B. **[Part of this paragraph has been changed by the Chamber President for privacy**

under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]

120. We were also concerned about the level of staff qualifications in school B (paragraph 79). When asked whether the complexity of the child's condition would require a high level of specialist care to enable her progression, witness C acknowledged that and advised that the authority work with partner organisations such as OT and SALT who have the ability to support any staff needs.

121. We are concerned that staff at school B do not have the necessary knowledge and experience required to respond to the child's very complex needs. The evidence of witness C was that the additional support needs class has a maximum capacity of 8 children and there are currently 6 children in attendance. She ruled out the possibility of other children being added to that room, but we were not confident that the room had sufficient capacity or staffing to ensure that the needs of the child would be met, particularly in relation to her mobility, responding to her communication and identifying areas of learning and response. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

122. Witness C provided photographs of the facilities at school B. The photographs were taken when there were no children present. We could not form a view about the space that would be available for the child to use equipment and move freely on the floor from any evidence provided but it does not alter our view about the suitability of school B.

123. We are also concerned about witness C's assertion that the sensory room would always be available to the child. That appears to us to be overoptimistic.

124. School B did not appear to have sufficient input from outside agencies to meet the child's needs. The child would benefit from a responsive approach when she initiates a new movement or response. A quick professional response to access and adapt teaching is advantageous and will reinforce learning. Hydrotherapy and rebound therapy available are likely to be highly beneficial to the child, particularly when they can be used regularly and as required. School B has never used such therapies before and would need to access them offsite. That would require the child travelling with two members of staff. Travelling time and the availability of staff to transport may negate the availability and frequency of these therapies at school B.

125. Witness C did not provide evidence about how often the child would be able to access external facilities nor the expertise of staff teaching or supervising these offsite facilities. No assessment of those facilities has been undertaken by school B relative to their use by the child. Such therapies are likely to bring the child significant benefit when delivered onsite as they can be accessed flexibly as the need arises.

126. In relation to communication approaches, we were impressed by the clear explanations provided by witness A. She explained that although the child's understanding of cause and effect is not yet established, her professional view is that it is essential that a robust system of communication is in place for her to have

the best chance to develop communication skills. In her view, the appropriate system is PODD, which is most effective when used consistently by all staff. Witness A stated that on body signing recommended by the child's current SALT is less appropriate given the child's significant motor difficulties. We accept that PODD should be used to allow expressive as well as receptive language to develop so that the child can communicate with a wide range of adults.

127. At school B, the approach to communication appears reactive and widely varying. A wide range of communication tools are being used which witness C advised was to enable each child to communicate using tools best suited to that child. Witness D told us that 'at this stage we are teasing out what [the child] will respond to. It's trial and error'. This mix and match reactive approach to communication may mean that staff may struggle to support the child consistently, which is essential to her development. As only one member of staff is currently using PODD in the additional support need class with another child (paragraph 88), we do not know what the general level of skill of staff is, and the child would not have an immersive experience of PODD. The evidence from witness D was that children with communication needs at school B are introduced to the easiest system and then moved onto something with more communicative potential in a linear progression. We accept the evidence of witness B that, especially for a child with complex needs, learning is not necessarily linear, and the usual rules do not apply. This is a key issue in helping the child to realise her potential. **[Part of this paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]**

128. Given that the child's potential is unknown, to allow her to develop a means of expressing herself through a robust AAC system and any other modality is crucial. This will enable her to develop and communicate her personality and allow her wishes to be known. This relies on the development of expressive communication. We do not think that school B can meet this need.

129. Accordingly, we conclude that the authority are not able to make provision for the additional support needs of the child in a school (whether or not a school under their management) other than the specified school.

3(1)(f)(iii)

It is not reasonable, having regard both to the respective suitability and to the respective cost (including necessary incidental expenses) of the provision for the additional support needs of the child in the specified school and in the school referred to in paragraph (ii) to place the child in the specified school.

Suitability

130. School A is a purpose-built school with specialist expertise and experience to meet the additional support needs of the child. The onsite integrated provision from a wide range of specialist services which is highly responsive to each child's needs meets the needs of the child in a manner which cannot be provided by school B for the reasons given above. Witness B has initiated planning, produced assessment reports and contacted the research team abroad for further information. School A's approach is proactive and comprehensive. **[Part of this**

paragraph has been changed by the Chamber President for privacy under rule 55(3)(b) and (4) of the First-Tier Tribunal for Scotland Health and Education Chamber Rules of Procedure 2018 (schedule to SSI 2017/366)]

131. The evidence of witnesses A and B indicates that it is difficult for the child to demonstrate her learning. We are not satisfied that school B would have the experience of children with such complex needs to notice and record subtle steps of learning and to reflect on that. They would need to seek assistance from outside agencies such as SALT to discuss developments and advise on how to optimise and reinforce the child's learning. The evidence from school B was that TAC meetings take place every 12 weeks and visits from SALT, OT or other professionals can be requested if necessary but are not more than weekly. That does not compare with the ability of school A to react to developments as they arise as they have onsite staff to do so.

132. The paediatric specialist's evidence (A026-A028) was agreed as true and accurate. She agreed with the appellant that the child may respond better to the way of working at school A, where the development of movement is incorporated into everyday nursery play and activities. She provided evidence that the child has a complex neurological condition which would benefit from the stability and predictability brought by that way of working. She also acknowledged the benefit to the child of on-site SALT, physiotherapy and OT as staff working with the child will require to vary care provision dependent on her needs.

133. We were impressed by the evidence provided by witness B in relation to the planning that had taken place to meet the child's needs should she attend school A, the research undertaken in relation to her condition and the assessments which had taken place in relation to the provision of education to meet her needs while engaging with a range of professionals who are onsite and able to interact immediately with the child to her benefit. The overall approach at school A was proactive whereas we had the impression from the evidence provided that the approach at school B was reactive. It is within the knowledge of the tribunal that obtaining equipment, and arranging multi-agency meetings takes time and is unlikely to happen within the week timescale described by witness C. This is of crucial importance in relation to the child as time is of the essence to maximise her brain development for all of the reasons described in detail by witness B.

Cost

134. Cost of the provision of the additional support needs of the child in school A are the cost of fees (£66,746.32) and transport costs of either parental transport (agreed at £2554.20) or taxi and escort costs (agreed at £38,700). This makes a total cost per annum of either £69,300.52 or £105,446.32.

135. Accepting the evidence of the respondent, that there will be no additional cost, other than transport costs for the child to attend school B, the additional costs will be £2073.60 for parental transport and £46,080 per annum if the child travels by taxi with an escort.

136. The additional cost to the respondent of the child attending school A rather than school B would be either £67,226.92 or £59,366.32, depending on whether a taxi and escort is needed or parents transport her

137. Witness B advised that the payroll cost for 25 hour a week ASNA is £20,500 but there would be no additional cost to the local authority as those assistants are already recruited.

138. Given that we do not think that school B can meet the child's needs to realise her full potential, the costs are reasonable considering the child's complex needs and, in our view, the ability of school A to meet these needs.

139. We do not accept the respondent's submission that the difference between schools A and B is negligible. For the reasons outlined above we consider that school A has a level of provision not equalled by school B in relation to meeting the needs of the child. The difference in provision necessary to meet the child's needs is significant and justifies the additional cost of school A.

140. We conclude that it is reasonable having regard both to the respective suitability and to the respective cost including necessary incidental expenses of the provision for the additional support needs of the child in the specified school and in the school referred to in paragraph (ii) to place the child in the specified school.

141. Accordingly, this condition does not apply.

142. We have regard to Section 1 of the 2004 Act in making our decision. School education includes, in particular, such education directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential. At school A, there is a considered plan for the child rather than an undeveloped and trial and error approach at school B. The expectation of staff at school A is that the child will develop to her full potential. They will respond and adapt as necessary and do not see that there are any limitations to the child's development.

143. Accordingly, we conclude that the respondent has not satisfied us that all four constituent conditions of the ground of refusal are met in this case.

Appropriateness

144. Having concluded that the grounds for refusal of the placing request have not been established by the respondent, upon whom the onus of proof falls, we do not need to consider the second stage of appropriateness in all the circumstances.

145. Accordingly, we overturn the respondent's decision to refuse the placing request and we require the respondent to place the child at school A with immediate effect or by such date as the parties agree.